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Contemporary Rural Social Work

Regular Issue

Volume 7, Number 2 (2015)

Dedicated to Sarah Hendrix

Peggy Pittman-Munke
Editor-in-Chief

It is with great pleasure that the editorial staff of CRSW bring you the 2015 regular issue of the journal following our special issue on promoting environmental justice.

Before we discuss the contents of this issue, it is with a sense of sorrow and loss that we mourn the death of one of our CRSW reviewers, Sarah Hendrix, and at the same time celebrate her life. Sarah, her husband, and younger daughter were murdered by her son in their home in rural Corbin Kentucky in spring of 2015. Sarah was Kentucky born and bred, grew up in Lexington, and studied at both the University of Kentucky and the University of Louisville. She was an urban person, as much as one can be urban in Kentucky, until she accepted a position at Union College in Barboursville Kentucky in eastern Kentucky.

Sarah embraced rural living and her rural students with great joy and curiosity. She became active in her community, not just in social services organizations, but in the Corbin farmer's market as she partnered with her husband to market and sell honey from their own beehives. She became very interested in economic development in the region, especially in the rural empowerment zone legislation and the implications for her area of Kentucky. She worked hard to understand the culture of both the region where she lived and the culture and context of the program where she taught. In her teaching she showcased the culture and achievements of the region.

CRSW was very important to Sarah, and she often assigned articles to her students. She spoke with great pride about her connection to the journal as a reviewer and looked forward to the day when she too would have an article in the journal. At the time of her death she was just beginning a case study on rural empowerment zones. Hers was a life well lived as well as a life cut short. I know she would want us to enjoy the splendid array of articles in this issue, a true buffet of gourmet delights for the mind.

In the first of our feature articles, **Building Collaboratives with Southern Rural African American Churches through the Integration of the Interorganizational Collaborative Framework**, Alex Colvin and Angela Bullock explain the important role that the rural Black church often plays in the lives of many African Americans, frequently functioning as an informal

helping network in meeting emergency service needs for this group. This article provides a review of the constructs of the Bailey and McNalley-Koney Interorganizational Community-Based Collaborative Framework. Additionally, this paper explores action-oriented measures for integrating constructs into practice to build interorganizational collaboratives with southern rural African American churches. This article will be especially useful for social service providers working in small rural areas where there are few professional social service agencies and services.

The second article, **Longitudinal Description of Developmental Youth Assets and Substance Use: A Cohort Study of Rural Youth** by Michael Vimont addresses the need for local data to guide strategies to enhance the well-being of the youth of the area. As a concept, developmental youth assets is increasingly used in measuring the psycho-social health of adolescents. This longitudinal study focuses on a cohort of over 200 youths residing in a rural community located in northeast Ohio. This five-year study observes trends of eight assets and the use of three substances. Results show that a decrease in asset scores took place between the sixth and eighth grade while the use of substances increased between the eighth and tenth grades. Additionally, outcomes show that youths coming from households without two parents have lower assets scores and higher substance use rates compared to youth residing in two-parent households. Strategies used by this community upon obtaining results are discussed.

In the next article, **Evaluation of the Demographics, Socioeconomics, and Satisfaction Levels of Recipients at a Rural Food Bank**, Michael J. Lyman and Jeongah Seo present a study that assesses the demographics, socioeconomics, behaviors, environment, and satisfaction of food bank clients as a way to inform food bank administrators about where their services could be more efficiently focused. Unfortunately, very little has been published in the research literature about levels of recipient satisfaction at food banks in any settings, but especially in rural settings. This descriptive study used existing demographic and socioeconomic data from intake forms at a rural food bank, in addition to the responses of a convenience sample of 44 foodbank recipients to the Client Satisfaction Questionnaire (CSQ-8). The data were used to assess the socioeconomic characteristics of recipients at a rural food bank and their satisfaction level with services provided. Findings indicate high levels of satisfaction among these food bank recipients. Also, small older-adult-dominated households reported higher overall income than larger households with working parents and children. Findings suggest that food banks focus their efforts, especially outreach, on the needs of young families who do not receive regular government benefits such as Social Security.

Two university professors, Tammy Piche and Keith Brownlee, and a practitioner, Glenn Halverson, from Thunder Bay in Ontario, Canada combine their expertise to bring us **The Development of Dual and Multiple Relationships for Social Workers in Rural Communities**. This article, written from the Canadian perspective, explores the commonalities of practice issues related to ethics on both sides of an international border. They explain that mental health professionals who work in small, rural communities often have to contend with dual and multiple relationships. The more integrated service providers are within the community, the more likely they will encounter overlapping personal and professional relationships with

clients. Although there is extensive literature on the potential risks of dual and multiple relationships, little empirical evidence exists which addresses the contextual factors that specifically lead to these relationships in rural social work practice. This qualitative study explored the experiences of twelve social service providers practicing in northern and northwestern Ontario. Findings provide some insight into the complexity and dynamics of dual and multiple relationships in small towns, as well as worker perspectives on the specific contextual circumstances that result in mental health workers encountering these relationships. The unique contribution of this paper to the literature is to highlight factors that increase the likelihood of dual and multiple relationships when they are not as obvious as a clear and immediate conflict of interest. Greater clarity about such precipitating factors will contribute to supervision, training, and sound policy development informed by contextual sensitivity.

In our fifth article, **Self-Efficacy and Mental Health Services Provided by Rural and Frontier Oncology Social Workers**, Lindsey R. Overstreet, Diane A. Kempson, and Carol J. Hermansen-Kobulnicky present a pilot study that explores the relationship between self-efficacy and professional behaviors of a non-random membership sample of the Association of Oncology Social Work (AOSW) who practice in rural and frontier settings (n=19). The New Generalized Self-Efficacy (NGSE) scale was used to measure provider self-efficacy; a researcher-designed questionnaire was used to assess the professional behaviors of conducting mental health assessments and providing supportive counseling to individuals diagnosed with cancer. Pearson correlation and two-sample t-tests were used to analyze data. While study results did not elucidate relationships explored, results revealed a disparity between participants' overall high sense of professional preparedness and comfort conducting mental health assessments and the regularity with which they perform these functions of oncology patient care.

In our next article, **Future Care Planning Practices of Aging Services Professionals in Rural Appalachia**, Natalie D. Pope, Jacquelyn Lee and Diane N. Loeffler discuss a growing area of social work practice. Planning for future care is an important aspect of professional practice with older adults, and social workers play a key role in helping elders engage in future care planning (FCP). This study examined geriatric social service professionals' practices and perspectives on helping older rural Appalachians plan for care needs in later life. Semi-structured interviews were conducted with 14 case managers who live and work in southeast Ohio, a part of rural north central Appalachia. Themes related to efforts made to assist elders with FCP include: 1) valuing client self-determination, 2) developing positive helping relationships, and 3) using initial crises to encourage FCP. Practice implications for rural social work professionals are included.

In our seventh article, **Rural Older Adults and Functional Health Literacy: Testing Self-efficacy, Knowledge and Skills Resulting from Hands-on Health Promotion**, Michele L. Dugan-Day, Susan C. Dollar, and Wafaa A. Kaf introduce us to an increasingly important topic for social workers working with older adults. Functional Health Literacy (FHL) involves the knowledge, skills and belief in self-efficacy to use health care information in self-care. FHL is critical for rural older adults since they are at risk of poor health care outcomes. As part of the Senior Health University project, we measured the FHL of rural older adults before and after educational sessions that included hands-on skill building. Ninety-eight participants aged 60 and

older were recruited from five rural congregate meal sites over two years. Survey methods allowed for paired sample *t*-tests of FHL variables. Findings included significant post-training increases in FHL, suggesting the potential benefit of FHL training for rural older adults. Andersen's (1995) Behavioral Model of Health Services Use guided this study of the effects of health promotion on health services use, standardization of practical measurement tools, and examination of modalities in rural settings. Research is needed to test the relationship of increased FHL and use of health services by rural participants and to explore the role of online resources and service use in vulnerable older adult populations.

In the eighth and final article of the issue, **Qualitative Experiences of Rural Postpartum Women and Implications for Rural Social Work**, Christopher D. Gjesfjeld, Addie Weaver and Kathy Schommer bring us rural women's often overlooked perspectives about their access to maternity and associated health care services during pregnancy and the postpartum period. Semi-structured interviews with 24 mothers residing in a rural North Dakota county were conducted to understand their perspectives about both accessing healthcare services and parenting children in a rural context, with emphasis on understanding these mothers' experiences using non-rural maternity care. Thematic analysis of qualitative interview data led to the emergence of three core themes. First, mothers in the sample minimized geographic barriers they had to overcome to access healthcare despite describing significant travel and weather challenges. Second, mothers expressed concern over the lack of affordable and flexible childcare in their rural community. Finally, mothers described different experiences within rural and non-rural settings, noting specific advantages and disadvantages of each. Although these findings cannot be generalized to other rural mothers, this article points out how local qualitative inquiry can inform and improve the competency of social work services within rural communities.

In an important area of CRSW, the Practice Note section, Margaret F. Sloan, Karen A. Ford and Daisha M. Merritt bring us critical material related to the impact of policy on practice. In **Shifts in Practice Based on Rapid Re-Housing for Rural Homelessness: An Exploratory Study of Micropolitan Homeless Service Provision**, based on interviews with rural homeless service providers, the authors examine how policy has created shifts in practice for organizations serving homeless populations. Homeless individuals find a decreasing opportunity for assistance while awaiting Rapid Re-Housing. Some organizations, dependent on Rapid Re-Housing monies, are facing a lack of funding to pay for general homeless care provision. Organizations are creating care networks to address requirements of the new policy in addition to pooling resources in underserved areas.

In the Teaching Note section of CRSW, Peter Kindle, CRSW's hardworking book review editor, shares his rationale for **Teaching Students to Write Book Reviews** and includes a book review assignment that has been effective in developing student authors. He argues that one value associated with his work for CRSW preparing book reviews for publication is the increased capacity to develop this skill in undergraduate and MSW-level social work students. After graduation, student authors ($N = 21$) agreed that acceptance for publication improved their self-confidence, increased attention to their studies, and enhanced their practice.

Another important Teaching Note is contributed by John Miller in **Integrating Service, Community, and Teaching: Inspiring Students While Building a Mentoring Program for African American Youth**. This author shares the various social work practice skills he used to design and effectively implement a community-based local mentoring program for African American adolescents. This program served as a case study for social work students who practice in rural areas to learn about community development since his program lacks formal rural community practice training module in its curriculum. He details the process of building the assignment and provides practical examples and recommendations for social work faculty on how to infuse community service experience into the classroom.

I think you will agree that this issue is truly a gourmet feast for the mind. And as everyone knows, gourmet feasts require great desserts. For dessert, Claudette Lynn Grinnell-Davis reviews Leah Schmalzbauer's *The last best place? Gender, family and migration in the New West*, Peter Kindle reviews Michael R. Daley's *Rural Social Work in the 21st Century*, Karen Harper-Dorton reviews Don E. Albrecht's *Rethinking Rural: Global Community and Economic Development in the Small Town West*, and our Poetry Editor, Dr. Danielle Dubrasky selected nine poems for our delight.

Building Collaboratives with Southern Rural African American Churches through the Integration of the Interorganizational Collaborative Framework

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Abstract. The rural Black church often plays an important role in the lives of many African Americans and frequently functions as an informal helping network in meeting emergency service needs for this group. This article provides a review of the constructs of the Bailey and McNalley-Koney Interorganizational Community-Based Collaborative Framework. Additionally, this paper explores action-oriented measures for integrating constructs into practice to build interorganizational collaboratives with southern rural African American churches.

Keywords: interorganizational collaboration, rural, African American, churches

Today, many African American congregations, in addition to meeting spiritual needs, are extensively involved in practical service provision (Cnaan & Boddie, 2001). Cnaan, Sinha, and McGrew (2004) found that almost nine of every ten congregations, regardless of size and ethnic composition, engage in at least one form of social service provision. Furthermore, Bositis (2006) found that African American churches were heavily involved in directly providing social services such as: food banks (71%), clothing banks (66%), prison ministry (58%), drug abuse counseling (46%), and child care (36%). Yet, many southern rural African American churches face challenges in providing these practical services (Bositis, 2006), in part due to social, economic, and geographic factors (Blank, Mahmood, Fox, & Guterbock, 2002).

Investigation of rural African American life has noted that these communities are among the poorest of the population (Lichter, Parisi, & Taquino, 2012). For example, Lichter et al. (2012), in a 2011 analysis conducted through the National Poverty Center, reported that more than 400 rural counties in the United States had poverty rates exceeding 20%, of which roughly three-fourths were linked directly to the economic circumstances of racial and ethnic minorities. Moreover, about 47% of those rural counties studied were largely African American (Lichter et al., 2012). More specifically, Farrigan, Hertz, and Parker (2014) reported that from 2006 to 2010, the average non-metro African American resided in a county where the poverty rate was 22%. In comparison, the average metro African American person resided in a county where 14-15% of the population was poor. This suggests that non-metro African Americans were significantly more likely to live in areas of high poverty than their metro counterparts, and were therefore likely to suffer many of the problems and limitations associated with poverty (USDA, 2015).

Additionally, it has been reported that rural communities tend not to have access to various specialty care professionals (Gamm, Stone, & Pittman, 2008). This is evidenced in a study by O'Grady, Mueller, and Wilensky (2002), who reported that labor force shortages as well as recruitment and retention of primary care providers were identified as major rural health

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concerns among state rural health offices. Further, Gamm and Hutchinson (2003) reported that access to quality health services was the most frequently recognized rural health priority by state and local rural health leaders across the nation. For these reasons, networks of informal care providers have often become commonplace in rural areas. Extended family, neighbors, and clergy often serve as alternatives to costly or inaccessible services (Chatters et al., 2002; Chatters, Taylor, Jackson, & Lincoln, 2008; Chatters et al., 2011; Taylor, Lincoln, & Chatters, 2005; Woodward et al., 2008; Woodward et al., 2010; Woodward, Taylor, & Chatters, 2011). In rural communities, the church is often a major institution on which community members can rely to support their fundamental core values and beliefs (Torrence, Phillips & Guidry, 2005). These churches are often sponsor assistance programs that address physical and mental health, as well as community concerns (Tangenberg, 2005). Subsequently, this structure requires churches to be responsive to the needs of their members and the external environment (Brown, 2003). An important challenge then is to effectively use the synergy between rural African American churches and the dynamic social services institutions to better meet the needs of struggling rural communities (Lewis & Trulear, 2008).

Increasingly, collaboration between nonprofit and for-profit organizations is being championed as a powerful strategy to achieve a vision that is impossible when such entities work alone (Gajda, 2004). Collaboration is predicated on establishing strategic alliances between local health, mental health and other service organizations, and communities to increase access to resources (Bailey & McNalley-Koney, 1996). The goal of these partnerships is to influence the direction of program creation to enhance service delivery (Bailey & McNalley-Koney, 1996). As such, interorganizational collaborations can encourage participation and representation for many southern rural groups that would otherwise be excluded (Cnaan et al., 2004).

With social workers playing a key role in providing human services to a diverse population, it is important to develop practice models that correspond to theoretical understandings of culturally proficient practice (Davis, 2009). The Bailey and McNalley-Koney model (1995) is one such conceptual framework that groups can use to develop interorganizational community-based collaboratives that are responsive to the human service needs of rural African American communities. The Bailey and McNalley-Koney model emphasizes the creation of a relationship, or partnership, among parties through the integration of eight core constructs that ideally lead to the achievement of a common goal (Bailey & McNalley-Koney, 1996).

Few studies address the establishment of interorganizational community-based collaboratives between rural social services agencies and southern rural African American churches. In a time of inter-professional collaboration, strategic alliances between churches and social service agencies are imperative. Therefore, the purpose of this paper is to explore the eight constructs of the Bailey and McNalley-Koney (2000) interorganizational framework for integration into community-based alliances between southern rural African American churches and human service agencies. These constructs are leadership, membership, environmental linkages, strategy, purpose, tasks, structure, and systems.

Brief History of Rural African American Churches' Engagement in Collaboratives

Lincoln and Mamiya (1990) argue that the African American church has been traditionally comprised of seven African American Christian denominations, which include the African Methodist Episcopal Church; the African Methodist Episcopal Zion Church; the Christian Methodist Episcopal Church; the National Baptist Convention, U.S.A.; the National Baptist Convention of America, Unincorporated; the Progressive National Baptist Convention; and the Church of God in Christ. The Church has served a prominent role as an informal social service provider throughout its history, and the churches' involvement in collaborative arrangements with social welfare services has been documented by several historians and researchers (Allen, Davey & Davey, 2010; Barnes, 2004; Hankerson, & Weisman, 2012). Although collaboratives have been examined throughout the history of African American churches, a limited number of studies have focused specifically on southern rural African American churches and their engagement in collaborative efforts.

The Free African Society, established by Richard Allen and Absalom Jones in 1787, was one of the earliest examples of the interconnection of the church and social services within the African American community. The Free African Society, which led to the founding of the Mother Bethel A.M.E. Church in 1794, was formed to address the economic, social and spiritual needs of African Americans (DuBois, 1899; Lincoln & Mamiya, 1990; Sernett, 1999). The National Negro Movement of 1915 provides another historical example of early collaborations between social service organizations and the African American church. From 1915 to 1950, in a national strategy to bring public health practices to Blacks, African American churches coordinated efforts with public health agencies in a movement known as "Health Improvement Week" (Bediako & Griffith, 2007). The movement's objectives were for church leaders to consult with state health officers on public health problems within the African American community, and use churches and their personnel as vehicles for disseminating information about preventable illnesses among African American people. Through collaborative arrangements, the churches and agencies would use expressions such as music, song, and sermons with a focus on health and healthy living to encourage parishioners to participate in the endeavor. Additionally, mass meetings were organized and speakers were invited to discuss issues regarding health and healthy living (Bediako & Griffith, 2007; Quinn & Thomas, 1996).

Subsequent studies examined African American churches' alliances with social service-type agencies. For instance, Mays and Nicholson (1933) published a notable study that was at the time one of the most extensive surveys of African American churches of a range of denominations located in both rural and urban areas. Mays and Nicholson (1933) examined outreach efforts by both urban and rural African American churches, particularly regarding cooperation with non-church programs. Mays and Nicholson (1933) found that while both urban and rural African American churches collaborated with a variety of social agencies and programs to enhance health and mental health service delivery within the African American community, African American urban churches were far more active than those in rural communities in cooperating with external agencies. They further suggest this lack of cooperation by rural African American churches was partly due to the paucity of social service agencies in rural areas (Mays & Nicholson, 1933). Lincoln and Mamiya (1990) contend that the Mays and Nicholson study established a basis for future research on African American churches, and identified the need for further studies addressing church-agency alliances.

The next major survey of African American church collaborative alliances was by Lincoln and Mamiya (1990). In their five-year national survey, Lincoln and Mamiya inquired whether African American churches engaged in securing and utilizing government funding and/or participating in government-funded programs for the purpose of creating a hub whereby non-church community groups could use the church facilities for other programs or meetings. The vast majority of urban African American churches participated in government-funded programs, while 95.2% of rural churches did not participate in any government-funded program, and only 2.7% claimed involvement in such programs (Lincoln & Mamiya, 1990). Of those rural churches that had participated in government-funded programs, only 1.4% received government funds. Lincoln and Mamiya (1990) reported that the lower rates of participation by rural African American churches could be attributed to the lack of knowledge and experience for applying to such programs and the absentee pastorate. Moreover, their study found no participation by rural African American churches in funded programs such as food services (breakfast or Meals on Wheels), the Comprehensive Employment and Training Act (CETA) programs, housing for the elderly and the indigent, daycare, job search, substance abuse prevention, food and clothing distribution, and other tutorial and remedial education programs (Lincoln & Mamiya, 1990). Further, their research noted that rural African American churches were less likely than African American churches in urban areas to allow their churches to be used by other groups such as civic entities like block associations, neighborhood improvement groups, citizens' patrols, and community organizations. On the other hand, rural churches were more inclined to allow civil rights groups to use their facilities (Lincoln & Mamiya, 1990).

Billingsley and Caldwell (1991) studied collaborative efforts by African American churches and reported that many of the churches in their study had established elaborate and extensive networks of collaboration with other churches and community agencies. For example, they found that 73% of churches with outreach programs collaborated with secular agencies in the community as part of their outreach efforts (Billingsley & Caldwell, 1991). Specifically, of the agencies studied, welfare departments ranked third among agencies that had working relationships with African American churches. Billingsley and Caldwell (1991) also reported on the tendency of African American churches to serve as centers for community activities. It was reported that more than 43% of the churches with outreach programs allowed their facilities to be used by non-religious groups, which suggests that the African American church could be considered a community institution (Billingsley & Caldwell, 1991).

Other studies further illustrate similar patterns of activities involving the wider community collaboration of services including employment counseling, senior citizens' services, hospice care, food pantries (Barnes, 2004; Brown, 2008), and youth programs (Cook, 2000). With regard to the establishment of faith-health collaborations, few rural African American churches engaged in this endeavor. For example, Steinman and Bambakidis (2008) examined the prevalence of religious congregations' collaborations with health agencies and found that rural African American churches were less likely than any other type of congregation to participate in faith-health collaborations. Further, in a study of rural African American churches' ability to develop health prevention campaigns, Torrence, Phillips, and Guidry (2005) note that creating collaborative partnerships with health professionals and African American churches aids in the success of church-based programs. What is more, Blank et al. (2002) noted that African American churches can be essential partners with formal care systems, particularly in the areas

of primary care delivery, community mental health, health promotion, disease prevention and health policy.

Consequently, forging a cooperative understanding between the groups may prove to be the best outcome for all parties in addressing social welfare service needs identified by members of African American communities (Lewis & Trulear, 2008). In light of these expectations, the central focus of this paper is on helping African American individuals, families, and communities in southern rural areas to access vitally needed specialty care services.

Bailey and McNalley-Koney Framework for Interorganizational Community-Based Collaboration

A number of models have been developed to enhance collaboration within social service-oriented alliances (Gajda, 2004; Chandler Center for Community Leadership, 1993; Peterson, 1991); however, the Bailey and McNalley-Koney (2000) framework of inter-organizational collaboration focuses on partnership building among organizations and individuals who unite to work collectively through common strategies toward a shared goal. This is accomplished through integrating eight core components: leadership, membership, environmental linkages, structure, strategy, purpose, tasks, and systems. Using these components, the framework emphasizes an understanding of key processes inherent to the development of collaboration (Bailey, 1992).

Leadership

Within this framework, leadership includes the individuals and/or organizations that formally or informally guide and direct the activities of the collaborative. Bailey and McNalley-Koney (2000) report that leadership may consist of one or both of the following: (a) the organizational leader(s), or the convening organization(s); and (b) the individual leader(s) or the entrepreneur(s). According to Bailey and McNalley-Koney (1996), the power of effective leadership comes through cooperation with others.

Thus, wise and effective leaders remain open and attentive at the same time, following the lead of other stakeholders. Therefore, they should be both assertive (guiding and directing) and responsive, articulating the larger vision of the alliance while constantly being aware of its smaller elements and how all the elements relate to the whole (Bailey & McNalley-Koney, 1996).

Membership

Within the Bailey and McNalley-Koney framework, members are the remaining participants in the collaboration who commit to work with united leaders to accomplish its goals. The membership of an organizational unit actually comprises multiple affiliations (i.e., members participating on behalf of any agency and members representing themselves and/or their communities) (Bailey & McNalley-Koney, 1995). These leaders, members, and community groups represent the primary stakeholders of the collaborative (Bailey & McNalley-Koney, 2000). Stakeholders are those individuals and groups of the community who have a vested interest in the collaborative.

Interaction between leaders and members is critical in determining the degree of synergy within a collaborative effort, as leaders are the “vehicles” by which diverse members (partners) are engaged, productive interactions are fostered, and meaningful participation are facilitated (Gadja, 2004).

Environmental Linkages

Leaders and members should solicit the assistance of environmental linkages. Within this framework, Bailey and McNalley-Koney (2000) describe environmental linkages as the relationships between the leaders of a collaborative and members of other external organizations and individuals. These connections are designed to expand the collaborative’s full range of stakeholders (Emery & Mamerow, 1986; Gentry, 1987; Sink, 1987).

Bailey and McNalley-Koney (2000) report that environmental linkages often contain the history of the community and its needs. As such, they can often be used to identify external environmental forces that support or oppose the development of strategic alliances. Consequently, as Bailey and McNalley-Koney (2000) note, it is essential that environmental linkages be functional and intentional.

The organizations and individuals involved in these linkages are not formal members; instead, they provide support for its efforts by donating meeting space, providing funding, or referring consumers (Bailey & McNalley-Koney, 2000). For these reasons, the environmental linkages may be critical to the collaborative’s existence.

Structure

As stakeholders are identified, the collaborative alliance should develop a specific structure and strategies for achieving the collaborative’s purpose. Within the Bailey and McNalley-Koney framework, structure refers to the way in which people and tasks are organized within the collaborative to achieve its purpose. These include how (sub)committees are arranged, the way decisions are made, the extent to which policies and procedures are formally defined, and the manner in which functions and services are assigned. The collaborative should adopt a task-driven structure in which specific activities are divided among the parties to operationalize the collaborative’s strategy (Bailey & McNalley-Koney, 1996).

Formal structures, such as committees, are groups of participants representing individual organizations aligned with the collaboration to accomplish specific task (Griffin, 2011). Without a structure to manage the scope of work, collaboratives cannot identify what strategies and tasks positively contribute to goal attainment (Bailey & McNalley-Koney, 2000).

Strategy

Within the model, strategy refers to the means through which the collaborative seeks to achieve its purpose (Bailey & McNalley-Koney, 2000). Strategy includes the extent to which groups’ stakeholders (i.e., leadership and members) agree on ideology, articulate activities and programs, and perform collaboratively (Gray, 1985; Roberts-DeGennaro, 1986). The fundamental strategy is to collaborate, or work together, to increase the impact of services and

products provided (Bailey & McNalley-Koney, 2000). Therefore, the strategy should embody the shared values, purpose, and goals of the stakeholders.

Purpose

Bailey and McNalley-Koney (2000) argue that the purpose of the collaborative is whatever the alliance seeks to jointly achieve (i.e., allocate resources, provide services, or suggest policies). The purpose can also be described in the collaborative's mission and overall goal, with an emphasis on end result. Who the participants are, what they do, and how they all come together to do it are three different components in articulating the mission and goals of the collaborative. In essence, the purpose of the collaborative unit is to serve as the ground on which the unit is built, and embody the shared values that bond the collaborative together. Therefore, the purpose provides the foundation for the development of collaborative components as well as synthesis of its various components.

Tasks

Bailey and McNalley-Koney (2000) suggest that neither the purpose nor the strategy of a collaborative can be achieved without first identifying the tasks appropriate to fulfilling the objectives. Accordingly, tasks within the Bailey and McNalley-Koney (2000) framework are the specific activities that collectively enable the collaborative to operationalize its strategy and accomplish its purpose. This includes the number of issues to be addressed by the collaborative and the degree to which the means for accomplishing the task(s) are imposed (Gray, 1985; Harris, 1984; Schopler, 1987). The outcomes of the tasks are the basis for achievement of the larger goals of the alliance. The collaborative body is ultimately responsible for the oversight of tasks in pursuit of the shared goal(s) (Bailey & McNalley-Koney, 2000).

Systems

The final part of the Bailey and McNalley-Koney (2000) collaborative framework are the systems. Systems are the operating ties that hold the collaborative structure together. Within the collaborative, systems include the established mechanisms for budgeting and resource allocation, inter- and intra-collaborative information flow, decision making, communication, planning, administration, human resource management, and evaluation. Stakeholders' assessment of the degree to which these systems are functioning successfully is a further consideration (Pascale & Athos, 1981).

Using these eight components, the Bailey and McNalley-Koney (2000) framework emphasizes the building of an alliance that is both dynamic and interdependent. It posits that all components within the collaborative alliance being implemented as suggested offer the potential for a greater impact in relationship building, information sharing, service delivery, and policy reform (Bailey & McNalley-Koney, 2000; Flynn & Harbin, 1987; Haynes & Mickelson, 1997).

Integration of the Bailey and McNalley-Koney Framework into Building Collaboratives with Rural African American Churches

Social workers often must assist individuals and communities in recognizing the many possibilities available to them. This includes assisting individuals, groups, and communities in

identifying their strengths and employing the empowerment perspective to help them obtain desired goals and outcomes necessary to reach their fullest potential. Below, we have synthesized four action-oriented measures from the eight core components within the Bailey and McNalley-Koney (2000) framework to aid in the integration of strategies for building collaboratives between human service agencies and southern rural African American churches. Because the constructs in the Bailey and McNalley-Koney model are closely aligned, many components have been merged to develop the action-oriented measures.

Leadership and Membership

At the center of Bailey and McNalley-Koney's (2000) construct regarding leadership and membership for building of rural collaboratives are influential church members who are frequently sought out for advice. In many rural African American communities, residents place total confidence in the advice or guidance of their pastors and church leaders regarding their spiritual, financial, mental, and physical well-being (Adkison-Bradely et al., 2005). Taylor et al. (2000) and Richardson and June (1997) found that the number of collaborative relationships an African American minister had with community agencies was closely associated with the number of referrals clergy made to health professionals. Since church leaders are potential resources for bridging the gap between formal social service agencies with informal services provisions (Wilson & Netting, 1989), collaboration between agencies and religious organizations can offer new opportunities to meet the needs of rural community members.

Action-centered leadership measures. To meet the objectives of the Bailey and McNalley-Koney model regarding establishing a leadership structure and soliciting members, social workers can initiate communication by facilitating public meetings between the agency and the rural community church leaders regarding their vision to address needed services. Member parties (church leaders and agency personnel) can then develop a formal process for collaboration. Membership should be a formal alliance including not only church leaders and social workers or interorganizational contacts, but also organizational staff and administrators (Bailey & McNalley-Koney, 2000).

An example of this was noted by Sutherland et al. (1989) in an examination of a collaborative partnership in rural Jackson County, Florida. This collaboration demonstrated how health-related programs can be organized and operated by churches with the support of public health agencies. In rural Jackson County, Florida, officials from county health and social service agencies determined, through data on health-related behaviors, that there were various health disparities within the African American community. Consequently, officials recognized that a targeted health promotion effort was needed. Local and area health and social agency officials felt it important to join with local church leaders, to formulate an initiative based on a culturally appropriate version of the Planned Approach to Community Health (PATCH) program model, which was developed by the Centers for Disease Control and Prevention (CDC) and geared toward planning and implementing community-based public health strategies (Lancaster & Kreuter, 2002). One of the initial steps taken by Jackson County was to establish a Health Advisory Council composed of 16 primarily African American Jackson County churches plus representatives of relevant agencies to establish public health goals. The outcomes of this partnership included increased community awareness regarding health promotion as evidenced by increasing program participation over the course of several years. More specifically, the

program appeared to produce improved nutritional behaviors of some people (e.g., decreases in consumption of fatty and high-sodium foods, and increases in consumption of healthful foods) and decreases in blood pressure among some high-risk individuals (Sutherland et al., 1989). This alliance demonstrates the value of creating true partnerships.

Environmental Linkages

Also critical to the success of collaboratives in Bailey and McNalley-Koney's (2000) model are environmental linkages among community members. Because economic conditions faced by pastors and church leaders in rural communities usually reflect to some degree the economic conditions of church members, they are frequently aware of community issues (i.e., poverty, medical and mental health issues, and incarceration) and can oversee the needs of community constituents of the interorganizational alliance (Lewis & Trulear, 2008). These can be employed to identify key individuals within the community who can provide informational, as well as emotional and tangible support, to collaborative members (Eng & Hatch, 1991).

Because the collaborative's formation often stems from both groups' desire to address certain community issues or public concerns, organizations thusly motivated often respond from the model's social responsibility perspective. Accordingly, social responsibility deals with the desire to contribute to the resolution of broad community issues while increasing goodwill. Here, an organization may establish itself as a member of the collaborative to enhance its reputation with its clientele and local residents, as well as with constituents of the rural African American community. By participating in the collaborative, social workers, their administrators, and agencies' personnel can demonstrate to the community that they are concerned about and active in responding to the community's needs (Bailey & McNalley-Koney, 2000). For this reason, successful partnerships result from establishing trust, credibility, and open communication (Torrence et al., 2005). Identifying environment linkages can aid in this effort.

Action-oriented practice measures. To create this connection, social workers and agencies should invest considerable time and energy in cultivating relationships with the rural African American community and its leaders (Adkison-Bradely et al., 2005; Alter, 1990; Benson, 1975; Knoke, 1990; Warren, 1967). This includes working with rural church leaders to identify environmental linkages (i.e., community stakeholders) that understand community strengths and needs. This will promote equitable relationships between social workers, agencies, rural African American church leaders, and community members, where all become stakeholders by jointly developing change strategies.

An example of this is provided by Centra and McDonald (1997) who documented the efforts of the Thurston County Public Health and Social Services Department of Olympia, Washington. Proponents of this initiative worked to identify community leaders and cultivate relationships during the initial stage of their Assessment Protocol for Excellence in Public Health (APEX/PH) project. In an effort to cultivate relationships for the purpose of strengthening their community health assessment and planning capabilities, the Thurston County Public Health and Social Services Department worked to establish a County Community Health Task Force to identify "key community informants." These key informants were individuals considered to represent important constituencies through their knowledge of or experience with the health issues of the community.

To cultivate relationships, agency personnel convened a breakfast meeting with community leaders, and asked participants to provide the names of appropriate individuals to participate in the Task Force. In essence, participants were asked: “Whose name would you have to see on a health plan to believe it was valuable?” Task Force members were then selected from among the names that appeared frequently in the responses (Centra & McDonald, 1997).

Structure and System

For social work professionals concerned with addressing the needs of underserved individuals in southern rural communities, the interorganizational community-based collaborative can become an important tool to develop and maintain. Social work professionals are in key positions to lead efforts in forming collaborative, community-guided initiatives. As advocates for social justice as well as individual and community empowerment, social work professionals bring essential skills of developing and implementing strategies for enhancing the quality of programs extended within the interorganizational community-based collaborative.

Many in the social work profession have had concerns about churches’ involvement in social welfare service delivery because of the lack of trained and certified church workers (Torrence et al., 2005). Since many African American congregations lack experience in strategic planning, or since their plans and ideas may be inappropriate or unrealistic according to human service organization standards (Cnaan et al., 2004), church leaders and interorganizational contacts may enter the alliance to share knowledge and work together in developing appropriate strategic action plans.

Action-oriented measures. To address Bailey and McNalley-Koney’s (2000) constructs regarding a system and structure establishment for successful work with these rural churches, collaboratives can consult on how best to strategically access resources and research funding designed to increase the church’s capacity to improve the quality of programs it offers, as well as identify and influence unfair social welfare policies or practices that impede effective service delivery (Lewis & Trulear, 2008). Social workers can further assist in this effort to increase capacity by improving the quality of their programs. Because the social work profession depends on key skills and knowledge essential to address the needs of individuals, families, and communities, starting up, aligning, or expanding programs using proven strategies, including technical expertise and grant and proposal writing skills for funding, would help rural African American churches improve outcomes for parishioners and community members and ensure the long-term sustainability of programs (Cnaan & Bodie, 2001).

As an example, in the Jackson County, Florida health promotion partnership that established the Health Advisory Council, church council members underwent a period of training and planning to acquire the skills and resources necessary to design, implement, and evaluate health promotion programs in their communities and teach other local churches how to do the same (Sutherland et al., 1989).

Strategy, Purpose, and Tasks

Because geographic and economic factors may create practical problems for rural communities, including the need to travel longer distances to receive care using unreliable or

inadequate transportation, and limited economic resources, thereby making services inaccessible (DHHS, 1999), African American churches and social service agency professionals can coordinate strategy, purpose, and tasks to address these needs (Lewis & Trulear, 2008). Leaders, members, and other stakeholders recognize that the strategy, purpose, and tasks of a collaborative are all connected. In order to achieve the purpose and implement the strategy, the appropriate tasks need to be identified and executed (Bailey and McNalley-Koney, 1996).

Action-oriented measures. To effectively achieve collaborative objectives, rural African American churches and the local social service agencies within the rural community can work together to create information centers on church grounds to assist parishioners and residents in connecting with existing services offered by agencies serving that community (Lewis & Trulear, 2008). The collaborative can work to arrange services such as health screening for mental and physical illnesses, nutritional services, and immunizations on church grounds.

For example, agencies located in the same county but some distance away from one another and their constituents can increase the efficiency of service delivery by offering a variety of services in one conveniently located facility. Community consumers will then be able to obtain all of the needed services through a single point of access. Instead of having to maintain their own facilities, each alliance member would contribute to the costs associated with offering services, as well as several staff members. In this way, they are able to use their limited resources to achieve greater benefits than each could have done individually. This creates a single service site that streamlines the client referral process and reduces administration and overhead costs for the member agencies (Bailey & McNalley-Koney, 2000).

An example of a single service site is provided by Eng and Hatch (1991) who developed one of the most notable rural church sponsored programs, collaborating with area service agencies to use rural churches in North Carolina as a focus for health promotion activities. Eng, Hatch, and Callan (1985) documented the development and impact of church health care programs in which pastors asked congregants to identify people within the congregation who could serve as health advisors. These “natural helpers” received training in resource mobilization, preventive and primary self-care skills, organization of educational and service-oriented activities, and interaction with health professionals. The roles of lay advisors were shaped by the needs and opinions of the congregation and were successful in fostering social support, connection with formal care systems, and promotion of general well-being (Eng et al., 1985). Through arrangements such as these, the church can serve a two-fold purpose, functioning as a spiritual haven as well as a sub-outlet for parishioners and community members to connect with existing agency services.

In a study in rural Jackson County, Florida, Sutherland et al., (1989) showed how a council made up of agency personnel and church leaders organized workshops to provide church participants with basic cardiovascular and health information and to help them plan and operate church-based programs. Church leaders then encouraged community members to participate in health promotion activities conducted at the churches and other community gathering places. The activities included blood pressure monitoring, direct health instruction, exercise programs, and other special health programs. A core of church leaders and members fulfilled a variety of functions, from taking blood pressure readings to serving as peer facilitators. Program planners

also emphasized the integration of health promotion activities with existing church events, for example, by scheduling an activity immediately after worship services.

These methods can work to increase what Bailey and McNalley-Koney (2000) term operational efficiency. The goal of operational efficiency according is to improve productivity relative to the available resources as well as to increase efficiency directed toward reducing duplication of services for a targeted population in a particular program area.

Conclusion

Implications point to the need for social work education and practice to begin focusing on collaboration and the development of interorganizational community-based collaboratives (Gray, 1989). Collaboration creates an understanding of the importance of culturally responsive engagement. The agency must obtain an initial understanding of the historical context and current importance of the African American church in the life of the African American community. Social workers should see the future clients' spiritual or religious beliefs as a source of strength. Through the use of culturally responsive practice, practitioners can develop a self-awareness that will aid in reducing personal bias, and consequently moving toward making more appropriate assessments and providing better quality care.

The social work profession risks losing relevance if it fails to acknowledge the usefulness of African American church leaders and congregations as a unique "context for action" (Wineburg, 1996). Therefore, the agenda for the coming decade must include efforts to link social work with the church.

References

- Adkison-Bradley, C., Johnson, D., Sanders, J. L., Duncan, L., & Holcomb-McCoy, C. (2005). Forging a collaborative relationship between the black church and the counseling profession. (Issues and insights). *Counseling and Values*, 49, 147-154.
- Alter, C. (1990). An exploratory study of conflict and coordination in interorganizational service delivery systems. *Academy of Management Journal*, 33, 478-502.
- Allen, A. J., Davey, M. P., & Davey, A. (2010). Being examples to the flock: The role of church leaders and African American families seeking mental health care services. *Contemporary Family Therapy*, 32(2), 117-134.
- Bailey, D. (1992). Using participatory research in community consortia development and evaluation: Lessons from the beginning of a story. *American Sociologist*, 23(4), 71-82.
- Bailey, D., & McNalley-Koney, K. (1995). Community-based consortia: One model for creation and development. *Journal of Community Practice*, 2(1), 21-42.
- Bailey, D., & McNalley-Koney, K. (1996). Interorganizational community based collaboratives: A strategic response to shape the social work agenda. *Social Work*, 41(6), 602-611 .
- Bailey, D., & McNalley-Koney, K. (2000). *Strategic alliances among health and human services organizations: From affiliations to consolidations*. Thousand Oaks, CA: SAGE .

- Barnes, S. L. (2004). Priestly and prophetic influences on Black church social services. *Social Problems, 51*(2), 202-221.
- Bediako, S. M., & Griffith, D. M. (2007). Eliminating racial/ethnic health disparities: Reconsidering comparative approaches. *Journal of Health Disparities Research and Practice, 2*(1), 51-64.
- Benson, J. K. (1975). The interorganizational network as a political economy. *Administrative Science Quarterly, 20*(2), 229-249.
- Billingsley, A., & Caldwell, C. H. (1991). The church, the family, and the school in the African American community. *Journal of Negro Education, 60*(3), 427-440.
- Blank, M. B., Mahmood, M., Fox, J. C., & Guterbock, T. (2002). Alternative mental health services: The role of the Black church in the south. *American Journal of Public Health, 92*(10), 1668-1672.
- Bositis, D. A. (2006). *Black churches and the faith-based initiative: Findings from a national survey*. Washington, DC: Joint Center for Political and Economic Studies.
- Brown, R. K. (2003, August). *The impact of race on churches' propensity to deliver social services and to politically mobilize*. Paper presented at the annual meeting of the American Sociological Association, Atlanta, GA. Abstract retrieved November 18, 2013 from http://citation.allacademic.com/meta/p_mla_apa_research_citation/1/0/7/7/6/pages107761/p107761-1.php
- Brown, R. K. (2008). Racial/ethnic differences in religious congregation-based social service delivery efforts. *Journal of Sociology and Social Welfare, 35*(4), 95-113.
- Centra, L., & McDonald, S. (1997, March). *APEX in practice*. In National Association of County and City Health Officials (NACCHO) Newsletter. Washington, DC : National Association of County and City Health Officials.
- Chandler Center for Community Leadership. (1993). *Community-based collaboration: Community wellness multiplied*. Retrieved from <http://www.uvm.edu/extension/community/ncco/collab/wellness.html>
- Chatters, L. M., Mattis, J. S., Woodward, A. T., Taylor, R. J., Neighbors, H. W., & Grayman, N. A. (2011). Use of ministers for a serious personal problem among African Americans: Findings from the national survey of American life. *American Journal of Orthopsychiatry, 81*(1), 118-127.
- Chatters, L. M., Taylor, R. J., Jackson, J. S., & Lincoln, K. D. (2008). Religious coping among African Americans, Caribbean Blacks, and non-Hispanic Whites. *Journal of Community Psychology, 36*(3), 371-386.
- Chatters, L. M., Taylor, R. J., Lincoln, K. D., & Schroepfer, T. (2002). Patterns of informal support from family and church members among African Americans. *Journal of Black Studies, 33*(1), 66-85.
- Cnaan, R. A., & Boddie, S. C. (2001). Philadelphia census of congregations and their involvement in social service delivery. *Social Service Review, 75*(4), 559-580.

- Cnaan, R. A., Sinha, J. W., & McGrew, C. C. (2004). Congregations as social service providers: Services, capacity, culture, and organizational behavior. *Administration in Social Work*, 28(3/4), 47-68.
- Cook, K. V. (2000). You have to have somebody watching your back, and if that's God, then that's mighty big: The church's role in the resilience of inner-city youth. *Adolescence*, 35(140), 717-730.
- Davis, T. S. (2009). Diversity practice in social work: Examining theory in practice. *Journal of Ethnic & Cultural Diversity in Social Work*, 18(1/2), 40-69.
- DuBois, W. E. B. (1899). *The Philadelphia negro: A social study*. Philadelphia, PA: University of Pennsylvania Press.
- Emery, K. J., & Mamerow, D. C. (1986). Making services integration work at the local level: The partnership in Dayton, Ohio. *New England Journal of Human Services*, 6(2), 12-15.
- Eng, E., & Hatch, J.W. (1991). Networking between agencies and black churches: The lay health advisor model. *Prevention in Human Services*, 10(1), 123-146.
- Eng, E., Hatch, J. W., & Callan, A. (1985). Institutionalizing social support through the church and into the community. *Health Education and Behavior*, 12(1), 81-92.
- Farrigan, T., Hertz, T., & Parker, T. (2014, March). *Rural poverty & well-being*. United State Department of Agriculture (USDA), Economic Research Service. Retrieved from <http://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being.aspx>
- Flynn, C., & Harbin, G. (1987). Evaluating interagency coordination efforts using a multidimensional, interactional, developmental paradigm. *Remedial and Special Education*, 8(3), 35-44.
- Gajda, R. (2004). Utilizing collaboration theory to evaluate strategic alliances. *American Journal of Evaluation*, 25(1), 65-77.
- Gamm, L. G., Stone, S., & Pittman, S. (2008). *Mental health and mental disorders: A rural challenge: A literature review: Rural healthy people 2010: A companion document to healthy people 2010* (Vol. 2). College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.
- Gamm, L., & Hutchison, L. (2003). Public health rural health priorities in America: Where you stand depends on where you sit. *Journal of Rural Health*, 19(3), 209-213.
- Gentry, M. E. (1987). Coalition formation and processes. *Social Work with Groups*, 10(3), 39-54.
- Gray, B. (1985). Conditions facilitating interorganizational collaboration. *Human Relations*, 38(10), 911-936.
- Gray, B. (1989). *Collaborating: Finding common ground for multiparty problems*. San Francisco, CA: Jossey-Bass.

- Griffin, G. (2011). An ideal model of inter-organizational collaboration: Evaluating the collaborative relationship of domestic violence service providers and child welfare agencies in Texas. Retrieved from <https://digital.library.txstate.edu/handle/10877/3789>
- Hankerson, S. H., & Weissman, M. M. (2012). Church-based health programs for mental disorders among African Americans: A review. *Psychiatric Services, 63*(3), 243-249.
- Harris, I. M. (1984, Summer). The citizens' coalition in Milwaukee. *Social Policy, 15*, 27-31.
- Haynes, K. S., & Mickelson, J. S. (1997). *Affecting change: Social workers in the political arena* (3rd ed.). New York, NY: Longman.
- Knoke, D. (1990). *Organizing for collective action: The political economics of associations*. Hawthorne, NY: Aldine de Gruyter.
- Lancaster, B., & Kreuter, M. (2002). Planned approach to community health (PATCH). *Encyclopedia of Public Health*. Retrieved from <http://www.encyclopedia.com/doc/1G2-3404000652.html>
- Lewis, C. E., Jr., & Trulear, H. D. (2008). Rethinking the role of African American churches as social service providers. *Black Theology: An International Journal, 6*(3), 343-365.
- Lichter, D. T., Parisi, D., & Taquino, M. C. (2012). The geography of exclusion: Race, segregation, and concentrated Poverty. *Social Problems, 59*(3), 364-388.
- Lincoln, C. E., & Mamiya, L. H. (1990). *The Black church in the African-American experience*. Durham, NC: Duke University Press.
- Mays, B. E., & Nicholson, J. W. (1933). *The Negro's church*. New York, NY: Institute of Social and Religious Research.
- O'Grady, M. J., Mueller, C. D., & Wilensky, G. R. (2002, March). *Essential research issues in rural health: The state rural health directors' perspective* (Policy Analysis Brief, W Series, Vol. 5, No. 1.). Bethesda, MD: Project Hope, Walsh Center for Rural Analysis. Retrieved from <https://www.raconline.org/pdf/WseriesVol5No1.pdf>
- Pascale, R. T., & Athos, A. G. (1981). *The art of Japanese management: Applications for American executives*. New York, NY: Simon and Schuster.
- Peterson, N. L. (1991). Interagency collaboration under Part H: The key to comprehensive, multidisciplinary, coordinated infant/toddler intervention services. *Journal of Early Intervention, 15*(1), 89-105.
- Quinn, S. C., & Thomas, S. B. (1996). The national Negro health week, 1915 to 1951: A descriptive account. *Journal of Wellness Perspectives, 12*(4), 172-180.
- Richardson, B. L., & June, L. N. (1997). Utilizing and maximizing the resources of the African American church: Strategies and tools for counseling. In C. C. Lee (Ed.), *Multicultural issues in counseling: New approaches to diversity* (2nd ed., pp. 155-170). Alexandria, VA: American Counseling Association.
- Roberts-DeGennaro, M. (1986). Factors contributing to coalition maintenance. *Journal of Sociology and Social Welfare, 13*(2), 248-264.

- Schopler, J. H. (1987). Interorganizational groups: Origins, structure, and outcomes. *Academy of Management Review*, 12, 702-713.
- Sernett, M. C. (Ed.) (1999). *African American religious history: A documentary witness* (2nd ed.). Durham, NC: Duke University Press.
- Sink, D. W. (1987). Success and failure in voluntary community networks. *New England Journal of Social Services*, 7(4), 25-30.
- Steinman, K. J., & Bambakidis, A. (2008). Faith-health collaboration in the United States: Results from a nationally representative study. *American Journal of Health Promotion*, 22(4), 256-263.
- Sutherland, M., Barber, M., Harris, G., Warner, V., Cowart, M., & Menard, A. (1989). Planning preventive health programming for rural Blacks: Developmental processes of a model PATCH program. *Wellness Perspectives: Research, Theory, and Practice*, 6(1), 57-67.
- Tangenberg, K. M. (2005). Faith-based human services initiatives: Considerations for social work practice and theory. *Social Work*, 50(3), 197-206.
- Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black churches. *Social Work*, 45, 73-87.
- Taylor, R. J., Lincoln, K. D., & Chatters, L. M. (2005). Supportive relationships with church members among African Americans. *Family Relations*, 54(4), 501-511.
- Torrence, W. A., Phillips, D. S., & Guidry, J. J. (2005). The assessment of rural African-American churches' capacity to promote health prevention activities. *American Journal of Health Education*, 36(3), 161-164.
- United States Department of Agriculture, Economic Research Service (USDA). (2015). Rural poverty & well-being. Retrieved from <http://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being.aspx#.U-JG3fldV8E>
- United States Department of Health and Human Services (DHHS). (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Author.
- Warren, R. L. (1967). The interorganizational field as a focus for investigations. *Administrative Science Quarterly*, 12(3), 396-419.
- Wilson, V., & Netting, F. E. (1989). Exploring the interface of local churches with the aging network: A comparison of anglo & black congregations. *Journal of Religion & Aging*, 5(1-2), 51-60.
- Wineburg, R. (1996). Relationships between religion and social services: An arranged marriage or a renewal of vows? *Social Work and Christianity*, 23(1), 9-27.
- Woodward, A. T., Chatters, L. M., Taylor, R. J., Neighbors, H. W., & Jackson, J. S. (2010). Differences in professional and informal help seeking among older African Americans, Black Caribbeans and non-Hispanic Whites. *Journal of the Society for Social Work and Research*, 1(3), 124-139.

Woodward, A. T., Taylor, R. J., Bullard, K. M., Neighbors, H. W., Chatters, L. M., & Jackson, J. S. (2008). Use of professional and informal support by African Americans and Caribbean Blacks with a mental disorder. *Psychiatric Services*, 59(11), 1292-1298.

Woodward, A. T., Taylor, R. J., & Chatters, L. M. (2011). Use of professional and informal support by Black men with a mental disorder. *Research on Social Work Practice*, 21(3), 328-336.

Longitudinal Description of Developmental Youth Assets and Substance Use: A Cohort Study of Rural Youth

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Abstract. Rural communities seeking strategies to enhance the well-being of their youth must have local data for guidance. As a concept, developmental youth assets is increasingly used in measuring the psycho-social health of adolescents. This longitudinal study focuses on a cohort of over 200 youths residing in a rural community located in northeast Ohio. This five-year study observes trends of eight assets and the use of three substances. Results show that a decrease in asset scores took place between the sixth and eighth grade while the use of substances increased between the eighth and tenth grades. Additionally, outcomes show that youths coming from households without two parents have lower assets scores and higher substance use rates compared to youth residing in two-parent households. Strategies used by this community upon obtaining results are discussed.

Keywords: youth assets, substance use, rural youth, longitudinal research, rural community, developmental systems theory

A central focus for rural communities is the enhancement of the well-being of its youth as they transition into adulthood. This effort is challenging when considering that adolescence is a time of disengagement from one's family of origin, testing of established norms, and experimentation with new ideas and concepts. In addition, adolescence is also a time of rapid change in biological, psychological and social learning. Coupled with these elements are the unique aspects attributed to rural living. Rural adolescents, who are seeking their identity, face challenges that differ from their urban counterparts. Attempts to maintain standards developed by their family and community may result in tremendous tension in adhering to those standards (Bushy, 1994). Close-knit relationships, while providing a source of comfort and support, may be a source of stress experienced by rural youth when they contemplate challenging existing norms.

Rural communities are tasked with equipping their adolescents with the ingredients necessary to cultivate their growing independence while at the same time supplying them with components required for healthy development. These objectives are challenged by shortages of economic, physical, and human resources in many rural communities (Belanger, 2005). On the other hand, many of these same rural communities harness the strengths found in rural living through the use of informal resource systems, such as neighbors, friends, local organizations and church congregations, to name a few.

In order to carry out the responsibility of cultivating its youth with limited resources, a select number of rural communities have implemented primary prevention efforts. A central component of this strategy is the notion that all youth need essential psycho-social elements in their lives. These elements are conceptualized as youth assets.

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A rural county located in northeast Ohio chose this strategy over a decade ago but needed localized data to assist in planning and evaluation. Social work practitioners were used in the collection and interpretation of data collected due to the profession's understanding and use of ecological systems theory in community-based planning efforts. This study is a sub-component of that effort. Following a cohort of youth from their entry into the 6th grade through the 10th grade, patterns of youth assets and behaviors were tracked and examined to assist in the development of community-based strategies.

Literature Review

Developmental Systems Theory and Youth Assets

Transforming youth into becoming productive adults requires an understanding of factors essential for the achievement of this objective. These factors are conceptualized by Leffert et al. (1998) and expressed in Developmental Systems Theory as assets that blend contextual and individual dynamics that serve to protect from or inhibit risky behaviors in youth, and enhance the propensity for positive developmental outcomes. Instead of concentrating on the problem of risk behavior, the developmental asset approach focuses on building the necessary foundation that young people need to become healthy and productive adults (Benson, 2006). This approach moves away from the familiar deficit reduction approach and emphasizes positive youth development.

Youth developmental assets are often referred to as building blocks (Leffert et al., 1998; Scales, Leffert, & Lerner, 1999) and are centered on the second decade of life (Benson, Leffert, Scales, & Blyth, 1998). When assets are present, they theoretically enhance essential developmental outcomes, reduce health-compromising behaviors, and increase positive outcomes (Leffert et al., 1998). Communities using Developmental Systems Theory as a prevention based framework seek to enhance the acquisition of assets by adolescents in order to achieve positive outcomes. Instead of focusing on a specific problem area, the theory emphasizes positive youth development which, if present, should decrease occurrences of most if not all high-risk behaviors. "It is assumed that increases in developmental assets, like a rising tide, raise all ships" (Lorion & Sokoloff, 2003, p. 133).

Assets may be either internal or external. Internal assets are psychological qualities that result in positive choices, and a sense of control, confidence, and purpose; whereas external assets are positive experiences given to youth from family, schools, and the community (Benson, 2003). The two assets categories are closely related to one another; however, there is a consensus among developmental theorists that for youth to possess high levels of internal assets, they must access external assets. Without them, internal assets are compromised.

Communities may either aid or undermine youth in obtaining or maintaining external assets essential for healthy development. Further, many communities, especially rural ones, may face challenges in obtaining the resources necessary to deliver these ingredients to their youth. Limited access or distrust of formal resource systems such as mental health services, medical services, and substance use resources (Kelleher & Robbins, 1997) may hinder a rural community's ability to respond to social problems. On the other hand, a rural population's

reliance on self-care practices and informal helping systems may provide positive benefits to youth (Bushy, 1994) that are unique to rural communities.

Personal conduct in matters of perceived morality, such as dating, personal associations, and attending church contributes considerably to a person's acceptance within the community. Social relationships are based on a person's identity rather than accomplishments. These relationships tend to be personal, lasting, and community-standing oriented (Daley & Avant, 2004). Loyalty to one's society is important, and a collective sense of belonging results in a lack of need to enforce social control externally (Tönnies, 2001).

Developmental Systems Theory posits that youth who acquire and maintain assets in their life are less likely to become involved in at-risk behaviors (Ford & Lerner, 1992). As such, the theory is a guide rural communities can use to develop primary prevention strategies to maximize assets and reduce unwanted and dangerous risk behaviors by youth. Several studies have displayed a significant positive relationship between a variety of youth assets and the lack of involvement in at-risk behaviors such as sexual activity (e.g., Harris et al., 2007); violence (e.g. Aspy et al., 2004); and substance use (e.g., Oman et al., 2004).

Substance Use and Risk Behaviors

Substance use is a common area of concern for most rural communities due to perceived proliferation of the problem. Efforts to combat adolescents' involvement in substance use such as alcohol, tobacco and illicit drugs, have gone through a number of transitions since the 1950s. Levitt, Selman and Richmond (1991) organized these efforts by describing three distinct stages of prevention efforts. The first stage used psycho-education programming to teach youth about the harmful effects of using substances. The presumption was that youths were ignorant of possible harms. The second stage emphasized teaching youth how to deal with peer pressure, popularized by the Just Say No campaign. The third stage, and the focus of this study, involved the conceptual developmental model approach mentioned earlier.

Rural prevention programming and community responses to risky behaviors in adolescents may require markedly different strategies than those conducted in urban or suburban areas. D'Onofrio (1997) recognized these possible differences and stressed the importance of conducting research specific to rural youths when it comes to addressing the problem of rural substance use. Rural programs must often use nationwide studies to provide strategies for their prevention planning, which may or may not be valid for the youths they serve. Rural prevention efforts must have information specific to their local youths' assets and behaviors.

Limitations of Previous Research

A limitation found in the literature is a lack of longitudinal studies regarding developmental youth assets. The lack of this type of study is rather ironic since the term *developmental* directly relates to variable change that should occur over time. Cross-sectional research provides information for a specific moment in time but fails to capture changes taking place over time. Another benefit of longitudinal studies is their capacity to determine whether changes in presumed independent variable(s) precede changes in presumed dependent variable(s) (Engel & Schutt, 2013). While this alone is not sufficient to assert causality among predictors

and the predicted, it does assist in establishing time order requirements for developmental youth assets and substance use associations.

Focus of Study

The purpose of this study was to describe trends in developmental youth assets and the reported use of substances within a youth cohort attending a rural school district in northeast Ohio over a period of five years. In addition, I conducted bivariate descriptive analyses of the relationship between assets and reported substance use. The aim was to assist community practitioners in the development of primary prevention efforts in order to maximize youth assets and target efforts to minimize the engagement of high-risk behaviors.

Specifically, this study focused on the following three sets of research questions. First, what were the trends within a cohort of rural youth in their reported use of substances during their 6th, 8th, and 10th grade years; and if significant changes in reported use rates occurred, was there a period when this was most likely? Second, what were the trends in asset levels within a cohort of rural youth during their 6th, 8th and 10th grade classes; and if significant changes occurred during this time, when were they most likely? Third, what was the relationship between youth assets and substance use within each of the three grade levels? Would asset scores differ significantly between youths who reported using substances and those who did not?

A secondary focus was on the question of how gender and household type (i.e., number of parents in the household) would impact the above associations. Prior research found these two characteristics to be frequent intervening variables between the relationship of assets and substance use (Blum et al., 2000; Oman et al., 2002; Oman et al., 2007; Scales, Benson, Leffert, & Blyth, 2000). In addition, Vimont's (2010) study of a similar population type found that females had significantly higher scores than males on six of the eight assets, and youths coming from two-parent households had significantly higher asset scores when compared to youths coming from other types of households. This current report will discuss the development and implementation of primary prevention strategies that rural community planners can use to reduce substance use behaviors among their youth, as well as possibly other at-risk behaviors that undermine youths' well-being.

Method

Design

Beginning in December of 2008, the Youth Asset and Substance Use Survey was administered to youth enrolled in the 6th, 8th, 10th, and 12th grade classes of a rural school district in northeast Ohio. Data were gathered every other academic school year through the spring of 2013. This current study examines cohort data gathered from the 6th grade class of 2008 - 2009, 8th grade class of 2010 - 2011, and 10th grade class of 2012 - 2013. The expected age range for the cohort study was a beginning measurement of youth when they were 11 or 12 years old, and ended when they were age 16. Grade levels six through eight were housed in the middle school building, while grade levels nine through twelve were located on the high school campus.

This rural school district is nestled between two major Ohio metropolitan areas, Cleveland and Columbus, and areas experiencing recessionary-induced economic problems.

Median income fell between 2008 and 2009, and had only slightly increased through 2012. Unemployment rates increased sharply within the same period to over 10% in 2009, and have only recently begun to level off. Nearly 20% of the county's children live in poverty with a near doubling of the number of children receiving food assistance between 2008 and 2011 (FCFCWC, 2012).

The school district administered the survey during regular school hours. Teachers were typically in charge of the administration of the survey in their respective classes. Specific written instructions were developed by this researcher to provide guidance on how best to administer the survey. Administrators of the survey were instructed not to clarify or explain the items on the survey to students, even if some students specifically requested help. Instead, they were to tell students to do the best they could in responding to the items on the survey, and skip items they did not understand.

The initial survey was performed using a paper version while subsequent surveys were administered through the online computer software system, *SurveyMonkey*. The school district adhered to its policies and standards regarding survey administration to students. The anonymity of the respondents was guaranteed by not including any identifiable information in the survey. Due to the survey's anonymity, the school district established passive parental consent for students to take the survey rather than active consent. Students were informed verbally and in writing that participation was voluntary. Additionally, students were informed that at any time while taking the survey they wished to stop they were permitted to do so, and that they could skip any item they did not want to answer. The institutional review board for the use of human subjects at the researcher's university approved the secondary use of this data for the purpose of presentation and publication.

Measures

All study variables were taken from surveys administered between the years 2008 and 2013. Youth assets were measured from 37 items extracted from The Youth Asset Survey (YAS) developed by Oman et al. (2002). The original survey purported to measure nine assets from 38 items; however, one item was removed due to the expectation that the survey would not be approved for use by the school board with its inclusion.

After the first administration of the survey, an exploratory principal axis factor analysis using varimax rotation was conducted on the Youth Asset Survey's 37 items to determine whether the items were sufficiently interconnected to make them factorable. Scree plots and eigenvalues were examined to determine the number of factors extracted. Items were considered for inclusion in a factor if they loaded at the .30 level or above (Pett, Lackey, & Sullivan, 2003). A factorial analysis of the scale's survey was conducted in two steps. First, factors with eigenvalues of 1.0 or greater were considered for retention (DeVellis, 2003). Second, scree plots were examined, and factors that were above an *elbow* created when eigenvalues started to trend toward a horizontal line were also considered for retention. Eight factors loaded with eigenvalues of 1.0 or greater, all of which were above the *elbow* in the scree plot. All 37 items had factor loading scores of .30 or above, and 36 of the 37 items had factor loading scores of greater than .40. Only one item had more than one factor with loading scores of .40 or greater. The eight factors represented eight of the nine assets proposed to be measured by the scale. These assets

were Family Communication (3 items), Future Aspirations (2 items), Responsible Choices (6 items), Use of Time (religion) (2 items), Use of Time (groups/sports) (4 items), Non-parental Adult Role Models (7 items), Peer Role Models (6 items), and Community Involvement (6 items). The one asset dropped from the analysis was Good Health Practices that had been measured by one item in Oman's et al. (2002) original study. The item, *you take good care of your body by eating well and exercising*, factored cleanly into the asset of Responsible Choices. Two of the eight assets, Future Aspirations and Responsible Choices, are conceptualized as internal assets, with the remaining six assets categorized as external assets.

An inter-item reliability analysis of the eight subscales was conducted after the first administration of the survey using Cronbach's alpha. Each of the eight subscales displayed acceptable internal consistency for the purpose of the type of analysis to be conducted (Nunnally, 1978). Peer role model displayed the highest degree of internal consistency ($\alpha = .87$, $M = 17.84$, $SD = 3.86$) and future aspirations with two items had the lowest alpha level ($\alpha = .71$, $M = 10.72$, $SD = 1.56$). In general, the inter-item reliability alpha levels were stronger than levels published by Oman and colleagues (2002) for their study.

Items were scored between 1 (low) and 4 (high). The mean score of items measuring each asset was used for the scoring of each of the eight assets as long as at least half of the items had a response. If less than half of the items had a response, then no score was rendered for that asset.

The risk behavior of substance use was measured using respondents' self-reports of how often they used alcohol, tobacco, and marijuana during the past year. Items related to substance use were constructed using a Likert-type, eight-point scale. This scale was coded with zero reflecting no use of the substance during the past year; one indicating use of the substance once during the past year; two, using the substance six times during the year; three, monthly use; four, twice per month; five, once a week; six, three times a week; and seven, use every day. Three substances (cigarettes, cigars, and smokeless tobacco) measured tobacco use. The most frequent type of tobacco used was the code used for this variable. Similarly, alcohol use was measured by taking the three substances reflecting the frequency of alcohol use (beer, coolers, and liquor) and taking the maximum score of the three to determine the code used for this variable. Marijuana use was measured based on the response to a single item regarding the frequency of smoking marijuana. Recoding was done by taking the most frequent reported use rates of the three substances in order to calculate the overall reported frequency rate of substance use.

Because of the study's focus on the avoidance of risk behavior, it was decided that there had to be discernment between behavior that exemplified experimentation, and behavior that was indicative of a lifestyle pattern. For this reason, the variable substance use was made a dichotomous variable based on the reported monthly use of substances defined as having a score of three or greater.

Demographic variables used in this study were gender and household type. Household type was based on the number of parents in the household, either two or other (one or zero). Parents were defined as mother, father, step-mother, step-father, foster mother or foster father. Although race/ethnicity was a variable collected in the survey by the school district, it was decided not to use it in the study due to the homogenous nature of the sample with over 96% identifying themselves as Caucasian.

Participants

The original sample size for the statistical analysis was 244 for the 6th grade class (2008-09); 186 for the 8th grade class (2010-11); and 236 for the 10th grade class in (2012-13). Youths whose responses indicated possible deception were excluded from the analysis (n=31). Deception was determined by youths who reported having used a fictitious substance during the past year. Respondents who did not have scores on each of the eight assets due to missing data were also excluded from the final analysis (n=29). This left a total of 606 responses (6th grade, N = 211; 8th grade, N = 176; 10 grade, N = 219) for the final analysis.

Table 1 displays the demographic characteristics of gender, age, and household type for each of the three grade levels. Approximately three-quarters of youth reported living in a two-parent household in each of the three grade levels. This proportion is higher than national figures of 66.03% reported by the U.S. Census (2013a). Slightly more females responded to the survey than males, and age range was within general expectations for each of the three grade levels. There was one youth who reported him or herself to be 12 years old among the 10th grade responders.

Analysis

Statistical analyses were performed using SPSS for Windows (Release 17.0). The first set of research questions related to the use of substances applied a chi-square analysis to provide conclusions regarding reported monthly substance use rates for each of the three grade levels, as well as use rates when controlling for gender and household type for each grade level.

To address the second set of research questions related to youth assets, a series of 3 x 2 Factorial ANOVAs of Cohort Effects were conducted using each of the eight assets for the dependent variables. In addition to grade level (6th, 8th, 10th) used as an independent variable, gender (male, female) was used as a second independent variable in one series of ANOVAs, and household type (two-parent, other) was used as an independent variable in the second series of ANOVAs in order to assess for possible interactional effects.

The third research question related to the relationship between reported substance use and youth assets were analyzed through a series of t-tests, comparing mean asset scores between youths reporting having used substances on at least a monthly basis and youths reporting not to be using substances on a monthly basis. A more robust analysis of the relationship between reported substance use and youth assets, such as the use of logistic regression, was not possible due the paucity of youth in the sixth and eighth grade years reporting monthly substance use.

Results

Trends in Substance Use

Eleven sixth graders (5.2%) reported having used substances at least monthly. Two years later in the eighth grade, 14 (8%) reported the same type of use, and two years later 49 youths in the tenth grade (22.4%) reported monthly substance use. A 3 x 2 chi-square test indicated that the relationship between grade levels and reported monthly substance use was significant, $\chi^2 (2, N = 606) = 33.72, p < .001, V = .24$. The significant relationship, however, was established due to differences seen between the 8th grade year and 10th grade year; $\chi^2 (1, N = 395) = 15.14, p < .001, V = .20$. No significant difference in reported monthly substance use rate was observed between the 6th grade and 8th grade years; $\chi^2 (1, N = 387) = 1.19, p = .28, V = .06$. Differences in use rates by gender were not significant for any of the three grade levels, while household type displayed

Table 1

Demographic and Family Characteristics, and Monthly Substance Use as a Percentage of the Sample By Grade Cohort

Characteristics/Variables	6th Grade (2008-09) (n = 211)	8th Grade (2010-11) (n = 176)	10th Grade (2012-13) (n = 219)
Gender			
Male	49.3	48.9	48.9
Female	50.7	51.1	51.1
Age			
11 years	68.7	0.0	0.0
12 years	30.3	4.0	0.5
13 years	0.1	42.1	0.0
14 years	0.0	51.1	1.8
15 years	0.0	2.8	28.8
16 or older	0.0	0.0	68.9
Household Type			
Living with both parents	75.8	73.3	75.3
Living with one or no parent	24.2	26.7	24.7
Substance Use (monthly)			
Alcohol	4.7	7.4	14.2
Tobacco	1.4	3.4	8.2
Marijuana	0.5	3.4	12.8
Any substance	5.2	8.0	22.4

lower monthly substance use rates for youths in two-parent households; however, the differences were not significant.

Trends in Developmental Youth Asset Scores

Table 2 displays the mean scores of the eight developmental assets for each of the three time measurements. Future Aspirations retained the highest mean score for each of the three grade levels while Community Involvement had the lowest mean. Use of Time (Religion) displayed the greatest degree of variance within each of the three grade levels. A general trend of decreasing asset levels between the 6th grade year and 10th grade year was observed for all eight assets; however, the magnitude of the decrease differed between the assets. Family Communication and Community Involvement displayed the greatest decrease, and Use of Time (Groups/Sports) displayed the smallest decrease.

Table 2

Means and Standard Deviations for Youth Asset Scores By Grade Cohort

	6th Grade (2008-09) (<i>n</i> = 211)	8th Grade (2010-11) (<i>n</i> = 176)	10th Grade (2012-13) (<i>n</i> = 219)
Asset Score ^a	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)
Family Communication	3.12 (0.66)	2.85 (0.79)	2.80 (0.80)
Peer Role Model	3.17 (0.61)	2.99 (0.70)	2.96 (0.59)
Future Aspirations	3.61 (0.53)	3.67 (0.49)	3.56 (0.53)
Responsible Choices	3.31 (0.55)	3.31 (0.61)	3.26 (0.54)
Community Involvement	2.58 (0.66)	2.41 (0.79)	2.28 (0.75)
Use of Time (Religion)	2.89 (1.04)	2.83 (1.02)	2.54 (1.08)
Non-Parental Adult Role Model	3.42 (0.42)	3.22 (0.56)	3.26 (0.47)
Use of Time (Groups/Sports)	2.83 (0.82)	2.83 (0.89)	2.81 (0.94)

^a asset scores range from 1 (low) to 4 (high)

All independent variables (asset scores) were interval and assessed for acceptable normality in order to conduct Factorial ANOVA and were found to be within acceptable ranges. According to Kennedy and Bush (1985), slight departures from normality and even larger deviations do not typically have much of an effect on the interpretation of results.

Eight separate two-way analyses of variances were conducted to examine asset score differences in the three grade cohorts and gender, used as a fixed factor. ANOVA results presented in Tables 3 and 4, show a significant main effect for grade level for the following five assets: Family Communication; Peer Role Model; Community Involvement; Use of Time (Religion); and Non-Parental Adult Role Model. The calculated effect size for each factor indicated a small proportion of asset scores being accounted for by the factor. A Tukey post hoc test was conducted to determine which grade categories were significantly different. Results

showed that significant decreases occurred between the 6th grade and 8th grade years, but not between the 8th and 10th grade years. Gender was not significant for any of the assets, nor were there any interactions between factors (grade and gender) that were significant.

Table 3

Two way Analyses of Variance (ANOVA) for Youth Assets (Family Communications, Peer Role Model, Future Aspirations, Responsible Choices) by Grade Level and Gender; & Grade Level and Household (HH) Type (N=606)

Variable	df	F			
		Asset 1	Asset 2	Asset 3	Asset 4
Grade Level and Gender					
Grade Level	2	10.67 ^{***}	6.32 ^{**}	2.48	0.60
η^2		.021	.021		
Gender	1	1.35	0.00	1.46	2.04
Grade x Gender	2	0.29	0.06	1.05	1.04
Within-cells variance	600	(0.56)	(0.40)	(0.27)	(0.32)
Grade Level and Household (HH) Type					
Grade Level	2	7.21 ^{**}	3.82 [*]	2.29	0.71
η^2		.023	.013		
Household (HH) Type	1	16.47 ^{***}	13.90 ^{***}	8.80 ^{**}	13.62 ^{***}
η^2		.027	.023	.014	.022
Grade x HH Type	2	0.08	0.93	0.11	2.25
Within-cells variance	600	(0.55)	(0.39)	(0.26)	(0.32)

Note. η^2 reported only for F scores significant at the .05 level or less. Values in parentheses represent mean square errors.

- Asset #
- 1 Family Communication
 - 2 Peer Role Model
 - 3 Future Aspirations
 - 4 Responsible Choices

* $p < .05$, ** $p < .01$, *** $p < .001$.

Also conducted were eight two-way analysis of variances to investigate asset score differences between the three grade cohorts and the fixed factor of household type (two-parent and other). Unlike with the demographic variable of gender, the demographic variable of household type displayed a significant main effect for all eight asset scores. Assets of Future Aspirations, Responsible Choices, and Use of Time (Groups/Sports) that were not significantly

different between grade levels were significantly different between two-parent and other type of households regardless of grade level. There were no significant interactions between factors for any of the eight assets.

Table 4

Two Way Analyses of Variance (ANOVA) for Youth Assets (Community Involvement, Use of Time [Religion], Non-Parental Adult Role Model, Use of Time [Groups/Sports]) by Grade Level and Gender; & Grade Level and Household (HH) Type (N=606)

Variable	df	F			
		Asset 5	Asset 6	Asset 7	Asset 8
Grade Level and Gender					
Grade Level	2	8.91 ^{***}	7.14 ^{**}	9.65 ^{***}	0.03
η^2		.029	.023	.031	
Gender	1	0.02	1.13	0.26	0.84
Grade x Gender	2	1.11	0.26	0.74	2.29
Within-cells variance	600	(0.54)	(1.09)	(0.23)	(0.78)
Grade Level and Household (HH) Type					
Grade Level	2	3.66 [*]	4.96 [*]	4.81 ^{**}	0.11
η^2		.012	.016	.016	
Household (HH) Type	1	9.37 ^{***}	8.22 ^{**}	12.37 ^{***}	33.77 ^{***}
η^2		.015	.014	.020	.053
Grade x HH Type	2	2.65	0.03	0.99	1.04
Within-cells variance	600	(0.53)	(1.08)	(0.23)	(0.74)

Note. η^2 reported only for F scores significant at the .05 level or less. Values in parentheses represent mean square errors.

Asset #

- 5 Community Involvement
- 6 Use of Time (Religion)
- 7 Non-Parental Adult Model
- 8 Use of Time (Groups/Sports)

* $p < .05$, ** $p < .01$, *** $p < .001$.

Trends in Relationships Between Substance Use and Assets

For each grade level, independent t-tests were used to compare asset scores between monthly users and non-monthly users of substances. As Tables 5, 6 and 7 show, non-monthly users of substances displayed higher mean asset scores for each of the eight assets regardless of grade level. The 6th grade year displayed significant differences for five of the eight assets; Peer Role Model $t(209) = 4.87, p < .001$; Responsible Choices $t(209) = 2.48, p < .05$; Community Involvement $t(209) = 2.08, p < .05$; Use of Time (Religion) $t(209) = 2.37, p < .05$; and Non-Parental Adult Role Model $t(209) = 2.71, p < .01$. The 8th grade year displayed differences for four of the eight assets; Family Communication $t(174) = 2.31, p < .05$; Peer Role Model $t(174) = 3.11, p < .01$; Responsible Choices $t(174) = 2.21, p < .05$; and Non-Parental Adult Role Model $t(174) = 2.59, p < .01$. Finally, for the 10th grade year, all assets displayed significant differences partially explained by a larger n among the monthly users. Among the assets displaying the highest t scores were Peer Role Model $t(217) = 5.08, p < .001$; Future Aspirations $t(217) = 3.55, p < .001$; Responsible Choices $t(217) = 4.21, p < .001$; and Community Involvement $t(217) = 3.58, p < .001$.

Table 5

Mean Asset Scores and Standard Deviations Between Groups Among 6th Graders (2008-09) Who Did and Did Not Report Using Substances (Alcohol, Tobacco or Marijuana) on a Monthly Basis.

Asset	Did not use	Used	$t(209)$
	($n = 200$)	($n = 11$)	
	$M (SD)$	$M (SD)$	
Family Communication	3.13 (0.64)	2.87 (0.85)	1.24
Peer Role Model	3.21 (0.58)	2.34 (0.57)	4.87***
Future Aspirations	3.63 (0.53)	3.33 (0.42)	1.80
Responsible Choices	3.33 (0.55)	2.91 (0.47)	2.48*
Community Involvement	2.61 (0.66)	2.18 (0.54)	2.08*
Use of Time (religion)	2.93 (1.02)	2.18 (1.05)	2.37*
Non-Parental Adult Role Model	3.44 (0.40)	3.09 (0.61)	2.71**
Use of Time (group/sports)	2.85 (0.82)	2.39 (0.69)	1.84

* $p < .05$, ** $p < .01$, *** $p < .001$.

Table 6

Mean Asset Scores and Standard Deviations Between Groups Among 8th Graders (2010-11) Who Did and Did Not Report Using Substances (Alcohol, Tobacco or Marijuana) on a Monthly Basis.

Asset	Did not use	Used	<i>t</i> (174)
	(<i>n</i> = 162)	(<i>n</i> = 14)	
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	
Family Communication	2.89 (0.76)	2.39 (0.99)	2.31*
Peer Role Model	3.04 (0.67)	2.45 (0.76)	3.11**
Future Aspirations	3.69 (0.49)	3.52 (0.50)	1.21
Responsible Choices	3.34 (0.57)	2.97 (0.96)	2.21*
Community Involvement	2.44 (0.79)	2.14 (0.84)	1.36
Use of Time (religion)	2.85 (1.00)	2.57 (1.18)	0.98
Non-Parental Adult Role Model	3.25 (0.53)	2.86 (0.76)	2.59**
Use of Time (group/sports)	2.85 (0.89)	2.59 (0.84)	1.03

* $p < .05$, ** $p < .01$.

Table 7

Mean Asset Scores and Standard Deviations Between Groups Among 10th Graders (2012-13) Who Did and Did Not Report Using Substances (Alcohol, Tobacco or Marijuana) on a Monthly Basis.

Asset	Did not use	Used	<i>t</i> (217)
	(<i>n</i> = 170)	(<i>n</i> = 49)	
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	
Family Communication	2.88 (0.77)	2.52 (0.85)	2.80**
Peer Role Model	3.07 (0.54)	2.61 (0.61)	5.08***
Future Aspirations	3.63 (0.49)	3.33 (0.58)	3.55***
Responsible Choices	3.33 (0.51)	2.98 (0.57)	4.21***
Community Involvement	2.38 (0.76)	1.95 (0.65)	3.58***
Use of Time (religion)	2.65 (1.08)	2.15 (0.96)	2.94**
Non-Parental Adult Role Model	3.31 (0.47)	3.08 (0.44)	3.01**
Use of Time (group/sports)	2.89 (0.90)	2.51 (1.03)	2.49*

* $p < .05$, ** $p < .01$, *** $p < .001$.

A more robust analysis, such as logistic regression analysis, would have been instrumental in order to control for the effects of household type; however, the lack of monthly users in the 6th grade and 8th grade made this problematic. Hence, follow-up independent *t*-test analyses were conducted comparing the mean score between two-parent and other households for each of the eight assets within each grade level.

The 6th grade year revealed significant differences in asset scores for six of the eight assets. Two-parent households displayed significantly higher asset scores for Family Communication $t(209) = 3.04, p < .01$; Peer Role Model $t(209) = 2.62, p < .01$; Responsible Choices $t(209) = 4.09, p < .001$; Community Involvement $t(209) = 4.20, p < .001$; Non-Parental Adult Role Model $t(209) = 3.73, p < .001$; and Use of Time (Groups/Sports) $t(209) = 4.51, p < .001$. In 8th grade, three of the eight assets displayed significantly higher scores for two-parent households: Family Communication $t(174) = 2.14, p < .05$; Peer Role Model $t(174) = 2.51, p < .05$; and Use of Time (Groups/Sports) $t(174) = 3.66, p < .001$. In 10th grade, Family Communication $t(217) = 2.00, p < .05$; Future Aspirations $t(217) = 2.11, p < .05$; and Use of Time (Groups/Sports) $t(217) = 2.12, p < .05$ were significantly higher in two-parent households as compared to other households.

Discussion

The purpose of this descriptive study was to investigate trends in developmental youth assets and substance use within a cohort of rural youth. Of primary interest was the contrast between three time periods of youth development operationalized by the grade levels of 6th, 8th, and 10th grade. Also of interest were the effects of two demographic variables, gender and household type, which in previous research have shown to impact asset acquisition and maintenance (i.e. Oman et al., 2002; Vimont, 2010). The study also sought to describe, despite sample size limitations, the relationship between youth assets and substance use.

Consistent with previous research on developmental youth assets (Vimont, 2010), the present study provided empirical findings that as youths age their asset levels decrease. This decrease was most evident between the sixth and eighth grade years with five of the eight assets showing significant declines between the two grade levels. All five of these assets were external, which as previously mentioned, are assets that are provided to youth by their family and community. The failure to provide such opportunities hinders the acquisition and maintenance of these assets by youth. Of the three assets not displaying a significant decline, two of these, Future Aspirations and Responsible Choices, were internal assets.

The study found no main effect for gender regarding assets scores. Household type was found to be a variable that significantly impacted all eight asset scores for each of the three time periods; however, there were no interactional effects. It is beyond the scope of this study to explore factors that might influence the differences between household types, but these differences are present regardless of the age of the youths in this study.

Also, consistent with previous research, current study results showed that as adolescents became older their propensity to engage in substance use increased significantly (Eaton et al., 2012; Oetting & Beauvais, 1990; Vimont, 2010; Windle, 1991). This cohort's reported substance use rate increased substantially between the eighth grade and tenth grade years. Seen as a

transition from middle school to high school, the impact on behavior related to substance use is noteworthy.

In summary, asset scores decreased between the sixth and eighth grade years, while substance use increased between the eighth and tenth grade years. Although the research design of the study does not allow for the deductive conclusion of causation, this finding provides some cursory evidence of a time order effect with developmental youth assets impacting decisions made later by youth on whether to use alcohol, tobacco, or marijuana.

A primary assertion of developmental systems theory is that youths who possess higher levels of developmental youth assets will be less likely to engage in health-compromising behaviors (Leffert et al., 1998). During the 6th grade year, youths who reported not using substances on a monthly basis had significantly higher assets scores for five of the eight assets. Similar findings were displayed for the 8th grade year with four of eight assets having significantly higher scores for reported non-users of substances. In the 10th grade year, all assets displayed significantly higher scores. It is noteworthy that all eight assets for each of the three grade levels displayed higher scores for youths not reporting monthly substance use. The lack of significance in the early grade levels was due to the low number of youths reporting monthly substance use.

The assets of Peer Role Model, Non-Parental Adult Role Model, and Responsible Choices had scores that were significantly higher for youths who were non-monthly users of substances for all three grade levels. These results are consistent with previous research of rural youth from the same geographical location that displayed through regression analysis all three assets being significant in predicting the frequency of substance use within the past year (Vimont, 2010).

Future Aspiration, as well as Use of Time (Groups/Sports), displayed the weakest relationship with reported monthly substance use for the 6th grade and 8th grade years. In the 10th grade year, Use of Time (Groups/Sports) and Family Communication were assets showing weaker relationships with reported monthly substance use, yet as mentioned previously were still significant.

Irrespective of grade level, youths living in other than two-parent households had significantly lower asset scores compared to youths living in two-parent households. The assets displaying the greatest level of differences were Use of Time (Groups/Sports), Family Communication, Peer Role Model and Responsible Choices. With the latter two assets exemplifying significant predictability in youths engaged in monthly substance use, it is not surprising that youths from non-two parent households were also more likely to be users of substances, especially in their 10th grade year.

Gender provided no significant explanation of variance found in asset scores for any of the three grade levels. A prior cross-sectional study with a similar population and a larger sample size displayed females having significant higher scores for six of the eight asset scores. The same study also showed males reporting the use of substances at a higher rate than females (Vimont, 2010). The lack of significance regarding gender as a predictor for either assets or substance use within this cohort study provides evidence that this type of longitudinal study delivers a fresh

perspective on the inquiry of trend information regarding both asset development and substance use. This cohort may have confronted unique external factors that contributed to found differences when compared to previous work. While the examination of possible factors contributing to this distinct difference in results related to gender is beyond the scope of this study, its effects are noteworthy for future research.

Implications for Community Practice

Rural communities desiring to initiate primary prevention-based strategies using developmental assets as a guiding framework must contain two components. First, they must have information pertaining to their local situation (Arthur & Blitz, 2000). This study provides an example of how a local community can obtain empirical information regarding trends in assets and the at-risk behavior of substance use. Although earlier studies (e.g., Arthur et al., 2002; Aspy et al. 2004; Oman et al., 2004; Vesely et al., 2004) consistently displayed a strong association between youth assets and at-risk behavior, using data from other communities may provide faulty conclusions regarding specific assets and their relationship to specific types of at-risk behaviors. Rural communities require data specific to their adolescent populations since there is a dearth of literature specific to this population. This approach rejects the cookie-cutter concept and instead leads to the perspective that building healthy communities requires an appreciation of the unique character found within each community (Ersing & Otis, 2004).

Second, communities must develop strategies and resources that enable adolescents to bond with their communities. Strategies would extend beyond the mere provision of groups and activities can involve youth, but would also include their empowerment to effect change within their community. Specific to these findings, rural adolescents have significant influence over their peers. Positive peer influence can be used to strengthen the community for youths who are likely to seek friends for guidance, advice, and support (Benson, 2006). Recognizing this mutual support propensity can help develop or refine its normalization. A peer-helping approach can also facilitate healthy youth relationships through conversation and decision-making (Benson, 2006). Other strategies that can enhance bonding to community include putting youths in leadership roles; allowing their involvement in the governance of operations and development of policy; using youths to communicate ideas, talents and skills to others; and providing an opportunity for youths to become active in philanthropic volunteer work.

The social work profession with its theoretical orientation coming from the ecological systems perspective is tailored-made to implement asset-based strategies on behalf of communities (Vimont, 2012). Social work practitioners are trained in recognizing barriers of inadequate economic, physical, and human resources often present in rural communities (Belanger, 2005); uncovering, accessing, and maximizing assets (Haulotte & Oliver, 2004); and empowering all layers of a community “in advocating and developing collaborative programs that address the needs of rural children and families” (Templeman & Mitchell, 2004, p. 202). Natural helping networks are essential for developing assets in youth (Watkins, 2004); and the reliance on these networks by members of a community, especially rural communities, requires practitioners invested in this process. Social work’s emphasis on the strengths perspective provides the type of practitioner ready to be engaged in primary prevention efforts.

A corresponding finding of this study that directly impacts primary prevention-based strategy for social work community planners is the significant reduction of asset scores related to peer role models and non-parental adult role models between the 6th grade and 8th grade years. Implementation strategies must initiate, at the latest, during these key years of youth development in order to reduce what appears to be a significant increase in substance use that takes place after the 8th grade year. Both of these external assets reflect the need for youth in this vulnerable period of development to establish positive connections with people outside of their immediate family. A youth's gradual disengagement from his or her family of origin is a normal developmental process, but needs to be managed through the establishment of positive connections as they leave this primary source of socialization.

Descriptive results showing youth from two parent households having significantly higher asset scores and lower substance use rates may be indicative of the socio-economic status of families based on the number of parents in the household. The American Community Survey (U.S. Census, 2013b) results from the local area indicated that the proportion of two-parent households with children under the age of 18 in poverty was 10.4 (95% CIs [8.6, 12.6]) compared to single female-headed households' poverty at 39.6 (95% CIs [31.9, 47.3]). These data indicate that the presence of two parents in a household may have its strength in building assets for youth stemming from a household being less likely to face the stress of living at or near poverty, and able to focus more its attention on the socio-emotional development of its youth.

In general, rural poverty rates are higher than those in urban areas, and are characterized by higher unemployment and a greater prevalence of low wage labor (USDA, 2013). The period for the survey took place during the time that the United States' economy was in the midst of a deep recession, further exacerbating challenges faced by impoverished households. For the social work community planner in rural areas, using skills in resource development and engagement are required.

Due to the survey's lack of variables addressing socio-economic conditions, it was not possible to control for this possible intervening variable. It does, however, merit attention for future survey development and administration. Other factors may also play a role in two-parent households having youth with higher asset scores and reduced chances of engaging in substance use; however, such factors are beyond the scope of the study but do warrant further exploratory research.

Limitations

There are limitations to this study. The small sample size limited the use of stronger statistical testing related to measurements of association between assets and substance use. While the purpose of this study was to provide a description of trends related to both youth developmental assets and substance use, a larger sample size would have produced more definitive findings regarding the association between the two variables over an extended period.

Another limitation of this study was the use of a survey that measured just eight assets. An updated version of this survey now includes concepts such as Cultural Respect, School Connectedness, General Self-Confidence, and Relationship with Mother and Father. The asset of

Good Health Practices dropped from this study, is also an asset measure in the updated survey. Unlike the original survey that measured this asset through one item, an updated version measures the concept using four items (Oman et al., 2010). Future work should include the analysis of this refined instrument regarding its validity and reliability for rural communities.

The inability to conduct repeated measurements at the individual level through the use of a panel study is also another limitation. Panel studies can provide greater capacity to study social life “as an interlocking series of events” (Ruspini, 1999, p. 220) than do cohort studies. Panel studies, however, require the use of identifiable data thereby precluding assurances of anonymity. For youth, disclosing information on sensitive issues related to high-risk behaviors may result in a limited number of youths choosing to participate, or for youths choosing to participate not being forthcoming regarding their behaviors.

This study employed the strategy of measuring substance use by asking responders about the frequency of use during the past year. This type of questioning emphasizes behavioral practices being incorporated within a lifestyle pattern, but such an approach has problems of the responder’s faulty memory. Whether this results in the over- or undercounting of actual behavioral practices is unknown; but accuracy may be compromised, especially for those behavioral practices that exist but not on a regular basis.

Finally, there were a limited number of demographic variables available in this study. Additional information such as economic status, specific geographical location of households (i.e., zip code information), and other family information would enhance factors that may contribute to the understanding of asset development, as well as youth engagement in at-risk behavior. These additional variables would require approval by school boards for their inclusion on surveys of this type, and often such governing bodies are reluctant to provide this required permission.

References

- Arthur, M., & Blitz, C. (2000). Bridging the gap between science and practice in drug abuse prevention through needs assessment and strategic community planning. *Journal of Community Psychology*, 28(3), 241-255.
- Arthur, M. W., Hawkins, J. D., Pollard, J. A., Catalano, R. F., & Baglioni, A. J., Jr., (2002). Measuring risk and protective factors for substance use, delinquency, and other adolescent problem behaviors: The communities that care youth survey. *Evaluation Review*, 26(6), 575-601.
- Aspy, C. B., Oman, R. F., Vesely, S. K., McLeroy, K., Rodine, S., & Marshall, L. (2004). Adolescent violence: The protective effects of youth assets. *Journal of Counseling & Development*, 82(3), 268-276.
- Belanger, K. (2005). In search of a theory to guide rural practice: The case for social capital. In L. Ginsberg (Ed.), *Social work in rural communities* (4th ed.) (pp. 75-93). Alexandria, VA: Council on Social Work Education.

- Benson, P. L. (2003). Developmental assets and asset-building community: Conceptual and empirical foundations. In R. M. Lerner & L. P. Benson (Eds.), *Developmental assets and assets building communities: Implications for research, policy, and practice* (pp. 19–43). New York: Kluwer Academic/Plenum.
- Benson, P. L. (2006). *All kids are our kids: What communities must do to raise caring and responsible children and adolescents* (2nd ed.). San Francisco, CA: Jossey Bass.
- Benson, P. L., Leffert, N., Scales, P. C., & Blyth, D. A. (1998). Beyond the "village" rhetoric: Creating healthy communities for children and adolescents. *Applied Developmental Science*, 2(3), 138-159.
- Blum, R. W., Beuhring, T., Shew, M. L., Bearinger, L. H., Sieving, R. E., & Resnick, M. D. (2000). The effect of race/ethnicity, income, and family structure on adolescent risk behaviors. *American Journal of Public Health*, 90, 1879-1884.
- Bushy, A. (1994). Implementing primary prevention programs for adolescents in rural environments. *The Journal of Primary Prevention*, 14(3), 209-229.
- D'Onofrio, C. (1997). *The prevention of alcohol use by rural youth*. Retrieved from National Institute on Drug Abuse: The Science of Drug Abuse and Addiction: http://archives.drugabuse.gov/pdf/monographs/monograph168/250-363_DOnofrio.pdf
- Daley, M. R., & Avant, F. (2004). Rural social work: Reconceptualizing the framework for practice. In T. L. Scales & C. L. Streeter (Eds.), *Rural social work: Building and sustaining community assets* (pp. 34-42). Belmont, CA: Brooks-Cole.
- DeVellis, R. (2003). *Scale development: Theory and applications* (2nd ed.). Applied Social Research Methods Series (Vol. 26). Newbury Park, CA: Sage.
- Eaton, D. K., Kann, L., Kinchen, S., Shanklin, S., Flint, K. H., Hawkins, J., ... Wechsler, H. (2012). Youth risk behavior surveillance: United States, 2011. *Morbidity and Mortality Weekly Report. Surveillance Summaries*, 61(4), 1-162.
- Engel, R. J., & Schutt, R. K. (2013). *The practice of research in social work* (3rd ed.). Thousand Oaks, CA: SAGE.
- Ersing, R. & Otis, M. (2004). An asset-building approach to promoting community well-being in a rural county. In T. L. Scales & C. L. Streeter (Eds.), *Rural social work: Building and sustaining community assets* (pp. 160 – 177). Belmont, CA: Brooks-Cole.
- Family and Children First Council of Wayne County (FCFCWC). (2012). *And how are the children?: A community report of outcomes and indicators*. Retrieved from <http://www.waynecfc.org/PDFs/And%20How%20are%20the%20Children%202012.pdf>
- Ford, D. H., & Lerner, R. M. (1992). *Developmental systems theory: An integrative approach*. Newbury Park, CA: SAGE.

- Harris, L. L., Oman, R. F., Vesely, S. K., Tolma, E. L., Aspy, C. B., Rodine, S. S., & ... Fluhr, J. (2007). Associations between youth assets and sexual activity: Does adult supervision play a role? *Child: Care, Health and Development*, 33(4), 448-454. doi:10.1111/j.1365-2214.2006.00695.x
- Haulotte, S. M., & Oliver, S. (2004). A strategy for uncovering, accessing, and maximizing assets and strengths in rural area social services. In T. L. Scales & C. L. Streeter (Eds.), *Rural social work: Building and sustaining community assets* (pp. 108-117). Belmont, CA: Brooks-Cole.
- Kelleher, K. J., & Robbins, J. M. (1997). Social and economic consequences of rural alcohol use. In E. B. Robertson, Z. Siobova, G. Boyd, Beatty, Lula, & N. Kozel (Eds.), *Rural substance abuse: State of knowledge and issues*, 196-219. Washington, DC: Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse.
- Kennedy, J. J., & Bush, A. J. (1985). *An introduction to the design and analysis of experiments in behavioral research*. Lanham, MD: University Press of America.
- Leffert, N., Benson, P. L., Scales, P. C., Sharma, A. R., Drake, D., R., & Blyth, D. A. (1998). Developmental assets: Measurement and prediction of risk behaviors among adolescents. *Applied Developmental Science*, 2(4), 209-230.
- Levitt, M. Z., Selman, R. L., & Richmond, J. B. (1991). The psychosocial foundations of early adolescents' high-risk behavior: Implications for research and practice. *Journal of Research on Adolescence*, 1(4), 349-378.
- Lorion, R. P., & Sokoloff, H. (2003). Building assets in real-world communities. In R. M. Lerner & P. Benson (Eds.), *Developmental assets and asset-building communities: Implications for research, policy, and practice* (pp. 121-156). New York, NY: Kluwer Academic/Plenum Publishers.
- Nunnally, J. C. (1978). *Psychometric theory* (2nd ed.). New York, NY: McGraw-Hill.
- Oetting, E. R., & Beauvais, F. (1990). Adolescent drug use: Findings of national and local surveys. *Journal of Consulting and Clinical Psychology*, 58, 385-394.
- Oman, R. F., McLeroy, K. R., Vesely, S. K., Aspy, C. B., Smith, D. W., & Penn, D. A. (2002). An adolescent age group approach to examining youth risk behaviors. *American Journal of Health Promotion*, 16(3), 167-176.
- Oman, R. F., Vesely, S., Aspy, C. B., McLeroy, K. R., Rodine, S., & Marshall, L. (2004). The potential protective effect of youth assets on adolescent alcohol and drug use. *American Journal of Public Health*, 94(8), 1425-1430.
- Oman, R. F., Vesely, S. K., McLeroy, K. R., Harris-Wyatt, V., Aspy, C. B., Rodine, S., & Marshall L. (2002). Reliability and validity of the youth asset survey (YAS). *Journal of Adolescent Health*, 31(3), 247-255.

- Oman, R. F., Vesely, S. K., Tolma, E. L., Aspy, C.B., & Marshall, L. D. (2010). Reliability and validity of the youth asset survey: An update. *American Journal of Health Promotion*, 25(1), e13-e24. doi:10.4278/ajhp.081009-QUAN-242
- Oman, R. F., Vesely, S. K., Tolma, E. L., Aspy, C. B., Rodine, S., & Marshall, L. D. (2007). Does family structure matter in the relationship between youth assets and youth alcohol, drug and tobacco use? *Journal of Research on Adolescence*, 17(4), 743-766.
- Pett, M. A., Lackey, N. R., & Sullivan, J. J. (2003). *Making sense of factor analysis: The use of factor analysis for instrument development in health care research*. Thousand Oaks, CA: SAGE.
- Ruspini, E. (1999). Longitudinal research and the analysis of social change. *Quality and Quantity*, 33(3), 219-227.
- Scales P. C., Benson, P. L., Leffert, N., & Blyth, D. A. (2000). Contribution of developmental assets to the prediction of thriving among adolescents. *Applied Developmental Science*, 4(1), 27-46.
- Scales P., Leffert, N., & Lerner, R. M. (1999). *Developmental assets: A synthesis of the scientific research on adolescent development*. Minneapolis, MN: Search Institute.
- Templeman, S. B., & Mitchell, L. (2004). Utilizing an asset-building framework to improve policies for rural communities: One size does not fit all families. In T. L. Scales & C. L. Streeter (Eds.), *Rural social work: Building and sustaining community assets* (pp. 196-205). Belmont, CA: Brooks-Cole.
- Tönnies, F. (2001). *Tönnies: Community and civil society* [Cambridge Texts in the History of Political Thought]. J. Harris (Ed.). Boston, MA: Cambridge University Press.
- U.S. Census Bureau. (2013a). American FactFinder. *Table B09005: Household type for children under 18 years in households (Excluding householders, spouses, and unmarried partners) 2011-2013 American Community Survey 3-Year Estimates*; generated by Michael Vimont; using American Factfinder; <http://factfinder2.census.gov> (2015, January)
- U.S. Census Bureau. (2013b). American FactFinder. *Table S1702: Poverty status in the past 12 months of families 2011-2013 American Community Survey 3-Year Estimates*; by Michael Vimont; American Factfinder; <http://factfinder2.census.gov> (2015, January)
- U.S. Department of Agriculture (USDA). (2013). *Rural America at a glance: 2013 edition*. Retrieved from http://www.ers.usda.gov/media/1216457/eb-24_single-pages.pdf
- Vesely, S. K., Wyatt, V. H., Oman, R. F., Aspy, C. B., Kegler, M. C., & Rodine, D., ... Kenneth, R. (2004). The potential protective effects of youth assets from adolescent sexual risk behaviors. *Journal of Adolescent Health*, 34(5), 356-365.
- Vimont, M. (2010). *Relationship between youth assets and substance use in rural youths: An empirical process for community based planning*. Saarbrücken, Germany: VDM Verlag Dr. Müller.

- Vimont, M. (2012). Developmental systems theory and youth assets: A primer for the social work researcher and practitioner. *Child & Adolescent Social Work Journal*, 29(6), 499-514.
- Watkins, T. (2004). Natural helping networks: Assets for rural communities. In T. L. Scales & C. L. Streeter (Eds.), *Rural social work: Building and sustaining community assets* (pp. 65-76). Belmont, CA: Brooks-Cole.
- Windle, M. (1991). Alcohol use and abuse: Some findings from the National Adolescent Student Health Survey. *Alcohol Health and Research World*, 15(1), 5-10.

Evaluation of the Demographics, Socioeconomics, and Satisfaction Levels of Recipients at a Rural Food Bank

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Abstract. The present study assesses the demographics, socioeconomics, behaviors, environment, and satisfaction of food bank clients as a way to inform food bank administrators about where their services could be more efficiently focused. Unfortunately, very little has been published in the research literature about levels of recipient satisfaction at food banks in any settings, but especially in rural settings. This descriptive study used existing demographic and socioeconomic data from intake forms at a rural food bank, in addition to the responses of a convenience sample of 44 foodbank recipients to the Client Satisfaction Questionnaire (CSQ-8). The data were used to assess the socioeconomic characteristics of recipients at a rural food bank and their satisfaction level with services provided. Findings indicate high levels of satisfaction among these food bank recipients. Also, small older-adult-dominated households reported higher overall income than larger households with working parents and children. Findings suggest that food banks focus their efforts, especially outreach, on the needs of young families who do not receive regular government benefits such as Social Security.

Keywords: *food bank, rural, client satisfaction, older adults, children, Social Security*

International guidelines suggest that one's food security should be guaranteed as a right (Food and Agricultural Organization of the United Nations, 1996); however, one in five U.S. children live in households experiencing food insecurity (Coleman-Jensen, Gregory, & Singh, 2014). This alarming situation results in part from the fact that food insecurity in the United States is addressed from a residual, needs-based approach. The result is a non-comprehensive patchwork of federal, state, local, and non-profit programs that only partly meet the food security needs of poorer citizens of this country, and completely fail to meet the needs of many sub-populations (Anderson, 2013). At the federal level, this patchwork of programs includes commonly known programs such as the Supplemental Nutrition Assistance Program (SNAP), or Food Stamps; school breakfast, lunch and after school programs; and Women Infants & Children (WIC). There are also other lesser-known programs such as the Child and Adult Care Food Program (CACFP); Summer Nutrition Programs; and the Fresh Fruit and Vegetable Program (FFVP); among others (Food Research and Action Center, 2014). While these programs provide important services, they do not adequately meet the food security of most recipients; thus, food banks in various forms fill in the service gaps left by these federal programs.

Unfortunately, the food bank experience often demeans recipients. As an illustration of this, Anderson (2013) points out that food bank recipients face some of the following obstacles: 1) the tendency of food banks to distribute as much food as possible to needy individuals, regardless of quality; 2) the cultural belief that it is solely the individual's responsibility to maintain one's own food security; and 3) the fact that the intake process to receive foods from

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both public and private non-profit food assistance programs is complicated, inhumane, and a general nuisance (see also, Bhattarai, Duffy & Raymond, 2005). In other words, the provision of food security in the United States from government and non-profit providers is dominated by the residual approach to social welfare. In this approach social services are seen as temporary, emergency functions to be withdrawn when the family and the market resume their proper roles as the “natural channel” for meeting food security needs (Hölscher, 2008).

The residual perspective’s focus on individual rather than social responsibility is a fundamental problem of the food bank experience in the United States (Anderson, 2013). One way to overcome this problem is to empower food bank recipients by assessing their perspectives, characteristics, environments, and opinions in order to determine whether they are indeed satisfied and if the services and products they receive meet their needs. Unfortunately, there appears to be no published evaluation of client satisfaction at a food bank that addresses the question: “Are food bank recipients satisfied with their food bank experience?” Although Mabli, Cohen, Potter, and Zhao, (2010) recently prepared a report for Feeding America in which they investigated many aspects of client satisfaction in a national sample of food bank recipients, there is no professional, peer-reviewed, journal article that investigates or assesses client satisfaction among food bank recipients. This mirrors a general attitude, confirmed by the literature, that since the food is free, recipients should be satisfied and grateful (Berner, Ozer, & Paynter, 2008; Blau, 1986; Duffy et al., 2006; Kicinski, 2012; Poppendieck, 1998). Thus, researchers have hitherto largely ignored client satisfaction among food bank recipients.

However, client satisfaction is not the only way to assess the quality of food bank service provision. Because client satisfaction surveys notoriously collect overwhelmingly positive responses with a “predictably positive skew” (Royse, Thyer, & Padgett, 2010, p. 177), it is important to assess the perspective and environment of food bank recipients. This can be done by investigating the general sociodemographic and socioeconomic characteristics of food bank recipients to determine whether their food security needs are being met. Unfortunately, evaluation research on food banks and other private food assistance programs lacks uniformity and typically uses food bank employees as a source of data rather than the recipients themselves (Berner, et al., 2008; Mosely & Tiehen, 2004). This approach misses an important opportunity to assess the perspective of clients and suggests a more efficient focus of food bank services. Measuring customer satisfaction with uniform, quantitative methods and investigating food bank recipient demographics are valuable additions to the food bank-related literature. Thus, the research questions for this study are: What are the client satisfaction levels of food bank recipients? Also, how might recipient socio-demographic characteristics inform the provision of quality services in a rural food bank?

Beliefs and Values about Poverty Interventions

Among the theoretical approaches to understanding food security for low-income households, the individualistic attribution is often the dominant focus. The individualistic perspective traces the causes of poverty back to the purported shortcomings of the individual, thus the individual is blamed and therefore held responsible for their poverty (Anderson, 2013; Bullock, 2004; Duffy et al., 2006). The dominance of the individualistic explanation for poverty in American culture creates a significant social and emotional obstacle for individuals who suffer food insecurity.

What is needed in the fight against poverty in the United States is a paradigmatic shift where provision of food security is viewed from a rights-based approach rather than the traditional residual, individualistic approach that dominates the current social service system (Anderson, 2013; Jarosz, 2011). As Anderson (2013) has eloquently stated, “thinking about access to healthy food as a right, rather than a privilege of those with sufficient purchasing power to buy good food, fundamentally changes how we see causes of and solutions to food insecurity” (p. 113). Anderson (2013) argues that there would be promising and lasting impacts from a shift to a rights-based approach to food security, including, fewer childhood developmental problems caused by food insecurity, greater dignity for the recipients of food assistance, and an increase in the adoption of environmentally sound farming practices.

National Anti-Poverty Programs for Food Security

Unfortunately, a rights-based approach to food security in the United States is still only a dream. In 2013, food insecurity was a problem for approximately 17.5 million Americans, roughly 14% of the population (Coleman-Jensen et al. 2014). This means that 17.5 million Americans had difficulty at some time during that year providing enough food for their household. The federal response to food insecurity includes programs such as: the Supplemental Nutrition Assistance Program (SNAP); the National School Lunch Program (NSLP); the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); the Child and Adult Care Food Program (CACFP); and the School Breakfast Program (SBP) (Anderson, 2013). The Supplemental Nutrition Assistance Program (SNAP) supports a majority of America’s poor in their efforts to acquire foods (Anderson, 2013; Tanner, 2013). However, benefits from SNAP and other federal anti-poverty programs do not provide low-income families with sufficient nutrition (Zhang & Lamichhane, 2014; Jensen, 2002; Olson, Rauschenbach, Frongillo, & Kendall, 1996; Rose, Gundersen, & Oliveira, 1998). The shortcomings of federal assistance programs in alleviating food insecurity are especially evident when one considers that 62% of food-insecure households are participants in one or more of the top three of those programs (Coleman-Jensen et al., 2014).

For many, the Old Age, Survivors and Disability Insurance Program (OASDI), commonly known as “Social Security,” provides some relief from the effects of poverty and disability (Glasmeyer, 2006). The number of retired workers and dependents receiving Social Security benefits has been steadily increasing to 40,801,365 recipients as of 2013 (Social Security, 2013). For 66% of older adults who receive Social Security, this was their primary income source (Barusch, 2012). In spite of the fact that Social Security is a somewhat viable source of income for older adults, 8.7% of households with an older adult present still report food insecurity (Coleman-Jensen et al., 2014). Thus, like the other aforementioned federal programs, it would appear that Social Security is only partially ameliorating food insecurity among older adults.

Nonprofit and Private Anti-Poverty Assistance for Food Security

Unfortunately, there is also room for critique of nonprofit and private food assistance programs and the social/cultural realities that surround the provision of assistance from these food pantries. Low-income individuals tend to seek support from non-profit organizations while also receiving support from government programs, such as Social Security and SNAP (Bhattari,

Duffy, & Raymond, 2005; Berner et al., 2008; Daponte, Lewis, Sanders, & Taylor, 1998; Duffy et al., 2006; Mabli et al., 2010). Unfortunately, staff at many non-profit food banks believe that food bank recipients simply need to work harder, change their behaviors, and pull themselves out of poverty by their own efforts (Barusch, 2012; Duffy et al., 2006). This thinking may be impacted by the differences in the recipients' lower socioeconomic background relative to that of program employees or volunteers (Anderson, 2013; Berner et al., 2008; Blau, 1986; Duffy et al., 2006; Kicinski, 2012; Poppendieck, 1998).

This discordance between workers and recipients is even more severe at rural nonprofit and private food banks where recipients are more likely to face humiliation and stigma (Bhattari et al., 2005; Molnar et al., 2001; Nooney et al., 2013). These rural food bank recipients also tend to suffer more food insecurity due to service systems that fail to deliver quality services (Holben, McClincy, Holcomb, Dean, & Walker, 2004; Huddleston-Casas, Charnigo, & Simmons, 2009). Occasionally food banks directors even view recipients with suspicion rather than showing sympathy and respect (Duffy et al., 2006).

Consequences of Food Insecurity among Rural Populations

In general, exposure to food insecurity is more pronounced in rural regions than urban or suburban areas because rural job markets are limited (Henderson & Akers, 2009). Children in rural low-income households are more vulnerable to poor nutrition because of lower quality foods provided (Sharkey, Dean, & Johnson, 2011). A majority of foods provided by food banks are not nutritionally balanced, which makes children more vulnerable to nutrition-related health issues, such as obesity, diabetes, and cardiovascular disease. Children with poor nutrition intake are also vulnerable to low academic achievement (Alaimo, Olson, & Frongillo, 2001; Alaimo, Olson, Frongillo, & Briefel, 2001; Anderson, 1990; Casey et al., 2005; Coleman-Jensen, Nord, Andrews, & Carlson, 2011; Jyoti, Frongillo, & Jones, 2005; Matheson, Varady, Varady, & Killen, 2002; USDA, 2009; Verpy, Smith, & Reicks, 2003). There is, therefore, much to be concerned about among the rural poor who seek assistance from food banks, especially those households with young children.

As a matter of equity and social justice, food bank recipients should not have to face any more stigma in their procurement of food at a food bank than they would when visiting their local grocery store. If food banks wish to reach the greatest number of people possible with their services, then they should ensure that stigma and bureaucracy are not chasing away potential recipients. In addition, as with any business, it makes sense that food banks put forth efforts to understand the sociodemographic, socioeconomic, and other pertinent characteristics of their recipients so that they can specifically tailor services to recipients.

Past Evaluation Methods at Food Banks

Many food banks have been critically evaluated, using qualitative research methods. Qualitative inquiry in the form of focus groups (Verpy et al., 2003) or case studies (Molnar et al., 2001) is well-suited for addressing the unique and specific issues that arise in individual food banks. However, the nature of qualitative sampling methods and the small sample sizes make it impossible to generalize the findings to a broader national level.

Few studies of food banks use longitudinal designs to collect long-term data from recipients and likewise few national studies of this population have been conducted (e.g., Mosley & Tiehen, 2004). The obvious exception is the recently completed report by Mabli, et al. (2010), which used a national sample of over 65,000 food bank recipients. One reason for these research deficiencies may be that while nonprofit and private food organizations have the advantage of working closely with low-income individuals in a community setting, they are not well-suited to contribute to the nationwide effort to evaluate (especially longitudinally) the entire food assistance system in the United States. Local, rural food banks serve a diverse and often transient reciprocity in different locations, but are often ill-equipped to maintain consistent records and documentation. This record keeping deficiency dramatically complicates long-term analyses and forces evaluators to rely primarily on staff feedback as a source of data.

Recipient Satisfaction Scales in Other Settings

Client satisfaction is a common evaluation focus when studying other populations (e.g., Attkisson, & Greenfield, 2004); however, it seems largely ignored in food bank research. Since most food banks are run by private and nonprofit organizations and are often administered by volunteers, they sometimes lack structured intake forms (Molnar et al., 2001), and are not equipped to collect or interpret client satisfaction data. The lower socioeconomic status of food bank recipients can also lead to the expectation among food bank staff that recipients should appreciate free food, and whether they are satisfied is not critical (Berner et al., 2008; Blau, 1986; Duffy et al., 2006; Kicinski, 2012; Poppendieck, 1998). In reality, a regular assessment of client satisfaction using a uniform tool could enhance communication and relationships between employees and recipients; however, there is little evidence that such assessments are used in the food bank arena (Garland & Besinger, 1996; Royse et al., 2010; Sutherland et al., 2012).

Satisfaction data among food bank recipients were recently collected and reported by staff at Mathematica Policy Research in a national assessment. This research was part of the Hunger in America 2010 report prepared for Feeding America (Mabli et al., 2010). The authors used a set of simple, proprietary client satisfaction questions to assess satisfaction, but they did not appear to use a standardized, reliable, and psychometrically evaluated client satisfaction scale, such as the Client Satisfaction Questionnaire (CSQ-8) (Pascoe & Attkisson, 1983). The CSQ-8 (Pascoe & Attkisson, 1983) documents satisfaction level among clients in a quantitative manner, and has been used to assess services at many types of agencies (e.g., Garland & Besinger, 1996; Sutherland et al., 2012). Given that food banks are essential to improving food security in the United States, researchers should consider assessing client satisfaction in food banks in order to ensure satisfactory service delivery.

Methods

This study was intended as a framework for enacting improvements at a rural food bank located in the eastern United States. This particular food bank provides free fresh produce, eggs, and some dairy products to low-income individuals and families, rather than the non-perishable foods traditionally provided at a food bank. The socioeconomic and sociodemographic characteristics of the area served by this food bank are as follows. The community is surrounded by farmland with some significant manufacturing and distribution facilities serving as major local economic engines (Fisher, Lyman, Butts, & Mosher, 2014). The total population in 2010

was 27,920, up 4000 from the 2000 census data (Fisher, Lyman, Butts, & Mosher, 2014). The median age in the area is 29.8 years, substantially lower than the state median of 40.1 years due to the presence of a small state university in the area. Of the 10,091 households in the community, 28.2% included children under 18 years old and 11% included people 65 years old and over. The area is made up of a 93.2% White/Caucasian population with much smaller Black/African American (3.5%) and Hispanic/Latino (2.8%) populations. The poverty rate in the area increased 7% during the last recession to 19.75%, which is 13% higher than the state average. The median income for the area is \$47,314, which is lower than the state median of \$52,267 (Fisher, Lyman, Butts, & Mosher, 2014). The unemployment rate is 4.5%, which is lower than the state rate of 8.5%.

The overall purpose of this formative evaluation was primarily to evaluate recipients' satisfaction, but also their basic demographics. The present article reports the quantitative sociodemographic, socioeconomic, and consumer satisfaction data collected during the evaluation.

Protection for Research Participants

This research was conducted only after receiving approval from the university Institutional Review Board and from the Board President of the organization. No identifying information was collected during the data collection, and informed consent was obtained from all research participants.

Measures

Recipient Demographic Analysis. Board members at the food bank provided the research team with hard copies of the intake forms completed for all first-time recipients during the 2012 calendar year with all identifying information redacted. These forms included self-reported information organized by household regarding age, employment, wages, other income, monthly expenses, and debts. The agency also provided attendance data collected by food bank volunteers for the first quarter (January-March) of 2013. Researchers also calculated the average age of each household and the distance that each recipient traveled to receive services from the food bank as a part of this demographic analysis.

Recipient Satisfaction Survey. The Customer Satisfaction Research Team (CSRT) developed the proprietary Recipient Satisfaction Survey (RSS) (Arnold, Berry, Bobby, Houck, & Shanahan, 2013) based on items requested by the Board of Directors of the food bank and the research team. Some questions were taken directly from Le Meur's (2011) study of food banks, and asked questions such as the number of times the recipient had used the program and the convenience of the hours of operation.

The Client Satisfaction Questionnaire (CSQ-8). The Recipient Satisfaction Survey incorporated the entire CSQ-8 which is made up of eight Likert-scale questions (Pascoe & Attkisson, 1983). The CSQ-8 is a standardized instrument with excellent reliability which has been used in numerous studies measuring client and staff satisfaction in health, mental health, and human service programs (e.g., Attkisson & Greenfield, 2004; Attkisson & Zwick, 1982; Larsen, Attkisson, Hargreaves, & Nguyen, 1979; Nguyen, Attkisson, & Stegner, 1983). The

internal consistency of the CSQ-8 has been reported as reliable (Cronbach's α ranging from .83 to .93) (Sederer, Dickey, & Hermann, 1996). The CSQ-8 has also been used to evaluate the criterion-related validity of newer client satisfaction instruments (e.g., Noda, et al., 2012), and yielded satisfactory internal consistency in this research (Cronbach's α value of .78).

Data Collection Procedure

Socioeconomic and sociodemographic data came from existing agency intake forms and reports. The RSS was distributed over the course of three Tuesday evenings when recipients collected their produce. Recipients were chosen using a convenience sampling procedure.

Sample

Demographic and attendance data were provided by the agency for 194 households who accessed services from the food bank during the calendar year 2012. Attendance data for that sample were also provided for the first three months of 2013. A convenience sample totaling 44 recipients successfully completed the Recipient Satisfaction Survey.

Data Analysis Procedure

The collected data were statistically processed through the Statistical Package for the Social Science (SPSS) software (Version 22.0). Descriptive statistics were used to report demographic characteristics of the sample, correlational analyses were used to investigate relationships between various demographic and satisfaction variables, and independent sample *t*-tests were used to assess differences between selected subgroups in the sample.

Results

Demographic Analysis of Food Bank Recipients

The food bank in this study primarily serves a White/Caucasian population (72.7%), although small numbers of other racial and ethnic groups are represented (see Table 1). The average number of people living in a recipient's household was relatively small ($M = 2.74$, $SD=1.73$) and the modal reported household size was one household member; the largest reported household size was nine.

Recipient age and income findings. A correlation analysis of household monthly expenses data showed significant moderate positive relationships between household size and the following monthly expenses: electricity expenses $r(192) = .36$, $p < .001$; auto expenses, including gasoline $r(192) = .34$, $p < .001$; and food expenses $r(192) = .45$, $p < .001$.

Table 1

Race/Ethnicity of Recipients

<u>Race/Ethnicity</u>	<u>Number</u>	<u>Percent</u>
White/Caucasian	145	74.7
Black/African American	7	3.6
Hispanic	4	2.1
Another Race Not Specified	5	2.6
Missing Data	33	17

A similar correlational analysis of the total household income found a significant moderate positive relationship between the size of the household and the total monthly earned income, $r(192) = .43$, $p < .001$. There was nothing close to a significant finding with the other income variables: income from non-employment sources, total monthly income, and total yearly income. This suggests that households with more members are more likely to have more earned income, while those with fewer members have less earned income. This becomes more meaningful with the further analysis of household income where there is an older adult present.

Of the 194 households from which socioeconomic and sociodemographic data were collected, approximately one-fifth (21.6%) reported having an older adult or person with a disability living in the home as indicated by their receiving Social Security. It turns out that the total yearly income for those households receiving Social Security ($M = \$17,675.19$, $SD = \$6,530.81$) was significantly higher ($t(192) = -6.21$, $p < .001$) than those without this income ($M = \$9670.04$, $SD = \$7,616.04$). On a related note, the size of the households with a Social Security recipient ($M = 1.90$, $SD = 1.17$) was significantly smaller ($t(100.38) = 4.63$, $p < .001$) than those without a Social Security recipient present ($M = 2.97$, $SD = 1.79$). Surprisingly, yearly income in households where an adult was employed ($M = \$7,528.77$, $SD = \$3,955.83$) was significantly lower ($t(131.09) = -5.77$, $p < .001$) than in those households where there was no employed adult ($M = \$13,935.69$, $SD = \$9,168.46$).

An additional variable was created to calculate the collective average age of the households receiving services from the food bank. The overall average household member age was 43 ($SD = 19.98$; range = 83.5, 10.5, 94). A correlational analysis of the average household size with various demographic variables found a significant strong negative relationship between the average age of the household and the number of people in the household, $r(192) = -.66$, $p < .001$. There were also significant moderate negative correlations between average household age and the following socioeconomic variables: hourly rate of pay at place of employment, $r(192) = -.41$, $p < .001$; hours per week worked at place of employment, $r(192) = -.43$, $p < .001$; and

monthly income from employment, $r(192) = -.44, p < .001$. Conversely, there was a significant moderate positive correlation between average household age and monthly income from sources other than employment, $r(192) = .33, p < .001$.

When taken together, these *t*-test and correlational findings suggest that smaller households were more likely to be made up of older adults who receive Social Security and in those households, there was very little income earned through employment. Yet, in those small, older-adult-dominated households, there was more overall income. There was a negative relationship between age of the household and employment income, but a positive relationship between age of the household and non-employment income from Social Security.

Attendance findings. Food bank recipients received assistance an average of 2.95 ($SD = 3.39$) weeks during the first twelve weeks of 2013 ($Mdn = 2.00$ weeks). There was a small significant positive correlation, $r(192) = .20, p = .006$, between the number of weeks recipients attended the food bank and their total yearly income. This suggests that those with higher incomes were more likely to attend the food bank. Based on anecdotal observations and the previous findings about older adults and their income, it is likely that older adults are more likely to consistently seek services from the food bank.

Employment and other income findings. Of 194 food bank recipients, 174 were currently employed at a minimum of at least one job. Fifteen recipients worked at two or more places of employment, and three had three places of employment.

A total of 67 recipients of the food bank's services received federal Food Stamp benefits. An independent samples *t*-test was conducted to determine whether recipients who received Food Stamps attended the food bank more often than those who did not receive Food Stamps. The test was insignificant $t(192) = -.08, p = .94$, suggesting that people who receive Food Stamps ($M = 2.99, SD = 3.16$) and those who do not receive Food Stamps ($M = 2.94, SD = 3.52$) attend the food bank about the same number of times. Similarly, insignificant findings arose from a *t*-test analysis of the income variables, debt variables, and expense variables for food stamp recipients versus non-food stamp recipients. Thus it appears that the receipt of food stamp benefits does not set recipients apart from those who do not receive those benefits in any statistically significant way.

General Client Satisfaction Analysis

The previous demographic findings relate to the recipients of the food bank as a whole. A smaller sample of those recipients completed the RSS. During the collection of these client satisfaction data from this sub-sample, a separate set of demographic variables were collected. The sample consisted primarily of females (77.3%; $N = 34$), while 22.7% ($N = 10$) were males. The sample ranged in age from 18 to 62 years of age, with 6.8% of recipients between ages 18 to 28, and 20.5% between ages 29 and 39. A large portion of the sample (38.6%) ranged between age 40 to 50; 15.9% were between ages 51 to 61, and the remaining 18.2% were 62 years or older. A large percentage (91%) of the participants had a high school education or higher.

Recipient responses to the open-ended questions on the RSS indicate that 80% of recipients saw no need for improvement in food bank services; however, some recipients

suggested the provision of additional staples, such as gas vouchers, cleaning products, and a more varied selection of foods. The second question dealt with transportation, and as would be expected from previous transportation analyses, little significance was found. The third and fourth questions dealt with likes and dislikes about the organization. As with the first question, most people (84%) answered in a way that suggested they did not dislike any aspect of their foodbank experience. The only dislike reported was that the time for distribution of the produce was inconvenient.

Client Satisfaction Results

The RSS asked the food bank recipients, “How satisfied are you with the [food bank]?” and then had them rate their satisfaction with the following: service of staff, quality of food, accessibility of building, and hours of operation. No recipient gave a score of “Not Satisfied;” and no response related to services provided was less than “Satisfied.” Of the four items, the item related to quality of food showed the lowest average satisfaction, but still ranked between the “Very Satisfied” and “Satisfied” range. Overall, 52.3% of respondents to the survey gave the agency a perfect “Very Satisfied” rating across all four service areas. For the recipients of this food bank, that average satisfaction score was 93.6% of the possible perfect score.

Client Satisfaction Questionnaire (CSQ-8) Results

Because the CSQ-8 (Pascoe & Attkisson, 1983) has eight questions based on a four-point Likert scale, the highest possible satisfaction score is a 32. Just under forty-six percent (45.5%) of study participants scored the agency at a perfect 32. The mean scores across all eight of the CSQ-8 items ranges from 3.66-3.90. The highest score was on the question relating to whether the respondent would recommend the program; the lowest score was on the question asking if the services helped the clients deal more effectively with their problems. The overall mean score on the CSQ-8 as a whole was a 30.53 out of 32 ($SD = 2.07$).

Discussion

Demographic Analysis: Differing Levels of Food Insecurity

Study results illustrate the realities faced by people in poverty who use both federal programs and private food bank services in a rural setting. First, a counterintuitive conclusion from this study is that employed food bank recipients are generally less financially secure than unemployed recipients. In larger households where there are young children present, there was less income reported than in smaller households with an older adult present. Yet, in the current sample, the households with young children were more likely to include at least one employed adult. This was illustrated by the negative correlation between average household age and hourly rate of pay, hours per week worked, and monthly income from employment.

As expected, among sampled food bank recipients, older people who receive Social Security as their primary annual income tend to enjoy more food security. The findings reported here mirror those of Zhang & Lamichhane (2014) who concluded that food bank recipients with children in the household faced a greater threat of food insecurity during the recent recession than the general population. Similarly, in their analysis of food security among households with

varying compositions, Coleman-Jensen et al. (2014) found the lowest rates of “very low food security” among households where there was an older adult present or an older adult was living alone. It appears that findings reflect those of other authors (Barusch, 2012; Coleman-Jensen et al., 2014; Glasmeir, 2006), suggesting that government benefits, such as Social Security, play a major role in bringing older adults and disabled adults one step further from poverty than their younger counterparts who do not have access to such benefits.

In this sample, families with young children struggled to meet their nutritional needs despite the fact that the average number of hours worked was 32.1 hours, and nearly ten percent of the recipients had two or more jobs. Also, it is clear from these findings and the literature (e.g., Tanner, 2013) that food stamps (SNAP) reciprocity does little to ameliorate poverty since those who received food stamps were just as likely to receive food bank services as those who did not have access to food stamps. In either case, it is clear that larger households with young children present have fewer institutionalized government benefits available to them, and face greater economic hardship than smaller households with older adults present. In addition, for many younger families with children, employment by itself is not a poverty panacea and is not enough to pull a family above the poverty level.

One clear conclusion from these findings is that the purposes of the Social Security system have been somewhat fulfilled, and those who receive these benefits enjoy some poverty relief. Unfortunately, for employed, young families with children who are not eligible to receive Social Security benefits, poverty and food insecurity remain in their reality. In fact, these findings coincide with recent reports that the majority of children (51%) in public schools in the United States come from low income families (Southern Education Foundation, 2015). The moderate success of Social Security in alleviating poverty among older adults lends credence to Anderson’s (2013) argument that governments should approach food security with a human rights perspective rather than with an underfunded patchwork of stigmatizing programs (Nooney et al., 2013) that fail to ensure that all families, not just older adults, have the food they need.

Client Satisfaction at Nonprofit and Private Food Organizations

Unlike past evaluations of food banks, this work is the first published formal evaluation of a food bank that used the CSQ-8 to measure client satisfaction (e.g., Michalski, 2003a; Michalski, 2003b; Molnar et al., 2001; Popielarski & Cotugna, 2010; Tarasuk & Beaton, 1999; Verpy et al., 2003). As expected with many client satisfaction evaluations, the study was successful in showing high satisfaction level among recipients (Mabli et al., 2010; Royse et al., 2010).

While client satisfaction findings are expectedly positive (Mabli et al., 2010; Royse et al., 2010), it is still worthwhile for food banks to consider simple tools such as the CSQ-8 (Pascoe & Attkisson, 1983) as a regular part of food bank documentation. This would enable staff/funders to consistently collect satisfaction data from program recipients as a part of an ongoing evaluative process. Food banks that collect such data could be well positioned to accrue funding and enhance service provision for recipients.

Limitations

There are a number of inherent limitations associated with the use of existing data in a fledgling social service agency. For example, there were instances when sampling procedures were not consistently applied due to the realities of collecting data while participants are more focused on receiving their weekly allotment of fresh produce. In addition, the data collection period was not long enough to ensure a representative sample of all recipients. The number of recipients who completed the CSQ-8 (Pascoe & Attkisson, 1983) and the RSS was quite small (n=44). Furthermore, there is potential bias in the data because subjects were conveniently surveyed only when they volunteered to participate in the study during produce distribution. This may have impacted the client satisfaction level data in particular, because recipients who were not willing to fill out a survey may also not be satisfied with services, and less likely to volunteer to complete a survey, and vice versa. Also, one small, rural, organization does not represent private and nonprofit food assistance programs in other regions and service settings.

Recommendations

While the food bank services and products are clearly beneficial, it is essential for private and nonprofit organizations to explore solutions to help meet recipients' needs, especially the needs of families with young children. Thus, interventions that would benefit young families should be a priority for food banks.

Follow-up client satisfaction research in other diverse settings with a larger and representative sample would enhance the performance of food banks in the United States. Because the CSQ-8 scale (Pascoe & Attkisson, 1983) typically shows uniformly positive responses, developing additional scales to discover the more nuanced satisfaction issues for recipients at food banks is also warranted.

Conclusion

The present study highlights the importance of assessing the demographics, socioeconomics, behaviors, and environments of food bank clients, in addition to collecting client satisfaction data, as a way to evaluate food bank services. Empowering food bank recipients to be a part of the evaluation process is a necessary step toward changing the current strategy to food security toward a rights-based approach (Anderson, 2013). An eventual paradigmatic change to a rights-based approach would improve the asymmetric dynamics between workers and recipients (Anderson, 2013). Until that change occurs, there will continue to be a need for food banks and related supports and programs that help working families meet the needs that their meager employment does not.

References

- Alaimo, K., Olson, C. M., & Frongillo, E. A. (2001). Food insufficiency and American school-aged children's cognitive, academic, and psychosocial development. *Pediatrics*, *108*(1), 44-53.

- Alaimo, K., Olson, C. M., Frongillo, E. A., & Briefel R. R. (2001). Food insufficiency, family income, and health in U.S. preschool and school-aged children. *American Journal of Public Health, 91*(5), 781-786.
- Anderson, M. D. (2013). Beyond food security to realizing food rights in the U.S. *The Journal of Rural Studies, 29*, 113-122.
- Anderson, S. A. (1990). Core indicators of nutritional state for difficult-to-sample populations. *Journal of Nutrition, 120*(11S), 1559-1599.
- Arnold, C., Berry, S., Bobby, M., Houck, A., & Shanahan, C. (2013). *Recipient Satisfaction Survey*. Unpublished instrument. Department of Social Work and Gerontology, Shippensburg University.
- Attkisson, C. C., & Greenfield, T. K. (2004). The UCSF client satisfaction scales: The client satisfaction questionnaire-8. In M. Maruish (Ed.), *The use of psychological testing for treatment planning and outcome assessment* (3rd ed., Vol. 1). Mahwah, NJ: Lawrence Erlbaum Associates.
- Attkisson, C. C., & Zwick, R. (1982). The client satisfaction questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning, 5*(3), 233-237.
- Barusch, A. S. (2012). *Foundations of Social Policy: Social Justice in Human Perspective* (4th ed.). Belmont, CA: Brooks/Cole Cengage Learning.
- Berner, M., Ozer, T., & Paynter, S. (2008). A portrait of hunger, the social safety net, and the working poor. *Policy Studies Journal, 36*(3), 403-420.
- Bhattari, G. R., Duffy, P. A., & Raymond, J. (2005). Use of food pantries and food stamps in low-income households in the United States. *Journal of Consumer Affairs, 39*(2), 276-298.
- Blau, P. M. (1986). *Exchange and power in social life*. New Brunswick, NJ: Transaction.
- Bullock, H. E. (2004). From the front lines of welfare reform: Analysis of social worker and welfare recipient attitudes. *The Journal of Social Psychology, 144*(6), 571-588.
- Casey, P. H., Szeto, K. L., Robbins, J. M., Stuff, J. E., Connell, C., Gossett, J. M., & Simpson, P. M. (2005). Child health-related quality of life and household food security. *Archives of Pediatrics & Adolescent Medicine, 159*(1), 51-56.
- Coleman-Jensen, A., Gregory, C., & Singh, A. (2014). Household Food Security in the United States in 2013 (Economic Research Report No. ERR-173). Retrieved from <http://www.ers.usda.gov/publications/err-economic-research-report/err173.aspx#.VBmJ-RZuU68>
- Coleman-Jensen, A., Nord, M., Andrews, M., & Carlson, S. (2011, September). *Household food security in the United States in 2010*. United States Department of Agriculture, Economic Research Services. Economic Research Report No. ERR-125.

- Daponte, B. O. (2000). Private versus public relief: Use of food pantries versus food stamps among poor households. *Journal of Nutrition Education*, 32(2), 72-83.
- Daponte, B. O., Lewis, G. H., Sanders, S., & Taylor, L. (1998). Food pantry use among low-income household in Allegheny County, Pennsylvania. *Journal of Nutrition Education*, 30(1), 50-57.
- Duffy, P. A., Irima-Vladu, M., Cashwell, S., Bartkowki, J. P., Molnar, J. J., & Casanova, V. (2006). Food pantries and the populations they serve: Strange bedfellows or strategic partners? *Sociological Inquiry*, 76(4), 502-527.
- Fisher, L., Lyman, M. J., Butts, L. A., & Mosher, M. (2014). *Shippensburg, Pennsylvania Community Assessment 2014*. Prepared by: Shippensburg Community Resource Coalition. Retrieved from <http://www.shippresources.org/SCRC%20reportfinal.pdf>
- Food and Agricultural Organization of the United Nations. (1996, November). *Rome declaration on world food security and world food summit plan of action*. Retrieved from <http://www.fao.org/docrep/003/w3613e/w3613e00.HTM>
- Food Research & Action Center. (2015). *Federal food/nutrition programs*. Retrieved from <http://frac.org/federal-foodnutrition-programs/>
- Garland, A. F., & Besinger, B. A. (1996). Adolescents' perceptions of outpatient mental health services. *Journal of Child and Family Studies*, 5(3), 355-375.
- Glasmeyer, A. (2006). *An atlas of poverty in America: One nation, pulling apart, 1960-2003*. New York, NY: Routledge Taylor & Francis Group.
- Henderson, J., & Akers, M. (2009). Recession catches rural America. *Economic Review*, 94(1), 65-87.
- Holben, D. H., McClincy, M. C., Holcomb, J. P., Dean, K. L., & Walker, C. E. (2004). Food security status of households in Appalachian Ohio with children in Head Start. *Journal of the American Dietetic Association*, 104(2). 238-241.
- Hölscher, D. (2008). The emperor's new clothes: South Africa's attempted transition to developmental social welfare and social work. *International Journal of Social Welfare*, 17(2), 114-123
- Huddleston-Casas, C., Charnigo, R., & Simmons, L. A. (2009). Food insecurity and maternal depression in rural, low-income families: A longitudinal investigation. *Public Health Nutrition*, 12(08), 1133-1140.
- Jarosz, L. (2011). Defining world hunger. *Food, Culture & Society*, 14(1), 117-139.
- Jensen, H. H. (2002). Food insecurity and the food stamp program. *American Journal of Agricultural Economics*, 84(5), 1215-1228.
- Jyoti, D. F., Frongillo, E. A., & Jones, S. J. (2005). Food security affects school children's academic performance, weight gain, and social skills. *Journal of Nutrition*, 135(12), 2831-2839.

- Kicinski, L. R. (2012). Characteristics of short and long-term food pantry users. *Michigan Sociological Review, 26*, 58-74.
- Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning, 2*, 197-207.
- Le Meur, A. (2011). *Sacramento's food insecure: Who is utilizing Sacramento's food bank emergency food services* (Master's thesis). Available from Sacramento State Scholar Works. Retrieved from <http://hdl.handle.net/10211.9/1413>
- Mabli, J., Cohen, R., Potter, F., & Zhao, Z. (2010, January). *Hunger in America 2010: National report prepared for feeding America*. Princeton, NJ: Mathematica Policy Research. Retrieved from <http://www.mathematica-mpr.com/our-publications-and-findings/publications/hunger-in-america-2010-national-report-prepared-for-feeding-america>
- Matheson, D. M., Varady, J., Varady, A., & Killen, J. D. (2002). Household food security and nutritional status of Hispanic children in the fifth grade. *American Journal of Clinical Nutrition, 76*(1), 210-217.
- Michalski, J. H. (2003a). Housing affordability, social policy and economic conditions: Food bank users in the greater Toronto area, 1990-2000. *The Canadian Review of Sociology and Anthropology, 40*(1), 65-92.
- Michalski, J. H. (2003b). The economic status and coping strategies of food bank users in the greater Toronto area. *Canadian Journal of Urban Research, 12*(2), 275-298.
- Molnar, J. J., Duffy, P. A., Claxton, L., & Bailey, C. (2001). Private food assistance in a small metropolitan area: Urban resources and rural needs. *Journal of Sociology and Social Welfare, 28*(3), 187-209.
- Mosley, J., & Tiehen, L. (2004). The food safety net after welfare reform: Use of private and public food assistance in the Kansas City metropolitan area. *Social Service Review, 78*(2), 267-283.
- Nguyen, T. D., Attkisson, C. C., & Stenger, B. L. (1983). Assessment of patient satisfaction: Development and refinement of a service evaluation questionnaire. *Evaluation and Program Planning, 6*(3-4), 299-314.
- Noda, T., Sugiyama, N., Ito, H., Soininen, P., Putkonen, H., Sailas, E., & Joffe, G. (2012). Secluded/restrained patients' perceptions of their treatment: Validity and reliability of a new questionnaire. *Psychiatry and Clinical Neurosciences, 66*(5), 397-404.
- Nooney, L. L., Giomo-James, E., Kindle, P. A., Norris, D. S., Myers, R. R., Tucker, A., & Stanley, R. J. (2013). Rural food pantry users' stigma and safety net food programs. *Contemporary Rural Social Work, 5*, 243-248.
- Olson, C. M., Rauschenbach, B. S., Frongillo, E. A., Jr., & Kendall, A. (1996, September). *Factors contributing to household food insecurity in a rural upstate New York County* (Discussion Paper no.1107-96). Cornell University, Division of Nutritional Sciences,

- Institute for Research on Poverty. Retrieved from <http://www.ssc.wisc.edu/irpweb/publications/dps/pdfs/dp110796.pdf>
- Pascoe, G. C., & Attkisson, C. C. (1983). The evaluation ranking scale: A new methodology for assessing satisfaction. *Evaluation and Program Planning*, 6(3-4), 335-347.
- Popielarski, J. A., & Cotugna, N. (2010). Fighting hunger through innovation: Evaluation of a food bank's social enterprise venture. *Journal of Hunger & Environmental Nutrition*, 5(1), 56-69.
- Poppendieck, J. (1998). *Sweet charity?: Emergency food and the end of entitlement*. New York, NY: Viking Penguin.
- Rose, D., Gundersen, C. & Oliveira, V. (1998, October). *Socio-economic determinants of food insecurity in the United States: Evidence from the SIPP and CSFII datasets* (Technical Bulletin No.TB-1869). United States Department of Agriculture (USDA), Economic Research Service. Retrieved from <http://www.ers.usda.gov/publications/tb-technical-bulletin/tb1869.aspx>
- Royse, D., Thyer, B. A., & Padgett, D. K. (2010). *Program evaluation: An introduction to an evidenced-based approach* (5th ed.). Belmont, CA: Wadsworth Cengage Learning.
- Sederer, L. I., Dickey, B., & Hermann, R. C. (1996). The imperative of outcomes assessment in psychiatry. In B. Dickey & L. I. Sederer (Eds.), *Outcomes assessment in clinical practice* (pp. 1-7). Baltimore, MD: Williams & Wilkins.
- Sharkey, J. R., Dean, W. R., & Johnson, C. M. (2011). Association of household and community characteristics with adult and child food insecurity among Mexican-origin households in *Colonias* along the Texas-Mexico border. *International Journal for Equity in Health*, 10(19). doi: 10.1186/1475-9276-10-19.
- Social Security Administration (SSA) (2013, December). *Social Security beneficiary statistics: Number of beneficiaries receiving benefits on December 31, 1970-2014*. Baltimore, MD: Author. Retrieved from <http://www.socialsecurity.gov/OACT/STATS/OASDIbenies.html>
- Southern Education Foundation (2015). *A new majority: Low income students now a majority in the nation's public schools*. Atlanta, GA: Author. Retrieved from <http://www.southerneducation.org/Our-Strategies/Research-and-Publications/New-Majority-Diverse-Majority-Report-Series/A-New-Majority-2015-Update-Low-Income-Students-Now.aspx>
- Sutherland, R. J., Mott, J. M., Lanier, S. H., Williams, W., Ready, D. J., & Teng, E. J. (2012). A pilot study of a 12-week model of group-based exposure therapy for veterans with PTSD. *Journal of Traumatic Stress*, 25(2), 150-156. doi: 10.1002/jts.21679
- Tanner, M. (2013). SNAP failure: The food stamp program needs reform (Policy Analysis No. 738). Washington, DC: Cato Institute. Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2432322
- Tarasuk, V. S. & Beaton, G. H. (1999). Household food insecurity and hunger among families using food banks. *Canadian Journal of Public Health*, 90(2), 109-113.

- U.S. Department of Agriculture (USDA), Economic Research Service. (2009, June). *Access to affordable and nutritious food: Measuring and understanding food deserts and their consequences*. Washington, DC: Author. Retrieved from http://www.ers.usda.gov/media/242654/ap036_reportsummary_1_.pdf
- Verpy, H., Smith, C., & Reicks, M. (2003). Attitudes and behaviors of food donors and perceived needs and wants of food shelf clients. *Journal of Nutrition Education and Behavior*, 35(1), 6-15.
- Zhang, Q., & Lamichhane, R. (2014). Labor market conditions and food security status of emergency food assistance program clients in the recession. *North American Journal of Medicine and Science*, 7(2), 57-62

The Development of Dual and Multiple Relationships for Social Workers in Rural Communities

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Abstract. Mental health professionals who work in small, rural communities often have to contend with dual and multiple relationships. The more integrated service providers are within the community, the more likely they will encounter overlapping personal and professional relationships with clients. Although there is extensive literature on the potential risks of dual and multiple relationships, little empirical evidence exists which addresses the contextual factors that specifically lead to these relationships in rural social work practice. This qualitative study explored the experiences of twelve social workers or social service workers practicing in northern and northwestern Ontario. Findings provide some insight into the complexity and dynamics of dual and multiple relationships in small towns, as well as worker perspectives on the specific contextual circumstances that result in mental health workers encountering these relationships. The unique contribution of this paper to the literature is to highlight factors that increase the likelihood of dual and multiple relationships when they are not as obvious as a clear and immediate conflict of interest. Greater clarity about such precipitating factors will contribute to supervision, training, and sound policy development informed by contextual sensitivity.

Keywords: social work, rural practice, dual relationships, multiple relationships, ethics, ethical dilemmas

Work as a mental health service provider (e.g., social worker, psychologist, marriage and family therapist) in small, rural communities is unique (Brownlee, 1996; Delaney & Brownlee, 2009; Graham, Brownlee, Shier, & Doucette, 2008). Providing services in such communities is regularly accompanied by any number of less formal client relationships that may potentially blur professional boundaries, and result in dual or multiple relationships, (Burgard, 2013; Delaney, Brownlee, Sellick, & Tranter, 1997; Reamer, 2003). It is well established that rural service providers integrated into the community often encounter clients in multiple community roles and face the possibility that they will be involved in providing services to acquaintances or associates when alternatives are limited (Brownlee, Halverson, & Neckoway, 2014; Campbell & Gordon, 2003; Humble, Lewis, Scott, & Herzog, 2013; Malone & Dyck, 2011). These circumstances can significantly impact the service provider's professional objectivity (Ringstad, 2008).

Most authors distinguish between non-sexual and sexual dual and multiple relationships (Kagle & Giebelhausen, 1994; Reamer, 2003; Ringstad, 2008; Strom-Gottfried, 1999).

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Consequently, the focus of the present study is exclusively on non-sexual dual and multiple relationships. One of the most challenging aspects of non-sexual dual and multiple relationships in small communities is that they are so often ambiguous. Many authors have attempted to facilitate discussion of the topic by categorizing dual and multiple relationships according to their nature and setting (Anderson & Kitchener, 1996; Borders & Leddick, 1987), while Reamer (2003) extended this analysis by considering the range of boundary issues that arise as precursors to dual and multiple relationships. Although such categorizing is helpful, an added consideration is that dual and multiple relationships usually do not happen suddenly; they more often develop over time (Pearson & Piazza, 1997). For instance, Kagle and Giebelhausen (1994) noted that, “a practitioner can engage in a dual relationship whether the second relationship begins, during or after the social worker relationship” (p. 213).

Beyond classifying dual and multiple relationships, researchers often distinguish between them as either involving acts of boundary crossing or boundary violation. Boundary crossings can sometimes be beneficial, while boundary violations may cause harm (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007). Smith & Fitzpatrick (1995) referred to boundary crossing as a “non-pejorative term that describes departures from commonly accepted clinical practice that may or may not benefit the client” (p. 500). Examples of boundary crossings include allocating extra time or considerations to a client (Barnett et al., 2007), inappropriate self-disclosure, accepting gifts (Hines, Ader, Chang, & Rundell, 1998), and interacting with clients via social media (Duncan-Daston, Hunter-Sloan, & Fullmer, 2013). A violation, on the other hand, refers to a boundary breach that has resulted in, or has the potential to result in, harm to the client (Hines et al., 1998). An example of boundary violation could include providing mental health counseling to a supervisor’s child. A dual or multiple relationship is not always a boundary crossing or a boundary violation, but can often represent a grey area that could eventually give rise to one or both.

The social work literature expresses concern that it is because of the personal interests or social obligations that emerge from a non-professional role that dual or multiple relationships might strongly influence, or even adversely affect, a practitioner’s professional judgement about their benefits or detriments to a client (Barnett et al., 2007; Marmarosh, 2012). Consistent with this concern, most professional regulatory bodies have traditionally had some form of ethical guidelines referring to dual and multiple relationships (Brownlee, 1996). For example, the National Association of Social Workers (2008) states that social workers “...should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client” (Section 1.06c). The NASW code also recognizes that there could be “instances when dual or multiple relationships are unavoidable” and the code notes that under these circumstances, “social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries” (Section 1.06c).

A sizable professional literature is available on dual and multiple relationships focused on the boundary issues, decision-making models, challenges, and ethical considerations that affect various human service professionals in both rural and urban settings (Biaggio, Paget, & Chenoweth, 1997; Blevins-Knabe, 1992; Paulus, Van Raak, & Keijzer, 2005). Several potential frameworks, guidelines, and tips to avoid problems with non-sexual dual and multiple relationships are also clearly articulated (Evans & Sherr, 2006; Gottlieb, 1993; Gripton & Valentich, 2004; Reamer, 2003; Younggren & Gottlieb, 2004). While most discussions have

focused on the exploitative nature of dual and multiple relationships, boundary issues can be subtle and may not always represent a clear, ethical violation (Reamer, 2003). This is especially the case in rural and remote communities that involve a more extensive inter-connected network of a person's life, where overlapping relationships readily occur. These relationships may not always result in a flagrant conflict of interest, but one where the relationship becomes strained. These less obvious aspects of overlapping relationships increase the likelihood of dual and multiple relationships, and represent an aspect of rural social work that needs close examination, especially if, as Daley and Hickman (2011) suggest, a strong understanding of the rural community context is needed in order to respond with sensitivity to ethical issues that arise.

Although there is extensive literature on the potential risks of dual and multiple relationships and the importance of information and training on the topic, little empirical evidence exists which addresses *the contextual factors* that specifically lead to these relationships in rural communities. In addition, there is inadequate data regarding the complexity and dynamics of dual and multiple relationships, as well as worker perspectives on the emergence of these relationships. Therefore, this study clarifies contextual circumstances that result in mental health workers encountering dual and multiple relationships in small towns, and provides unique insights into factors that may promote dual or multiple relationships when factors that are less obvious than a clear and immediate conflict of interest. Greater clarity about these factors would contribute to supervision, training, and sound policy development informed by contextual sensitivity. Specifically, this research posed the question, "In a rural context, which factors increase the likelihood of a dual or multiple relationship developing?"

This work was part of a broader research study conducted by Lakehead University in northwestern Ontario, Canada aimed at exploring dual and multiple relationship decision-making processes in small, rural, and remote communities. Within this broader study a number of tangential but significant themes related to the development of dual and multiple relationships emerged. It is these findings that are the foundation for this paper.

Methods

Participants

The target population for the broader research study was social service practitioners who worked in northern and/or northwestern Ontario for a period of five or more years. The eight target communities were each more than 100 km from a larger urban centre, and each with a population of less than 10,000 persons. From these eight communities, 12 social service practitioners were recruited through agency invitation and third party referral.

Prior to proceeding with interviews, the study received ethics approval from the lead investigator's university (Lakehead University) ethics review board. Participants included ten females and two males, and ranged in age from 20 to 50 years, a sample similar to ones reported in previous research in this region of rural Canada (Graham, Brownlee, Shier, & Doucette, 2008; Graham, Fukuda, Shier, Kline, Brownlee, & Novik, 2013). Of the sample, three participants worked in supervisory roles while the remainder ($n = 9$) provided front-line service; all worked in mental health and counseling. Four of the participants were original residents working in their

community of origin while the remainder ($n = 8$) had migrated to the community, usually from a larger centre.

Interviews and Analysis

Interviews and analysis followed generally accepted qualitative methods and utilized a descriptive phenomenological approach (Creswell, 2007; Laverty, 2003; Moustakas, 1994). Initial interviews ($n = 12$) were completed in person ($n = 10$) or by telephone ($n = 2$), and were loosely based on an interview guide and series of open-ended questions. Questions were revised and further formulated from interview to interview as themes emerged. In addition to the initial interviews, two follow-up interviews were conducted by telephone in an effort to further elaborate on some of the more salient themes. Interviews ranged in length from 30 to 90 minutes and were recorded for transcription and analysis.

Data analysis was inductive, moving from open coding to selective coding with the goal of generating overarching themes from the individual participant data with the assistance of NVivo 10 computer assisted data analysis software. In addition to primary data analysis of dual and multiple relationship decision making in small rural and remote communities, a secondary analysis was conducted to expand on themes related to the *development* of these relationships.

As with all research, there are certain limitations within this study. One methodological limitation for this research has to do with the sample itself. Although the 12 respondents who participated in this research were from a large and dispersed geographical area, the region is nevertheless relatively homogenous in comprising mostly small and remote single industry towns. In the future it may be plausible to obtain a sample from communities in other geographical areas to gain perspectives from more diverse geographical contexts. A second limitation is that the majority of the data collected for this study were from participant interviews exploring previous experiences, a methodology vulnerable to lapses in memory as well as intentional recall bias (Dex, 1995; Hassan, 2006).

Findings

The outcome of the secondary analysis suggests that there are several factors inherent in a rural life that increase the chances of dual or multiple relationships which would require rural social workers to make ethical decisions. Specifically, three main factors emerged from the participant interviews: social and family life; interconnectedness and layers of knowing; and the complexity of rural social work practice. These factors appeared to be fluid in nature and the degree to which they affected individual workers varied.

Social and Family Life

Rural social workers' social and familial integration into their community varied to some extent depending on their values, beliefs, and worldview. For some, being integrated within the community meant volunteering and participating in community events. For others, integration into their community meant having a rich social life and family involvement in the community. Participants described the latter as an integral tool to maintain personal well-being and a sense of balance in their work/personal lives, even perhaps helpful to the clinical relationship.

I'm from this community, I have friends from here and my kids have friends. It's very important for me to be social with them.

Interacting in the community actually helps me. I sing. I sing in a choir and I have a big mouth so they let me do ridiculous parts now and then and I'm willing to make a fool of myself in public...

I clean the toxic waste with the community (members)... we develop that range of emotion for clients and work with them (outside of the office) on understanding that – the fullness of life. It has nothing to do with the therapy work and yet you get to see each other as a whole person and that goes two directions.

Some participants chose to be a part of the community while others preferred staying isolated to protect their professionalism. Respondents described a deliberately limited social life in the community:

I've never been in the bars or [involved in] community activities. Like, I've never. Just because of the work I do, I have that boundary and if I want to go out and socialize, I'll go to [urban city redacted] and do that...I don't really socialize all that much in the community.

I limit my engagement [in the community]. Give you an example [for my reason], ... I went to a birthday party for my kid and there were a bunch of grownups there too, and I'm looking around, Okay, current client, former client, former client.

While some participants managed their integration within the community, if these workers had family in the community the inability to manage the lives of their family members presented the rural social worker with some unique dilemmas. For example, being invited to family events was not something respondents felt they had much control over and required deliberate management of professional and social boundaries:

One of my family members had a gathering at their house and she was friends with my active client. I had to make a decision whether or not to go because I knew she was also going. So I made the choice to go to the party, to not drink, and I let her know that I was going to be at that party.

Rural social workers also, of course, have no control over whom they are related to. Rural social workers who are lifelong residents of rural communities may have strong kinship ties, and may often have multiple family members who reside in the same community (Bradley, Werth, & Hastings, 2012). More than one respondent expressed being related to 'almost everybody' in the community in some way, either by marriage or by blood. As one participant stated:

I have a lot of generations of relatives in [community name redacted]. Makes for a big family when you consider all of their husbands and wives.

This is a reality for many members of smaller communities. As a social worker's network grows with time, so does the network of his or her family members. The growing network of a

worker's social ties and his or her family members' ties means an increased chance of conflicts of interest and a dual or multiple relationship emerging.

Interconnectedness and Layers of Knowing

Life in a rural community provides a strong sense of connection for all its members (Reamer, 2003). For community members, their interconnectedness with the community is acquired across both space and time. For a social worker, being interconnected comes with challenges, such as knowing considerable, even personal information about their clients. Any third-hand client information, for example, can inform a worker's opinion about their client:

I had one client report that he witnessed another client of mine sexually abuse his child ... and the alleged abuser, my other client, we have kids the same age so he came to a birthday party for my son maybe three weeks before this came out. So much feelings and dual relationships and difficulty in that.

This knowledge can impact not only professional objectivity, but also impact the worker personally:

When you hear he's sexually abusing a kid that's the same age as yours, makes you want to tell the wife to never leave our son alone with these people. Especially knowing he just came to the birthday party three weeks ago. Him coming to the house again, that would never happen.

Community interconnectedness also impacts what the client knows about the social worker, which may significantly affect the relationship. One respondent recounted a client's comment:

We know that it was your nieces that our daughter hit. Do you think you can remain nonjudgmental?

Most, if not all, participants described receiving some form of third party information, without their client's written consent, by conversing with others in the community. For example, a social worker described a hairdresser's appointment where she was subsequently privy to intimate information about her client. Although this is not a question of unethical behavior, it is collateral information that was obtained without the client's control. This sharing of information, this interconnectedness across space, is the norm in small communities because of high visibility and 'inspection' of one another (Levin & Kimmel, 1977).

Another aspect of interconnectedness and layers of knowing was interconnectedness across time, such as when respondents didn't realize they were 'connected' to their client until therapy was mid-way. One participant established a therapeutic client relationship before realizing that she knew more information about this person than she should. The client was a colleague's ex-spouse. Similarly, another respondent shared a second example of the impact of interconnectedness across time:

I was doing work with a client for a phobia, and marital relationship issues arose along the way with some parenting stuff. It got ‘tangly’ after that because I knew the partner.

A few respondents described a conflict of interest arising because of having acquired too much third-hand information about a client, a circumstance they feared would impact their objectivity. While these workers believed that compartmentalizing this knowledge would be too difficult, others in similar situations believed the knowledge would not contaminate the therapeutic relationship:

I focus on strengths and trying to keep my thinking always focused on what this parent is doing well and what we can use and build on, rather than, ‘Oh, I heard this about her.’

I try not to make assumptions based on the stuff I hear. It won’t help anyone.

Interconnectedness and layers of knowing may not directly result in a dual or multiple relationship, but may increase the chances of some form of dual or multiple relationship emerging over time. The more interconnected a social worker, that is, the more client knowledge one has, the more likely some level of overlapping relationship or conflict of interest may emerge.

Complexity of Rural Social Work Practice

Rural living and rural practice have been well documented as being challenged by the lack of resources in rural practice settings, resulting in fewer workers managing multiple cases and multiple roles simultaneously. As one participant stated:

We are only two in this office ..., we share the caseload ... [and] she’s the intake worker and child worker, but she ends up taking some of my cases because it’s too busy.

Also unique to rural social work is the consistency with which rural practitioners apply a generalist approach. Although urban social workers occasionally provide multiple services, including community development, advocacy, counselling, child welfare, etc. using this generalist approach, study respondents described frequently providing different services as part of their daily practice:

I have no choice but to be an expert in addiction, serious mental illness, and couples therapy.

My first three years I was the only counsellor in the office. I was carrying kids, adults, mental health, and addiction. I was just a one-stop shop; anything that walked in, you had to handle.

We’re not therapists, we’re intake and should do intake. But we are doing it all.

To some extent this generalist approach results from limited local resources. A small number of staff is expected to serve a large number of community members accessing a wide variety of services, thus increasing their network of connections yet again.

Network connections may be even further problematical when limited family resources sometimes prevent clients from accessing services in neighbouring communities. Several workers described driving as far as 200 km to communities to serve dual and multiple relationship clients from partner agencies.

Discussion

Although most research and commentary on dual and multiple relationships and mental health services in rural areas acknowledges that the relevance of the code of ethics can be challenging (Brownlee, Halverson, & Neckoway, 2014; Halverson, Brownlee, & Delaney, 2009), there is still a tendency to frame the discussion of these relationships as though they arise in a straightforward manner with clear knowledge that a dual or multiple relationship could exist. Even when the discussion refers to future, and by extension unknown, relationships, there is the assumption that the mental health worker has a large measure of control over the relationship that occurs. In this paper we sought to take a closer look at factors leading to complex relationships arising for the worker without assuming that the relationship is exclusively a dual one, or that there was always prior knowledge of the overlapping roles or connections between the worker and client. Our inquiry led us to explore the complex and interrelated network of relationships in small, rural towns and the likelihood of a dual or multiple relationship emerging.

Most study participants referred to social and family life as significant contributors to the development of dual and multiple relationships. Family life was raised as a factor that extends the connections between the worker and people in the community, meaning that a link between the worker and client can surface without it necessarily involving either party directly, but the link can still have a significant effect on the relationship. For instance, professional objectivity can easily be compromised if it becomes apparent after a few sessions that a client was involved with a family member and was perceived to have behaved badly towards that family member. Similarly, participants revealed that the more involved the worker and family members are in the community, the more potential points of contact and relationships they have within the community. While this might seem obvious, what is not always apparent from prior research is that each one of these points of contact could potentially lead to conflicts of interest. For instance, it is not always predictable that a worker's child will be in a class or on a team with a client as a teacher or coach and that the teacher or coach relationship might itself become strained.

Related factors raised by the participants are the layers of knowing and considerable knowledge about people and their business that emerge in rural settings. As noted above, the more socially involved workers are, the greater the chances they will be exposed to, or directly receive information about, people. The social worker may come to realize the connections that exist with other people within the worker's life, that this could represent a conflict of interest and, thus, represent an indirect dual or multiple relationships. For some, this induces them to retreat from various social engagements because it increases the chances of awkward moments with clients, and the possibility of dual or multiple relationships.

Another feature of rural social work in small towns is that the generalist model of social work is the model advocated in the rural practice literature (Daley, 2010; Riebschleger, 2007; Schank & Skovholt, 2006). By engaging in generalist practice, a social worker is encouraged to become involved with community development and other community support activities (Schank & Skovholt, 2006). Study participants indicated that not only do they often have to work with a wide variety of clients, they also become involved with a wider circle of people through community work. This form of practice expands the interconnectedness of worker and community members, which greatly increases the chances that a conflict of interest can arise in the same way as it does as a function of having prior relationships within a community or through having family members in a community who also have a network of relationships.

One way in which social workers might manage the extensive connections and relationships in a community is by limiting their social life, as several of the respondents noted, although this effort to maintain professional boundaries can lead to feelings of isolation (Schank & Skovholt, 2006; Zapf, 1993). The social worker who chooses to practice in a small rural community should consider beforehand what their social life will look like. Whether their choice is to set clear boundaries or to actively integrate into the community, the social worker needs to be aware of the potential consequences of either choice. For workers who choose to work in a rural community that is also their community of origin, the challenges are more complex. While any social worker working in a rural community cannot manage all of the connections and relationships of their immediate family members, workers working in their community of origin would struggle significantly more.

For those social workers who choose to practice within this rural context, however, there may be options to help manage these connections/relationships. Options include: (a) technology; (b) the use of informal and natural helping systems; and (c) sharing or swaping communities when proximity allows.

As technology brings about new ways of providing services, social workers are, in turn, exploring new ways to manage dual and multiple relationships. Access to videoconferencing and Telehealth are already helping rural social workers better navigate these relationships, for those workers who have access to the Internet through their social agency (Brownlee et al., 2010; Reed, Messler, Coombs, & Quevillon, 2014). Given the apparent effectiveness of internet-based psychotherapeutic interventions (Barak, Hen, Boniel-Nissim, & Shapira, 2008), the ability of rural practitioners to refer clients to professionals who can provide service at a distance would appear to be a viable alternative to the problem of having to manage dual and multiple relationships. Although there are pros and cons, the use of text or email technology can imply informality in the relationship, which could potentially be interpreted by the client as making the relationship more personal and special (McEnery-West & Mulvena, 2008). However, by using technology, rural social workers can also potentially engage clients who would benefit from services but are avoiding services due to stigma, confidentiality concerns, a wish for anonymity, or scheduling difficulties (Tregeagle & Darcy, 2008).

Another alternative for practice in rural communities, especially very remote communities where there are no alternatives for service, is to engage the services of informal, natural helper systems (Avey, McFaul, DeHay, & Mohatt, 2012). For example, in situations where transferring a client to another worker, either directly or through the use of technology, is

not practical, using a community member recognized as a natural helper might be an option (Avey et al., 2012). Non-traditional helpers such as clergy, elders, family, and other natural helpers may be able to provide some alternative support to a client with whom a social worker has a dual or multiple relationships (O'Neill, George, Koehn, & Shepard, 2013). However, it should be recognized that informal or natural helpers can introduce confidentiality problems (Helbok, 2003) and do not necessarily follow a code of ethics, which may be an important consideration limiting this option. Another potential course of action could be *combining* the use of a natural helper and a social worker to provide treatment as a way to mitigate concerns related to dual or multiple relationships.

A final option for managing dual and multiple relationships is for rural social workers to share/swap communities. As rural social workers have a sense of commonality and shared knowledge due to similar experiences of rural practice, agencies and communities might consider working together to share or swap social workers, either in person, via Skype, or through videoconference, to serve sister community members in the comfort of their home community. This option could build capacity within rural communities by addressing challenges related to limited resources, staff recruitment, and retention issues.

Conclusion

A social worker's professional and personal relationships are enmeshed and intertwined when they work and live in a rural community (Brownlee, Halverson, & Chassie, 2012). Social and family life, interconnectedness and layers of knowing, and complexity of rural social work practice have been identified as factors that increase the likelihood of social workers experiencing dual and multiple relationships. However, these factors can also lead to less obvious connections between a worker and client that equally represent conflicts of interest that can impinge on the worker's professional objectivity. Participants also suggested that each social worker or social service worker may experience these factors very differently. For example, the length of time someone lives and works in a community or the presence of a wider family network will impact the extent, intensity, and complexity of dual and multiple relationships. This knowledge can assist policy-makers and educators to begin considering the implications of a wider net of possible dual and multiple relationships. Similarly, further research on decision-making and managing of these relationships would also deepen the understanding of this continuum.

References

- Anderson, S. K., & Kitchener, K. S. (1996). Nonromantic, nonsexual posttherapy relationships between psychologists and former clients: An exploratory study of critical incidents. *Professional Psychology: Research and Practice*, 27, 59-66. doi:10.1037/0735-7028.27.1.59
- Avey, J. P., McFaul, M., DeHay, T. L., & Mohatt, D. (2012). Working in frontier communities. In K. B. Smalley, J. C. Warren, & J. P. Rainer (Eds.), *Rural mental health: Issues, policies, and best practices*. New York, NY: Springer.
- Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of internet-based psychotherapeutic interventions.

- Journal of Technology in Human Sciences*, 26(2-4), 109–160.
doi:10.1080/15228830802094429
- Barnett, J. E., Lazarus, A. A., Vasquez, M. J. T., Moorehead-Slaughter, O., & Johnson, W. B. (2007). Boundary issues and multiple relationships: Fantasy and reality. *Professional Psychology: Research and Practice*, 38(4), 401-410. doi:10.1037/0735-7028.38.4.401
- Biaggio, M., Paget, T. L., & Chenoweth, M. S. (1997). A model for ethical management of faculty—student dual relationships. *Professional Psychology: Research and Practice*, 28(2), 184-189. doi:10.1037/0735-7028.28.2.184
- Blevins-Knabe, B. (1992). The ethics of dual relationships in higher education. *Ethics & Behavior*, 2(3), 151-163. doi:10.1207/s15327019eb0203_2
- Borders, L. D., & Leddick, G. R. (1987). *Handbook of counseling supervision*. Alexandria, VA: Association for Counselor Education and Supervision. Retrieved from <http://files.eric.ed.gov/fulltext/ED324623.pdf>
- Bradley, J. M., Werth, J. L., Jr., & Hastings, S. L. (2012). Social justice advocacy in rural communities: Practical issues and implications. *The Counseling Psychologist*, 40(3), 363-384. doi:10.1177/0011000011415697
- Brownlee, K. (1996). The ethics of non-sexual dual relationships: A dilemma for the rural mental health professional. *Community Mental Health Journal*, 32(5), 497-504. doi:10.1007/BF02251048
- Brownlee, K., Graham, J. R., Doucette, E., Hotson, N., & Halverson, G. (2010). Have communication technologies influenced rural social work practice? *The British Journal of Social Work*, 40(2), 622-637. doi:10.1093/bjsw/bcp010
- Brownlee, K., Halverson, G., & Chassie, A. (2012). Multiple relationships: Maintaining professional identity in rural social work practice. *Journal of Comparative Social Work*, 1, 1-11.
- Brownlee, K., Halverson, G., & Neckoway, R. (2014). Influences on ethical decision making regarding dual relationships in rural and remote communities. In S. Hesse (Ed.), *Global social transformation and social action: The role of social workers* (Vol. 3, pp. 172-177). Burlington, VT: Ashgate.
- Burgard, E. L. (2013). Ethical concerns about dual relationships in small and rural communities: A review. *Journal of European Psychology Students*, 4(1), 69-77. doi:[10.5334/jeps.az](https://doi.org/10.5334/jeps.az)
- Campbell, C. D., & Gordon, M. C. (2003). Acknowledging the inevitable: Understanding multiple relationships in rural practice. *Professional Psychology: Research and Practice*, 34(4), 430-434. doi:10.1037/0735-7028.34.4.430
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: SAGE Publications.
- Daley, M. R. (2010). A conceptual model for rural social work. *Contemporary Rural Social Work*, 2, 1-7.

- Daley, M. R., & Hickman, S. (2011). Dual relations and beyond: Understanding and addressing ethical challenges for rural social work. *Journal of Social Work Values and Ethics*, 8(1), 99-108.
- Delaney, R., & Brownlee, K. (Eds.). (2009). *Northern and rural social work practice: A Canadian perspective*. Thunder Bay, ON: Centre for Northern Studies, Lakehead University.
- Delaney, R., Brownlee, K., Sellick, M., & Tranter, D. (1997). Ethical problems facing Northern social workers. *The Social Worker/Le Travailleur Social*, 65(3), 55-65.
- Dex, S. (1995). The reliability of recall data: A literature review. *Bulletin of Sociological Methodology*, 49(1), 58-89. doi:10.1177/075910639504900105
- Duncan-Daston, R., Hunter-Sloan, M., & Fullmer, E. (2013). Considering the ethical implications of social media in social work education. *Ethics and Information Technology*, 15(1), 35-43. doi:10.1007/s10676-013-9312-7
- Evans, A. L., & Sherr, M. E. (2006). Navigating through dual relationships: Applying an ethical continuum in a rural field placement. *The New Social Worker*, 13(1), 4-5.
- Gottlieb, M. C. (1993). Avoiding exploitative dual relationships: A decision-making model. *Psychotherapy: Theory, Research, Practice, Training*, 30(1), 41-48. doi:10.1037/0033-3204.30.1.41
- Graham, J. R., Brownlee, K., Shier, M., & Doucette, E. (2008). Localization of social work knowledge through practitioner adaptations in northern Ontario and the Northwest Territories, Canada. *Arctic*, 61(4), 399-406.
- Graham, J. R., Fukuda, E., Shier, M. L., Kline, T. B. J., Brownlee, K., & Novik, N. (2013). Demographic, work-related, and life satisfaction predictors of Northern social workers' satisfaction with work and profession. *International Social Work*, 56(5), 588-607. doi:10.1177/0020872811429953
- Gripton, J., & Valentich, M. (2004). Dealing with non-sexual professional-client dual/multiple relationships in rural communities. *Rural Social Work*, 9(2), 216-225.
- Halverson, G., Brownlee, K., & Delaney, R. (2009). Ethical issues in Northern social work practice. In R. Delaney & K. Brownlee (Eds.), *Northern and rural social work practice: A Canadian perspective*, (pp. 130-146). Thunder Bay, ON: Centre for Northern Studies, Lakehead University.
- Hassan, E. (2006). Recall bias can be a threat to retrospective and prospective research designs. *The Internet Journal of Epidemiology*, 3(2), 339-412.
- Helbok, C. M. (2003). The practice of psychology in rural communities: Potential ethical dilemmas. *Ethics & Behavior*, 13(4), 367-384. doi:10.1207/S15327019EB1304_5

- Hines, A. H., Ader, D. N., Chang, A. S., & Rundell, J. R. (1998). Dual agency, dual relationships, boundary crossings, and associated boundary violations: A survey of military and civilian psychiatrists. *Military Medicine*, 163(12), 826-833.
- Humble, M. N., Lewis, M. L., Scott, D. L., & Herzog, J. R. (2013). Challenges in rural social work practice: When support groups contain your neighbors, church members, and the PTA. *Social Work with Groups: A Journal of Community and Clinical Practice*, 36(2-3), 249-258. doi:10.1080/01609513.2012.753807
- Kagle, J. D., & Giebelhausen, P. N. (1994). Dual relationships and professional boundaries. *Social Work*, 39(2), 213-220.
- Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3), 1-29.
- Levin, J., & Kimmel, A. J. (1977). Gossip columns: Media small talk. *Journal of Communication*, 27(1), 169-175. doi: 10.1111/j.1460-2466.1977.tb01813.x
- Malone, J. L., & Dyck, K. G. (2011). Professional ethics in rural and northern Canadian psychology. *Canadian Psychology/Psychologie Canadienne*, 52(3), 206-214. doi:10.1037/a0024505
- Marmarosh, C. L. (2012). Empirically supported perspectives on transference. *Psychotherapy*, 49(3), 364-369. doi:10.1037/a0028801
- McEnery-West, N., & Mulvena, T. (2008). As counsellors and psychotherapists we are in the business of communication. But how well are we coping with the impact of newer forms of communication in our interactions with clients? *Therapy Today*, 19(8), 21-28. Retrieved from <http://therapytoday.net/>
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: SAGE.
- National Association of Social Workers (NASW). (2008). *Code of Ethics of the National Association of Social Workers*. Washington, DC: Author. Retrieved from <http://socialworkers.org/pubs/code/default.asp>
- O'Neill, L., George, S., Koehn, C., & Shepard, B. (2013). Informal and formal mental health: Preliminary qualitative findings. *International Journal of Circumpolar Health*, 72, 1-7. doi:10.3402/ijch.v72i0.21203
- Paulus, A. T. G., van Raak, A., & Keijzer, F. (2005). Informal and formal caregivers' involvement in nursing home care activities: Impact of integrated care. *Journal of Advanced Nursing*, 49(4), 354-366. doi:10.1111/j.1365-2648.2004.03299.x
- Pearson, B., & Piazza, N. (1997). Classification of dual relationships in the helping professions. *Counselor Education and Supervision*, 37(2), 89-99. doi:10.1002/j.1556-6978.1997.tb00535.x
- Reamer, F. G. (2003). Boundary issues in social work: Managing dual relationships. *Social Work*, 48(1), 121-133. doi:10.1093/sw/48.1.121

- Reed, R. N., Messler, E. C., Coombs, T. E., & Quevillon, R. P. (2014). Social media use and the acceptability of telepsychological services in rural populations. *Journal of Rural Mental Health*, 38(1), 2-8. doi:10.1037/rmh0000007
- Riebschleger, J. (2007) Social workers' suggestions for effective rural practice. *The Journal of Contemporary Social Services*, 88(2), 203-213. doi:10.1606/1044-3894.3618
- Ringstad, R. (2008). The ethics of dual relationships: Beliefs and behaviors of clinical practitioners. *Families in Society: The Journal of Contemporary Social Services*, 89(1), 69-77.
- Schank, J. A., & Skovholt, T. M. (2006). *Ethical practice in small communities: Challenges and rewards for psychologists*. Washington, DC: American Psychological Association.
- Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice*, 26, 499-506. doi:10.1037/0735-7028.26.5.499
- Strom-Gottfried, K. (1999). Professional boundaries: An analysis of violations by social workers. *Families in Society*, 80(5), 439-449.
- Tregeagle, S., & Darcy, M. (2008). Child welfare and information and communication technology: Today's challenge. *British Journal of Social Work*, 38(8), 1481-1498. doi:10.1093/bjsw/bcm048
- U.S. Census Bureau (USCB) (2010). *2010 Census Urban and rural classification and urban area criteria*. Washington, DC: Government Printing Office. Retrieved from <http://www.census.gov/geo/reference/ua/urban-rural-2010.html>
- Younggren, J. N., & Gottlieb, M. C. (2004). Managing risk when contemplating multiple relationships. *Professional Psychology: Research and Practice*, 35(3), 255-260. doi:10.1037/0735-7028.35.3.255
- Zapf, M. K. (1993). Remote practice and culture shock: Social workers moving to isolated northern regions. *Social Work*, 38(6), 694-704.

Self-Efficacy and Mental Health Services Provided by Rural and Frontier Oncology Social Workers

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Abstract. This pilot study explores the relationship between self-efficacy and professional behaviors of a non-random membership sample of the Association of Oncology Social Work (AOSW) who practice in rural and frontier settings (N = 19). The New Generalized Self-Efficacy (NGSE) scale was used to measure provider self-efficacy; a researcher-designed questionnaire was used to assess the professional behaviors of conducting mental health assessments and providing supportive counseling to individuals diagnosed with cancer. Pearson correlation and two-sample t-tests were used to analyze data. While study results did not elucidate relationships explored, results revealed a disparity between participants' overall high sense of professional preparedness and comfort conducting mental health assessments and the regularity with which they perform these functions of oncology patient care.

Keywords: oncology social work, self-efficacy, social work, self-efficacy scale, mental health assessment, supportive counseling, professional behavior, rural social work

Holistic treatment of persons diagnosed with cancer requires that medical and allied health professions work collaboratively; however, special attention to the psychosocial needs of persons diagnosed with cancer have traditionally been delegated to oncology social workers (Fobair et al., 2009; Gamm, Stone, & Pittman, 2003; King et al., 2008; Zebrack & Walsh-Burke, 2004). Oncology social workers are the primary providers of psychosocial services related to cancer diagnosis and treatment (Burg et al., 2010; Hewitt, Greenfield, & Stovall, 2006; King et al., 2008; Zebrack & Walsh-Burke, 2004). This important role is magnified in rural or frontier (population \leq 50,000 people) (Cromartie, n.d.) health care settings where oncology social workers assume multiple practice roles and must have specified knowledge about cancer's psychosocial impact (Zebrack, Walsh, Burg, Maramaldi, & Lim, 2008). Anxiety is diagnosed in a higher percentage of rural cancer patients (60-75%) when compared with the general population of cancer patients (50%) (Burman & Weinart, 1997b; Herschbach et al., 2004). Yet researchers have found that mental health concerns are less likely identified and/or addressed in the course of rural patients' oncology treatment for multiple reasons including increased travel distances to oncology care, geographic isolation, limited mental health services, high rates of inadequate health insurance, delayed cancer diagnosis, and frontier values such as stoicism and independence (Davis, Williams, Redman, White, & King, 2003; Eberhardt & Pamuk, 2004; Pistella, Bonati, & Michalic, 1999).

The Association of Oncology Social Work (AOSW) Scope of Practice includes providing clinical psychosocial services for persons diagnosed with cancer, such as conducting psychosocial assessments and therapeutic counseling interventions which are standard practices

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among oncology social workers (AOSW, 2001). The U.S. National Cancer Institute and the Canadian Association of Psychosocial Oncology have pushed to integrate mental health assessment tools into routine oncology care (National Cancer Institute, n.d.a; Wright et al., 2007). Face-to-face psychosocial screenings, structured psychological interventions, and individual therapy with cancer patients are correlated with significant reductions in pain, better physical and social role functioning, better overall mental health, and improved quality of life (Bramsen et al., 2008; National Cancer Institute, n.d.b; White & Macleod, 2002). Early incorporation of mental health assessments and interventions can enhance medical outcomes and may reduce the stigma of mental health concerns for persons diagnosed with cancer (Zabora et al., 2001).

While the benefits of professionals conducting mental health assessments and providing supportive counseling are well-documented and advocated for by national organizations, people diagnosed with cancer largely report dissatisfaction with the way that their emotional distress and mental health concerns are addressed and treated (Cwikel & Behar, 1999; Taylor et al., 2010). This is particularly true among rural patients (Burman & Weinert, 1997a). Sixty-six percent of participants in one study reported their primary unmet need one year after diagnosis was assistance dealing with emotional distress (Cwikel & Behar, 1999). Greater than 70% of patients undergoing radiotherapy for the treatment of cancer report the need for professional psychosocial support during treatment (Brix et al., 2008). Failure to directly address patients' concerns can contribute to the development of additional mental health distress for persons diagnosed with cancer (Parle, Jones, & Maguire, 1996; Taylor et al., 2010). The rate at which rural and frontier AOSW members perform mental health assessments or offer supportive counseling is not well established. Additionally, the self-efficaciousness of these providers and how it is related to their performance of standard job functions have not been well documented.

Few studies have examined the professional practices of oncology social workers (King et al., 2008). Rural oncology social workers' self-efficacy and professional mental health practices remain understudied despite the critical role these professionals can play in cancer patients' lives. Mental health concerns are important to persons diagnosed with cancer, and it appears that professionals in medical and allied health fields are not adequately addressing patients' needs (Burman & Weinert, 1997a; Cwikel & Behar, 1999; Taylor et al., 2010). Additionally, initial exploration of areas of competence of AOSW practitioners reveals a need for additional training on psycho-educational and clinical interventions (Zebrack et al., 2008). This pilot study examined oncology social worker self-efficacy and the professional practices of conducting mental health assessments and providing supportive counseling to cancer patients in rural and frontier settings.

Theoretical Framework

Self-efficacy, a construct of social learning theory, is concerned with a person's belief in their capability to produce given attainments or achieve specific tasks (Bandura, 1977; Peterson & Arnn, 2005). According to Bandura (1977, 2006), individuals who have strong self-efficacy to perform a behavior are more likely to initiate the behavior and to persist in the face of difficulty. Self-efficacy plays a key role in human functioning, influencing how much effort individuals put into the tasks ahead of them, the outcomes they expect their work to produce, and how long they will persevere in the face of adversity (Bandura, 2006). Social workers who practice in rural and

frontier settings need to have a strong sense of self-efficacy, as they may be the only providers in the region who address the psychosocial concerns of persons diagnosed with cancer.

Expectations of personal mastery impact initiation and persistence of coping behaviors. People fear, and therefore avoid, threatening situations they perceive to exceed their mastery level (Bandura, 1977, 2006). A stronger sense of self-efficacy results in greater individual perseverance and active efforts to accomplish a given task, resulting in a higher likelihood of success (Bandura, 1977, 2006).

Study Objective

The objective of this pilot study was to describe rural oncology social workers' self-reported mental health-related professional practices, including preparedness and comfort level, and to examine the relationships between these practices and these social workers' general sense of self-efficacy.

Methods

Participants

University Institutional Review Board approval was obtained for this study. Oncology social workers who were members of AOSW and practicing in rural or frontier communities within the United States (city/town population at or below 50,000) (Cromartie, n.d.) were recruited for participation in this study. The U.S. Bureau of Labor's occupational employment statistics suggest that approximately 16,470 healthcare social workers practice in non-metropolitan areas of the United States (Cromartie, n.d.); however, data are not available which identify what portion of health care social workers may be practicing oncology social workers in rural or frontier areas. Therefore, reaching rural oncology social workers was difficult. As a result, participant recruitment for this pilot study was conducted via one point of contact by means of personal email from the Association of Oncology of Social Work (AOSW) research chair sent to all AOSW members. AOSW is the primary professional organization for oncology social workers, with 1,200 current members (AOSW, 2014). While membership in AOSW is not required for practice, recruiting participants from AOSW membership was an appropriate starting point for this exploratory study. Although it is unknown exactly how many members of AOSW practice in rural locations, a study that yielded over 50% response rate of AOSW practitioners showed that approximately 13% of members ($N = 80$) identify as rural practitioners (Zebrack et al., 2008). Given historically low rates of return in previous AOSW member studies (20-30%) (M. A. Burg, personal communication, July, 2010), participants were encouraged to enter a drawing for one-year paid AOSW membership as incentive.

Design and Data Collection

A quantitative, cross-sectional design with an online survey was used. Contact with potential respondents was limited to a single email sent inviting participants to complete a 10-minute online survey. The email sought to appeal to the unique experiences of rural and frontier oncology social workers. All AOSW members were contacted once via email through the AOSW Research Group with information about the study. No pre-notification or reminder

emails were sent, per the agreement established with the AOSW Research Group. To maintain anonymity, researchers did not access participants' contact information.

The New Generalized Self Efficacy (NGSE) scale was used to measure generalized self-efficacy. The NGSE scale demonstrated strong internal consistency and reliability ($\alpha = .86-.88$) and higher content validity than other measures of self-efficacy (Chen, Gully, & Eden, 2001). The ordinal NGSE scale is unidimensional and uses unipolar ratings of "not at all true," "hardly true," "moderately true," and "exactly true" (Chen et al., 2001). The NGSE scale was chosen based on brevity (eight items), validation in employment self-efficacy studies, and strengths-based orientation of items.

In addition to the NGSE scale, twenty additional survey questions were included. These included a mixture of yes/no, nominal, ordinal, interval and ratio questions to gather information about the participants' basic demographics, educational background, years in practice, practice setting(s), number of social work colleagues at their agency, primary client populations served, expectation of persons diagnosed with cancer to experience emotional distress, frequency of conducting mental health assessments and providing supportive counseling, and assessments of their own preparedness and comfort conducting mental health assessments and providing supportive counseling. The development of this 20-item researcher-designed questionnaire was based on findings from the literature indicating of the following topics warranted investigation: whether oncology social workers perform mental health assessments and/or provide counseling for persons diagnosed with cancer, if they feel adequately prepared to perform these tasks and discuss psychosocial concerns with patients, and when in the cancer disease trajectory they conduct assessments or provide counseling. The questionnaire was designed using principles set forth by Dillman (2007), including defining a clear navigational path to prevent rereading instructions or questions and using visual navigation to guide subjects in order to avoid missing key terms or skipping items. A pretest of the researcher-developed instrument was conducted with two medical and oncology social workers to determine response burden and readability, and recommended changes from this pretest were incorporated prior to dissemination of survey.

Statistical Analysis

Parametric tests require a normal distribution, a certain level of data (usually interval), and homogeneity of variances when two samples are being compared. While it is acknowledged that with smaller samples non-parametric tests might seem more appropriate, it has long been established that moderate violations of the assumptions may have little or no effect on the conclusions (Cohen, 1969). A recent statistical investigation confirmed Gosset's original intent of using the Student t-test in small sample sizes with and without equal variances when sample sizes are equal (de Winter, 2013).

Statistics used to analyze the data include descriptive, inter-item correlations, Pearson correlation and the two-sample t-test. Significance was set at an alpha of 0.05 (Aron & Aron, 2002). The variables were 1) frequency rate of conducting mental health assessments, and 2) frequency rate of providing supportive counseling. These variables were ordinally classified as *never*, *rarely*, *often*, and *always* based on the information reported on the researcher-designed questionnaire. Reported self-efficacy of rural and frontier AOSW members was measured by their mean NGSE score. These scores were then classified as *low* ($N = 10$) and *high* ($N = 9$),

based on the distribution of scores due to the limited sample size of this pilot study, creating two nearly equal sample sizes. Two-sample (two-tailed) t-tests were conducted to examine: 1) the relationship between self-efficacy of rural and frontier AOSW members and the frequency with which they conducted mental health assessments for persons diagnosed with cancer; and 2) the relationship between self-efficacy of rural and frontier AOSW members and the frequency with which they provided supportive counseling for persons diagnosed with cancer.

Results

Twenty-one AOSW members responded to the survey; however, two respondents did not complete the survey and their responses were excluded from assessment resulting in 19 useable responses. The estimated response rate represents approximately 24% of AOSW members that identified as rural practitioners based on population response rates from other studies of AOSW members (Zebrack et al., 2008) (see Table 1 for demographic information).

Table 1

Basic Demographics of Study Participants

Participant Demographics	%	N
Female	94.7	18
Male	5.3	1
BSW	10.6	2
MSW	89.5	17
≥10 years in practice	68	13

Rural and frontier AOSW members almost unanimously expect persons diagnosed with cancer to experience emotional distress. Ninety-five percent ($N = 18$) of participants *agreed* or *strongly agreed* that emotional distress is a routine outcome of receiving a cancer diagnosis, while only five percent ($N = 1$) *disagreed*.

Respondents were split into two groups based on the mean (2.34) of respondents' NGSE scores ($M = 2.34$, $SD = .17$), classified as *low self-efficacy* (≤ 2.33) and *high self-efficacy* (≥ 2.34) in order to accommodate the small sample size of this pilot study (see Table 2 for measures of central tendency for each NGSE item). Consistent with two NGSE scale validation studies with sample sizes exceeding 300 participants each (Chen et al., 2001), the results of this study support the measure's high internal consistency and reliability ($\alpha = .90$) and inter-item correlation, ranging from .369 to .899 (see Table 3 for demographic distribution of two self-efficacy groups).

Fifty-eight percent ($N = 11$) of respondents reported they *never* or *rarely* conduct mental health assessments in their position as oncology social workers. Only two participants (11%) reported that they *always* conduct mental health assessments for persons diagnosed with cancer.

Table 2

Measures of Central Tendency for Items on NGSE Scale

NGSE Items ^a	Mean	Median	Mode	SD	Range
I will be able to achieve most of the goals I have set for myself.	2.21	2	2	0.42	2-1
When facing difficult tasks, I am certain I will achieve them.	2.11	2	2	0.71	1-3
In general, I think I can obtain outcomes that are important to me.	2.26	2	2	0.56	1-3
I believe I can succeed at most any endeavor to which I set my mind.	2.21	2	2	0.54	1-3
I will be able to successfully overcome many challenges.	2.37	2	2	0.50	1-3
I am confident I can perform effectively on many tasks.	2.57	3	3	0.51	2-3
Compared to other people, I can do most tasks very well.	2.53	3	3	0.51	2-3
Even when things are tough, I can perform quite well.	2.47	2	2	0.51	2-3

Note. Items reprinted from “Validation of a new general self-efficacy scale,” by G. Chen, S. M. Gully, & D. Eden, 2001, *Organizational Research Methods*, 4, pp. 62-83. Reprinted with permission.

^a 0 = Not True at All; 1 = Hardly True; 2 = Moderately True; 3 = Exactly True

The rate at which participants conduct mental health assessments for persons diagnosed with cancer does not appear to be significantly related to self-efficacy. Frequencies of conducting mental health assessments were collapsed into: low (*never / rarely*) ($N = 11$) and high (*often / always*) ($N = 8$). There was no significant difference in the NGSE scores of participants in the low frequency group ($M = 2.34$, $SD = .43$) and the high frequency group ($M = 2.39$, $SD = .34$); $t=0.29$, $p=0.78$.

When asked to report the degree to which they felt comfortable conducting mental health assessments, 21% ($N = 4$) of respondents indicated they were *not comfortable*, 58% ($N = 11$) reported that they were *moderately comfortable*, and 21% ($N = 4$) reported they were *fully comfortable*. In contrast, 26% ($N = 5$) of participants reported that they did not feel they were professionally prepared (via their education, training, etc.) to conduct mental health assessments

for persons diagnosed with cancer. A Pearson correlation coefficient shows a strong, positive correlation between rural and frontier AOSW members' sense of professional preparedness and their comfort administering mental health assessments ($r = .827, N = 19, p = .01$).

Table 3

Demographics of Participants According to Self-Efficacy Group (Low v. High)

Demographics	Low Self-Efficacy Group		High Self-Efficacy Group	
	%	N	%	Sample Size
Female	52.6	10	42.1	8
Male	0	0	5.3	1
BSW	5.3	1	5.3	1
MSW	47.3	9	42.1	8
≥10 years in practice	37.0	7	31.0	6

Use of the non-standardized clinical interview was reported by 84% ($N = 16$) of respondents. Only four participants reported using standardized assessment tools (Burns Depression Inventory and the National Comprehensive Cancer Network (NCCN) Distress Tool) to evaluate potential mental health concerns of persons diagnosed with cancer.

The most frequently reported time for conducting assessments was at diagnosis (42%). It is notable that all but one participant reported that they *never* or *rarely* conduct mental health assessments after the patient has completed oncology treatment. Open-ended survey responses reveal participants also conduct mental health assessments for persons diagnosed with cancer upon hospitalization, patient request, physician request, and recurrence of the disease.

Frequency of conducting supportive counseling were collapsed into two groups: lower (*rarely / often*) ($N = 12$) and higher (*always*) ($N = 7$). No one in the study indicated they *never* provide supportive counseling. The rate at which respondents provide supportive counseling does not appear to be related to self-efficacy: there was no significant difference in the NGSE self-efficacy scores of participants in the lower frequency group ($M = 2.31, SD = .38$) and the higher frequency group ($M = 2.45, SD = .41$); $t = 0.57, p = 0.58$).

A Pearson correlation coefficient reveals a perfect, positive correlation between respondents' sense of professional preparedness and their comfort with providing supportive counseling ($r = 1.0, N = 19, p = 0.01$). The perfect correlation is likely due to the small sample size.

Participants who indicated that their job description includes providing supportive counseling to persons diagnosed with cancer reported that they were more likely ($M = 3.36, SD = .63$) to provide supportive counseling than those who were not required to do so by their employer ($M = 2.8, SD = .84; t(18) = 1.56, p = 0.14$), although the difference was not statistically

significant. Participants reported that patient education (79%), supportive counseling (74%), referrals (95%), and advocacy (95%) are the primary tasks they perform as oncology social workers.

Discussion

Overall, the rural and frontier AOSW members who participated in this study are comfortable conducting mental health assessments and providing counseling, regardless of whether they regularly perform these tasks. In addition, study respondents are highly educated and have largely spent a great deal of their careers as medical or oncology social workers.

The most significant findings from this study are the strong relationships between professional preparedness and comfort in conducting mental health assessments and providing supportive counseling for persons diagnosed with cancer. Although these results are based on clinical experience, the statistical significance demonstrated among this sample emphasizes the importance of education focused on the role of mental health assessments and supportive counseling in oncology settings.

Despite the push from national organizations, such as the National Cancer Institute and the Canadian Association of Psychosocial Oncology (National Cancer Institute, n.d.a; Wright et al., 2007), routine use of standardized mental health assessment tools for persons diagnosed with cancer does not appear to be the practice norm for rural and frontier AOSW members who participated in this study. Although 16 participants made use of clinical interviews to conduct mental health assessments, 11 of these same participants reported *rarely* or *never* performing assessments. These conflicting figures suggest that participants did not consider the non-standardized clinical interview as an assessment tool when answering previous questions about how frequently they conducted mental health assessments.

Study results indicate that rural and frontier AOSW members conducted mental health assessments most frequently upon diagnosis (42%). While it is important to capture the mental health concerns of individuals upon diagnosis, these concerns can evolve and change over the course of the disease (White & Macleod, 2002). Treatment of cancer, including chemotherapy and radiation, can create new mental health concerns and exaggerate existing symptoms of depression and anxiety, reinforcing the importance of follow-up mental health assessments (American Cancer Society, 2009; Brix et al., 2008; Cwikel & Behar, 1999; National Cancer Institute, n.d.a; National Institute of Mental Health, n.d.; White & Macleod, 2002). Persons diagnosed with cancer often (66%) report that the greatest unmet need one year after diagnosis is assistance dealing with emotional distress (Cwikel & Behar, 1999). However, approximately 94% of study participants report that they *never* or *rarely* conduct any form of post-treatment mental health assessments.

Based on the results of this study, it is possible that by adjusting the job descriptions of oncology social workers to include the expectation that they conduct mental health assessments and provide supportive counseling, employers may increase the frequency at which these tasks are completed, as AOSW membership alone does not appear to influence adherence to the AOSW Scope of Practice among sample members. Literature suggests that conducting mental health assessments and providing supportive counseling can reduce physical pain and increase

life expectancy for persons diagnosed with cancer (Bramsen et al., 2008; Zabora et al., 2001). Therefore, employers may need to be more explicit in their job descriptions about the expectations that oncology social workers conduct mental health assessments and provide supportive counseling in hopes of promoting the best treatment outcomes for persons diagnosed with cancer.

Reimbursement rates from insurance companies and medical practice policies could be additional explanations for the low frequency rates of conducting mental health assessments as reported in this study. For oncology social workers practicing in inpatient centers (hospitals, etc.), these types of mental health assessments are generally not reimbursable by insurance nor required by agency or governmental policy, unlike federal requirements that mandate routine mental health screening in dialysis units. Perhaps health insurance reimbursements and health care policy changes that standardize oncology standards of care involving regular mental health assessments and provisions for supportive counseling could lead to improved patient satisfaction and overall health outcomes.

One important result to emerge from this study is that more than half of rural and frontier AOSW members sampled do not regularly assess the mental health needs of persons diagnosed with cancer; however, 78% of these members provide supportive counseling. It is unclear what guides these supportive counseling sessions. Without some form of assessment, standardized or non-standardized, these supportive counseling sessions may not be adequately addressing the mental health needs and concerns of persons diagnosed with cancer.

Ninety-five percent of respondents expect persons diagnosed with cancer to experience some form of emotional distress related to their diagnosis. The expectation of emotional distress may influence providers to circumvent mental health assessments and operate on the assumption of emotional distress or mental health concerns. However, operating on assumptions of generalized emotional distress and failing to directly and adequately address patients' needs or concerns can contribute to the development of additional mental health issues (Parle, Maguire, & Heaven, 1997; Taylor et al., 2010). This may help explain why some patients are dissatisfied with the way their emotional distress and mental health concerns are addressed and treated during their experience with cancer (Burman & Weinert, 1997a, 1997b; Cwikel & Behar, 1999; Taylor et al., 2010).

The NGSE scale measured participants' general sense of self-efficacy and did not measure their specific occupation or work-related sense of self-efficacy as oncology social workers. Although this scale was developed to evaluate occupational and organizational self-efficacy and correlates similarly with other scales of occupational self-efficacy (Chen et al., 2001), the NGSE may have been too general to capture the unique occupational-specific self-efficacy of oncology social workers in rural and frontier settings.

Limitations and Future Research

This pilot study, which appears to be the first to examine rural and frontier oncology social workers' self-efficacy and practices related to attending to the mental health needs of cancer patients, included a small, non-random sample of rural and frontier AOSW members who work in communities of 50,000 residents or less. While the estimated response rate for this study

is approximately 24% of rural and frontier AOSW members based on population data (Zebrack et al., 2008), it is difficult to determine the exact response rate given that AOSW does not track the rurality of members (M. A. Burg, personal communication, August, 2010). Therefore, study results are not generalizable to the population of rural and frontier oncology social workers in the U.S. Defining “mental health assessments” in the survey instrument could have minimized any confusion by respondents that may have occurred based on inconsistent responses regarding frequency of such assessments and the use of the non-standardized clinical interview (i.e., 58% of participants reporting they rarely or never conduct mental health assessments, while respondents indicated use of non-standardized clinical interview 84% of the time). The perfect correlation between preparedness and comfort providing supporting counseling, while likely attributable to the small sample size of this study, could suggest participants interpreted these characteristics as identical or interchangeable; a qualitative study design may be able to explore how AOSW members conceptualize “mental health assessments” in a way that this study was unable to capture and also parse out the differences practitioners see between preparedness and comfort in relation to providing supportive counseling.

Study results suggest that providers expect persons diagnosed with cancer to experience emotional distress, but this study was not able to fully elucidate how practitioners respond to and address this perceived emotional distress. Future qualitative exploration of the mental health-related professional practices of rural and frontier AOSW members may provide useful into insights of how practitioners define professional preparedness, the factors that contribute to feeling professionally prepared, and the ways practitioners define mental health assessments and supportive counseling. Research is needed to gather more in-depth information since it appears that access to large numbers of rural oncology social workers is difficult and little is known about their professional practices. Additionally, AOSW membership is voluntary and is not required for professional oncology social work practice; therefore, research examining the professional practices of a randomized sample of oncology social workers who practice in rural and frontier settings may yield more generalizable results than this pilot study

Self-efficacy predicts work-related outcomes, such as job attitudes, training proficiency, skill acquisition, and job performance (Chen et al., 2001; Stajkovic & Luthans, 1998). Without moderate self-efficacy, employees will not perform the duties required of their position (Peterson & Arnn, 2005). In particular, self-efficacy is a stronger predictor of task-specific performance than overall job performance (Judge, Jackson, Shaw, Scott, & Rich, 2007). Research examining the professional practices of oncology doctors and nurses suggests that conversations with patients regarding their emotional distress and psychological concerns are among the most difficult and stressful conversations professionals have with persons diagnosed with cancer (Pollak et al., 2007; Wilkinson, Gambles, & Roberts, 2002). In fact, medical professionals report they are less likely to solicit disclosure of patients’ psychological distress (Wilkinson et al., 2002) and frequently terminate the discussion when patients bring up emotional issues during their appointments (Pollak et al., 2007). Future research of oncology social work practices is needed to evaluate providers’ task-specific self-efficacy, particularly in relation to assessing and exploring patients’ emotional distress.

Conclusion

Based on the outcomes of this pilot study, there does not appear to be a relationship between self-efficacy and the frequency which rural and frontier AOSW members conduct mental health assessments or provide supportive counseling; however, study participants appeared to have a strong sense of self-efficacy overall. This is of significance as they may be the only providers of psychosocial services for oncology patients in their communities (Burg et al., 2010; Hewitt et al., 2006; King et al., 2008; Zebrack & Walsh-Burke, 2004). Respondents reported feeling professionally prepared and comfortable with the tasks of conducting mental health assessments and providing supportive counseling to persons diagnosed with cancer, which are components of the AOSW Scope of Practice (AOSW, 2001); and yet, they are not completing these tasks regularly. This finding is consistent with research documenting patients reporting insufficient mental health care in oncology settings (Burman & Weinert, 1997a, 1997b; Cwikel & Behar, 1999; Taylor et al., 2010).

References

- American Cancer Society. (2009). *Cancer affects your emotional health*. (2009, August 17). Retrieved from <http://www.cancer.org/Treatment/TreatmentsandSideEffects/EmotionalSideEffects/AnxietyFearandDepression/anxiety,-fear,-and-depression-cancer-and-your-emotional-health>
- Aron, A., & Aron, E. N. (2002). *Statistics for the behavioral and social sciences: A brief course*. Upper Saddle River, NJ: Prentice Hall.
- Association of Oncology Social Work (AOSW). (2001). *Health care professionals: Scope of practice*. Retrieved from <http://www.aosw.org/aosw/main/professionals/scope-of-practice/aoswmain/professional-development/scope-of-practice.aspx?hkey=4b9dc2ae-bd4f-47a7-9cf7-0337628e34c1>
- Association of Oncology Social Work (AOSW). (2014). *Welcome to AOSW*. Retrieved from <http://www.aosw.org/aosw/Main/About-AOSW/AOSWMain/About-AOSW/about-aosw.aspx?hkey=21cb6f38-bf7b-4f6b-8ec7-aaa0400d9460>
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191-215. doi:10.1037//0033-295X.84.2.191
- Bandura, A. (2006). Guide for constructing self-efficacy scales. In F. Pajares & T. Urdan (Eds.), *Self-efficacy beliefs of adolescents*, (pp. 307-337). Greenwich, CT: Information Age.
- Bramsen, I., van der Linden, M. H. M., Eskens, F. J. M., Bijvank, E. M., van Groenigen, C. J., Kaufman, H. J., & Aaronson, N. K. (2008). Evaluation of a face-to-face psychosocial screening intervention for cancer patients: Acceptance and effects on quality of life. *Patient Education and Counseling*, 70(1), 61-68. doi:10.1016/j.pec.2007.09.010
- Brix, C., Schleussner, C., Füller, J., Roehrig, B., Wendt, T. G., & Strauss, B. (2008). The need for psychosocial support and its determinants in a sample of patients undergoing radiooncological treatment of cancer. *Journal of Psychosomatic Research*, 65(6), 541-548. doi:10.1016/j.jpsychores.2008.05.010

- Burg, M. A., Zebrack, B., Walsh, K., Maramaldi, P., Lim, J. W., Smolinski, K. M., & Lawson, K. (2010). Barriers to accessing quality health care for cancer patients: A survey of members of the Association of Oncology Social Work. *Social Work in Health Care*, 49(1), 38-52. doi:10.1080/00981380903018470
- Burman, M. E., & Weinert, C. (1997a). Concerns of rural men and women experiencing cancer. *Oncology Nursing Forum*, 24(9), 1593-1600.
- Burman, M. E., & Weinert, C. (1997b). Rural dwellers' cancer fears and perceptions of cancer treatment. *Public Health Nursing*, 14(5), 272-279.
- Chen, G., Gully, S. M., & Eden, D. (2001). Validation of a new general self-efficacy scale. *Organizational Research Methods*, 4(1), 62-83. doi:10.1177/109442810141004
- Cohen, J. (1969). *Statistical power analysis for the behavioral sciences*. New York, NY: Academic Press.
- Cromartie, J. B. (n.d.). *Measuring rurality: What is rural?* Economic Research Service, U.S. Department of Agriculture. Retrieved from <http://www.soc.iastate.edu/sapp/What is Rural.pdf>
- Cwikel, J. G., & Behar, L. C. (1999). Organizing social work services with adult cancer patients: Integrating empirical research. *Social Work in Health Care*, 28(3), 55-76.
- Davis, C., Williams, P., Redman, S., White, K., & King, E. (2003). Assessing the practical and psychosocial needs of rural women with early breast cancer in Australia. *Social Work in Health Care*, 36(3), 25-36.
- de Winter, J. C. F. (2013). Using the student's t-test with extremely small sample sizes. *Practical Assessment, Research, & Evaluation*, 18(10), 1-12.
- Dillman, D. A. (2007). *Mail and internet surveys: A tailored design method* (2nd ed.). Hoboken, NJ: John Wiley & Sons, Inc.
- Eberhardt, M. S., & Pamuk, E. R. (2004). The importance of place of residence: Examining health in rural and nonrural areas. *American Journal of Public Health*, 94(10), 1682-1686.
- Fobair, P., Sterns, N., Christ, G., Dozier-Hall, D., Newman, N. W., Zabora, J., ...DeSonier, M. (2009). Historical threads in the development of oncology social work. *Journal of Psychosocial Oncology*, 27(2), 155-215. doi:10.1080/07347330902775301
- Gamm, L. D., Stone, S., & Pittman, S. (2003). Mental health and mental disorders – a rural challenge. In L. D. Gamm, L. L. Hutchison, L. Linnae, B. J. Dabney, J. Betty, & A. M. Dorsey (Eds.), *Rural healthy people 2010: A companion document to rural healthy people 2010*, (Vol. 1) (pp. 165-173). College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.
- Herschbach, P., Keller, M., Knight, L., Brandl, T., Huber, B., Henrich, B., & Marten-Mittag, B. (2004). Psychological problems of cancer patients: A cancer distress screening with cancer-specific questionnaire. *British Journal of Cancer*, 91(3), 504-511.

- Hewitt, M., Greenfield, S., & Stovall, E. (Eds.). (2006). *From cancer patient to cancer survivor: Lost in transition*. Washington, DC: The National Academies Press.
- Judge, T. A., Jackson, C. L., Shaw, J. C., Scott, B. A., & Rich, B. L. (2007). Self-efficacy and work-related performance: The integral role of individual differences. *Journal of Applied Psychology, 92*(1), 107-127. doi:10.1037/0021-9010.92.1.107
- King, L., Quinn, G. P., Vadaparampil, S. T., Miree, C. A., Wilson, C., Clayton, H., & Zebrack, B. (2008). Oncology social workers' perceptions of barriers to discussing fertility preservation with cancer patients. *Social Work in Health Care, 47*(4), 479-501. doi:10.1080/00981380802255215
- National Cancer Institute. (n.d.a). *Depression—for health professionals (PDQ®)*. Retrieved from <http://www.cancer.gov/cancertopics/pdq/supportivecare/depression/healthprofessional>
- National Cancer Institute (n.d.b). *Adjustment to cancer: Anxiety and distress—for health professionals (PDQ®)*. Retrieved from <http://www.cancer.gov/cancertopics/pdq/supportivecare/adjustment/healthprofessional>
- National Institute for Mental Health. (n.d.). *Depression: Examining the sex/gender differences and links to other diseases*. Retrieved from <http://www.nimh.nih.gov/health/topics/depression/depression-examining-the-sex-gender-differences-and-links-to-other-diseases.shtml>
- Parle, M., Jones, B., & Maguire, P. (1996). Maladaptive coping and affective disorders among cancer patients. *Psychological Medicine, 26*(4), 735-744.
- Parle, M., Maguire, P., & Heaven, C. (1997). The development of a training model to improve health professionals' skills, self-efficacy and outcome expectancies when communicating with cancer patients. *Social Science Medicine, 44*(2), 231-240. doi:10.1017/S0033291700037752
- Peterson, T. O., & Arnn, R. B. (2005). Self-efficacy: The foundation of human performance. *Performance Improvement Quarterly, 18*(2), 5-18. doi:10.1111/j.1937-8327.2005.tb00330.x
- Pistella, C. L. Y., Bonati, F. A., & Mihalic, S. (1999). Social work practice in a rural community collaborative to improve perinatal care. *Social Work in Health Care, 30*(1), 1-14.
- Pollak, K. I., Arnold, R. M., Jeffreys, A. S., Alexander, S. C., Olsen, M. K., Abernethy, A. P., ...Tulsky, J. A. (2007). Oncologist communication about emotion during visits with patients with advanced cancer. *Journal of Clinical Oncology, 25*(36), 5748-5752. doi:10.1200/JCO.2007.12.4180
- Stajkovic, A. D., & Luthans, F. (1998). Self-efficacy and work-related performance: A meta-analysis. *Psychological Bulletin, 124*(2), 240-261. doi:10.1037//0033-2909.124.2.240
- Taylor, S., Harley, C., Campbell, L. J., Bingham, L., Podmore, E. J., Newsham, A. C., ...Velikova, G. (2010). Discussion of emotional and social impact of cancer during outpatient oncology consultations. *Psycho-Oncology, 20*(3), 242-251. doi:10.1002/pon.1730

- White, C. A., & Macleod, U. (2002). ABC of psychological medicine: Cancer. *British Journal of Medicine*, 325(7360), 377-380.
- Wilkinson, S. M., Gambles, M., & Roberts, A. (2002). The essence of cancer care: The impact of training on nurses' ability to communicate effectively. *Journal of Advanced Nursing*, 40(6), 731-738. doi:10.1046/j.1365-2648.2002.02432.x
- Wright, P., Smith, A., Roberts, K., Selby, P., & Velikova, G. (2007). Screening for social difficulties in cancer patients: Clinical utility of the social difficulties inventory. *British Journal of Cancer*, 97(8), 1063-1070. doi:10.1038/sj.bjc.6604006
- Zabora, J., Brintzenhofeszc, K., Jacobsen, P., Curbow, B., Piantadosi, S., Hooker, C., ...Derogatis, L. (2001). A new psychosocial screening instrument for use with cancer patients. *Psychosomatics*, 42(3), 241-246. doi:10.1176/appi.psy.42.3.241
- Zebrack, B., Walsh, K., Burg, M. A., Maramaldi, P., & Lim, J. W. (2008). Oncology social worker competencies and implications for education and training. *Social Work in Health Care*, 47(4), 355-375. doi:10.1080/00981380802173954
- Zebrack, B., & Walsh-Burke, K. (2004). Advocacy needs of adolescent and young adult cancer survivors: Perspectives of pediatric oncology social workers. *Journal of Psychosocial Oncology*, 22(2), 75-87. doi:10.1300/J077v22n02_05

Future Care Planning Practices of Aging Services Professionals in Rural Appalachia

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Abstract. Planning for future care is an important aspect of professional practice with older adults, and social workers play a key role in helping elders engage in future care planning (FCP). This study examined geriatric social service professionals' practices and perspectives on helping older rural Appalachians plan for care needs in later life. Semi-structured interviews were conducted with 14 case managers who live and work in southeast Ohio, a part of rural north central Appalachia. Themes related to efforts made to assist elders with FCP include: a) valuing client self-determination; b) developing positive helping relationships; and c) using initial crises to encourage FCP. Practice implications for rural social work professionals are included.

Keywords: Appalachia, future care planning, older adults, qualitative

As the population in the United States continues to age, it is important to understand how older adults, their families, and service providers plan for the eventualities of increased assistance with activities of daily living (ADLs) and other healthcare needs. According to the United States Department of Health and Human Services (USDHHS), most people who live past the age of 65 will need help with ADLs and/or health-related care at some point in their lives (USDHHS, n.d.). In 2009, 38% of Americans age 65 and older reported some type of impairment, including physical, cognitive, and sensory disabilities (USDHHS, n.d.). While it is difficult to predict exact needs, Kemper, Komisar, and Alexih (2005) found that older adults spend an average of three years receiving long-term care (in a nursing home or assisted living facility) or receiving care (paid or unpaid) at home. How older adults make plans for this care is under-studied and not well understood. Thus, this paper focuses on future care planning (FCP) – specifically direct service providers' practices and perspectives related to helping rural Appalachian elders plan for late-life needs.

Planning for future care is broadly defined as an information-seeking and decision-making framework with the purpose of maintaining quality of life (Sörensen, Mak, & Pinquart, 2011). More specifically, it “occurs when an individual, couple, or family, considers the possibility that frailty or disability might be a future health state” (Sörensen et al., 2011, p.113). Rooted in Proactive Coping Theory (Aspinwall & Taylor, 1997), planning for late-life needs is a dynamic process that includes: 1) becoming aware of future care needs, 2) gathering information, 3) developing preferences, and 4) concrete planning (Sörensen & Pinquart, 2000). Planning for future care is an important aspect of professional practice. Social service providers, specifically

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social work professionals working with older adults in home and community-based settings, are uniquely positioned to help elders engage in future care planning. As a profession, social work needs to better understand these future care planning needs and also provide social work students and nascent social workers with knowledge and skills related to helping older clients and their families prepare for late-life care. As the number of older Americans increases twofold between 2005 and 2030, the need will grow for social workers well prepared for geriatric practice (Institute of Medicine, 2008). Thus, research that helps social work professionals and practitioners to understand future care planning is paramount.

In addition to studies of rural elders' later life planning, research highlighting the experiences of *rural* social workers is also needed, given the documented paucity of empirical social work articles on rural populations in the U.S. (Slovak, Sparks, & Hall, 2011). Within this broad purpose, this paper provides in-depth descriptions of the skills and social work roles assumed by practitioners to help older clients plan for future care needs. Although preparation for future care can also involve making choices around treatment for terminal illness and end-of-life decisions (i.e., advance care planning), this study focuses on planning for a time of increased disability and frailty that often occurs in late life (Sörensen et al., 2011).

Review of the Literature

The benefits of planning ahead for future care needs are well-documented. Individuals often have more options and more control over their options the earlier they plan (Pinquart, Sörensen, & Peak, 2004; USDHHS, n.d.). Elders who communicate their preferences and plan ahead have a better chance of receiving the type of care they prefer (Brechling & Schneider, 1993; Holden, McBride, & Perozek, 1997). Planning ahead for future care also means less stress on family members by giving them time to prepare for the caregiving role and relieving them of the burden of making decisions for the care recipient (Pinquart et al., 2004; USDHHS, n.d.). In addition, thinking about the future and the likelihood of needing help in later life, without making concrete plans, is associated with high levels of worry and depression (Pinquart & Sörensen, 2002a).

There may be other benefits to considering future care planning for rural older adults separate from future care planning for urban older adults. Rural communities are notoriously underserved with respect to health care providers and services (Kropf, 2003) and alternative long-term care services are also scarce in these communities (Buckwalter & Davis, 2011). Thus, how rural elders interface with healthcare and social service providers may differ from that of their urban counterparts. Further, specific cultural norms and values should be considered when looking at rural populations.

Rural Appalachian elders represent an understudied population and are recognized as a group facing health disparities (Behringer & Friedell, 2006; Halverson, Ma, & Harner, 2004). In 2000, 14% of Appalachians were 65 or older, compared with 12% of the overall U.S. population. The baby boom cohort living in this region is also steadily advancing towards later life (Haaga, 2004). There is considerable evidence documenting the poor physical health of Appalachians (Halverson et al., 2004; Smith & Holloman, 2011), and of older Appalachians specifically (Behringer & Friedell, 2006; Haaga, 2004). Compared with other regions of the country, Appalachia has a greater percentage of older adults with disabling and chronic conditions

(Halverson et al., 2004) and often experiences shortages in health and social services (Smith & Holloman, 2011). Most older adults with long-term care needs are supported by family members; in 2012, only 3.5% of older adults lived in institutional settings such as nursing homes (Administration on Aging, 2014). For Appalachian older adults, the out-migration of young adults in the area (Haaga, 2004) could potentially limit the availability of family caregivers (Carter & Wang, 2006). Moreover, high rates of poverty in the region (Pollard & Jacobson, 2013) might make it difficult for elders to pay out-of-pocket for formal care (Carter & Wang, 2006). In central Appalachia, the median household income between 2007 and 2011 was \$32,887, only 62 percent that of the U.S. during the same period (Pollard & Jacobson, 2013). Given the poor health status, high poverty rates, and potentially limited available formal and informal resources, planning for future care is crucial for Appalachian elders and their families.

Older Appalachians have a unique culture that likely influences their attitude and behaviors toward planning for later life. Coyne, Demian-Popescu, and Friend (2006) found that “a deep sense of place” characterized the attachment that Appalachians often have to their communities. This desire to age in place is typical of many older adults in the United States (Alley, Liebig, Pynoos, Banerjee, & Choi, 2007; U.S. Census Bureau, 2003). Aging in place while maintaining quality of life and safety requires thinking ahead and preparation, even more so for rural elders who may have fewer community and familial supports. A second Appalachian characteristic that may affect future care planning is a tendency to live for the moment and focus on the present as a way to maintain health and continuity (Hayes, 2006). This “here and now” orientation (Pope, 2013, p. 516) may prove to be harmful if it prevents forethought and keeps older adults from making concrete plans for their care. Third, some middle age and older adults rely on reciprocity from family and friends rather than preparing for later life. Close relationships with friends and relatives mean they have knowledge of each other’s personal troubles, which allow them “to anticipate, offer, and provide informal care before the need to ask [arises]” (Hayes, 2006, p. 288). This tendency to not ask for help and expect others to offer care, found in Hayes’ (2006) research with elder Appalachian women, may hinder the receiving of adequate and appropriate help when long-term care needs arise. A fourth characteristic of Appalachian older adults that can impact future care planning is that of self-reliance. Long and Weinert (1989) identified themes of self-reliance as important considerations when trying to understand and anticipate health care needs of rural populations. Specific to Appalachia, self-reliance as it relates to access to and utilization of health care services has been documented as an important issue (Goins, Spencer, & Williams, 2011; Vance, Basta, Bute, & Denham, 2012). These distinct cultural values and norms must be considered when thinking about future care planning with Appalachian elders.

Social service professionals are uniquely situated to encourage and support older adults and their families in future care planning. While the National Association of Social Workers (2010) has developed guidelines on working with family caregivers, no standards exist regarding best practices for social workers involved in future care planning for older adults and their families. There has been little research on how geriatric service providers support older clients in preparing for late-life needs. Previous work by Black and her colleagues (Black, 2007, 2011; Black & Fauske, 2008) examined personal and professional factors associated with advance care planning practices of geriatric case managers. Based on her research, professionals’ advance care planning practices included giving information, providing referrals, developing options, facilitating communication with families, and informing providers (Black & Fauske, 2008).

Advance care planning practices were also strongly correlated to certain practice skills, educational activities about advance care planning, and personal experiences in planning (Black, 2011).

The present study differs from Black's in several ways. First, whereas Black framed advance care planning as a concept that included future care and end of life care planning, this study focuses only on planning for future care needs (i.e., "the possibility that frailty or disability might be a future health state" (Sörensen et al., 2011, p.113)). Second, the sample in this study includes social service providers working in various settings, rather than only those working in Area Agencies on Aging (Black, 2007, 2008, 2011). Lastly, the present study highlights the experiences of rural social service professionals who live and work in rural Appalachia. Given that most older adults do not proactively plan for future care needs (AARP, 2007; McGrew, 2000; Pinquart & Sörensen, 2002b), this study makes important contributions to our understanding of the direct practice roles and skills used by geriatric practitioners as they encourage older adults to prepare for future care needs. A clearer understanding of effective practices in the context of rural older adults is critical to increasing proactive planning within a population facing multiple challenges. Additionally, findings from this research are potentially relevant to elders and their families living in rural areas throughout the United States.

Methods

This study used qualitative methods because the aim was to provide in-depth descriptions of the skills and social work roles assumed by practitioners to help older clients plan for future care needs. Qualitative methods allow the researcher to "capture data on the perceptions of local participants from the inside through a process of deep attentiveness, of empathetic understanding, and of suspending or bracketing preconceptions about the topics under discussion" (Miles, Huberman, and Saldaña, 2014, p. 9). North Central Appalachia (Appalachian Regional Commission, 2009), specifically rural southeast Ohio, serves as the study setting and is significant in this research. The Appalachian region has unique cultural traditions (Lengerich et al., 2006); and although some aspects of the culture may put Appalachian elders at risk for adverse health and social consequences in late life (e.g., self-reliance and present orientation), other values and beliefs may be protective (e.g., strong family ties) (Coyne, Demian-Popescu, & Friend, 2006; Hartley, 2004).

Sample Selection and Recruitment

A purposive sampling methodology was used to recruit social service professionals for the study. Participants were recruited by the authors through existing personal and professional contacts. Five participant inclusion criteria were considered: 1) self-identified as a direct service provider, 2) were currently working with or had worked with older adults in the past year, 3) provided services within the North Central Appalachian region of Ohio, 4) had been working in the field for at least one year, and 5) lived within the southeastern Ohio counties of North Central Appalachia.

Fourteen geriatric social service professionals, ranging in age from 24 to 69, comprised the final sample. Participants averaged 13 years of practice experience, and 11 had worked with older adults for more than 5 years. Four participants self-identified as supervisors of other direct

service workers. All participants were White, all were female, and all but two worked full-time. All of the professionals had attended at least some college; six had completed undergraduate programs, and six had master's degrees. The educational backgrounds of participants included social work ($n = 6$), counseling/family studies ($n = 3$), and nursing ($n = 2$). Other disciplines represented were philosophy, marketing, and applied behavioral science. Six participants worked at an Area Agency on Aging, two worked in a hospital, two worked in adult protective services, and two worked in a community crisis center. Work settings also represented were an aging-focused nonprofit and private practice with one participant at each.

Data Collection

All procedures and interview protocols for this study were approved by the Institutional Review Board (IRB) at Ohio University. Before beginning the interviews, the first author reviewed with potential participants the IRB-approved informed consent document describing their rights and responsibilities. If they agreed with the consent form, participants signed the form, keeping one copy for their records, while the researcher retained the other copy. All participants were assigned a pseudonym, and names of towns and agencies mentioned by participants were changed. Participants were offered a \$35 gift card to a vendor of their choosing as a thank-you for participating.

The first author collected data through semi-structured interviews, using an interview guide. Some of the questions included were, "What is involved in helping your clients prepare for future care needs?" and "Describe the conversations you have with clients about future care planning." Prior to each interview, participants were read the following to ensure they understood the concept that was being referred to during the interview.

For the purposes of this interview, *future care planning* is defined as an information-seeking and decision-making that occurs when an individual, couple or family, considers the possibility that frailty or disability might be a future health state. Planning for late-life needs is a process that includes: a) becoming aware of future care needs, b) gathering information, c) developing preferences, and d) concrete planning (Sørensen et al., 2011; Sørensen & Pinquart, 2000).

Data were collected between August, 2012 and May, 2013, and interviews averaged one hour in length. Interviews were digitally recorded and transcribed by the first author and a graduate assistant using Express Scribe® software.

Data Analysis

The first author adapted grounded theory methods to analyze the data, specifically the techniques of coding and constant comparison. Open-coding procedures were used during initial reading of the transcripts. After identifying initial codes, the first author moved to focused coding; this involved making decisions about what codes were most relevant to the research questions, discarding codes that were not relevant, and combining earlier codes that were similar. The technique of constant comparison was used to look for similarities and differences in categories across the transcripts (Charmaz, 2014). Segments of data pertaining to participants' future care planning practices (e.g., attitudes, beliefs, relevant experiences, and statements) were

copied and pasted into a separate document using Microsoft Word®. Sorting the data into emergent categories (i.e., crisis, education, and self-determination) and assigning codes to segments of data occurred simultaneously and were iterative processes. Some of the codes relevant to helping relationship included “rapport”, “self-determination”, and “empathy.”

To help ensure rigor, member checks were employed (Bogdan & Biklen, 2007; Merriam, 2009). After preliminary data interpretations were developed, this information was presented to a few participants. The first author then provided a summary of the findings to seven participants via email. Three participants provided feedback on the common themes, and adjustments were made based on their feedback (e.g., clarifying the label of a theme or category).

Findings

Three themes emerged regarding future care planning practices of geriatric social service professionals in rural southeast Ohio. First, planning was facilitated by providing education and outreach to older adults and their families prior to a point of crisis. Second, professionals used initial crises that brought these clients to them to encourage future care planning. Third, participants focused on the helping relationship (i.e., building rapport, valuing client self-determination, and asking open-ended questions) to assist rural elders in preparing for late-life needs.

Providing Education and Outreach Prior to a Point of Crisis

Education and outreach prior to the onset of crises were central to how participants viewed their efforts to help older clients prepare for future care needs. This included providing information on a large scale, such as campaigns in the community to raise awareness of existing services, as well as education on an individual level, such as answering the questions of someone who calls the agency for information about Medicaid. Karen, a supervisor with 24 years of experience at the Area Agency on Aging (AAA), shared:

We’re constantly encouraging people to take advantage of long-term consultations [and] to get the agency name and word out there so they know that resources are available. We do that over the phone when people will just call and ask questions. We try to be as available and accessible as we possibly we can through Facebook and our webpage and by phone and by emails and whatever method folks want to seek information.

Education was viewed as integral to increasing individuals’ capacity for decision-making and planning about their late life. Linda, a program coordinator at an AAA, saw one of her primary jobs as “empowering [the community] through education.” She went on to say:

[It’s] getting them over the hump and getting them to be proactive. It’s aging [and] death. All of those things are taboo subjects in our society. Nobody wants to think about it. They don’t want to talk about it. They’re in denial and I guess I’m trying to let folks know it’s okay [to talk about].

Jacquelyn, the director of operations at an aging-focused non-profit, also spoke about her efforts to provide information to her consumers. “My role has been coordinating a kind of education

effort.... A lot of people just aren't educated about what, you know, the payment options are [for long-term care]." The one-on-one brokering of services is especially needed for rural elders, given "physical barriers" that exist in the region, such as limited internet and cell phone reception. Overall, participants' knowledge of community resources and their ability to connect clients with tangible services helped support clients' efforts to anticipate and plan for care needs.

Using Initial Crises to Encourage Clients to Plan for Future Care

Social service providers shared that most of their clients were not proactive in planning for future care. Marge, a service broker at a community crisis center noted, "most people are today [focused]...just today." Amy, a supervisor with Adult Protective Services, also observed a tendency "within Appalachian culture [to say], 'Oh, I'll deal with it later.'" According to participants, the small percentage of their client population who did approach aging and potential care needs with some thought and planning were characterized by having more family support, financial resources, and education. Taylor, a 24 year-old case manager with AAA, said, "I think if people have really good family involvement they're often, or the family is, better able to help them look towards the future." Similarly, Amy observed differences in planning based on socio-economic status; she stated, "If [people] are more middle-class or upper-class...they are thinking about planning more."

Participants revealed that most of the clients were not thinking about and preparing for potential care needs that might arise as they aged. Karen, a supervisor with 24 years of experience with an AAA described it this way:

A few folks have called just to see what's available because somebody suggested that they call. But often, it's that they truly are at the point of need. Very rarely just someone calls just because they want to really understand what might be available out there for them in the future.

Linda, who also worked at an AAA, echoed this sentiment: "Usually, people don't contact us until they're forced into it for one reason or another – like some sort of crisis. Or it is...a benefit that they want or they need." However, she went on to say, "Programs like our Senior Farmer's Market [and others], people want those coupons. So they come to the door, but all of those things are creating a higher sense of awareness of our agency and what's available."

Initial crises that brought older adults to the attention of these professionals included incontinence issues, wandering, and impaired judgment demonstrated by behavior such as giving money away. Although older adults initially came into contact with social services because of an acute situation, participants tried to use these situations to encourage clients to consider care needs that might occur in coming years. Amy, a 36 year-old supervisor with Adult Protective Services said, "I would say in the beginning we are a little more directive....Then, once we get the stability in place, then we can start talking to them about more long-term care." In her work as a case manager at an AAA, Taylor was always looking ahead to anticipate her clients' needs, even when her clients were not thinking proactively. "I guess it's being aware of present needs as well as always looking to the future for, you know, what if this happens, what can we do to help this person." Contact with their agency also provided an opportunity for these professionals to connect older clients with aging-related services and resources. In her work as a supervisor at an

AAA, Carolyn said, “A lot of what we do is in crisis mode. So it’s not good planning. But at least, [clients] are thinking, ‘Okay, we’ve got to do something and we don’t know what to do. Help us find the resources that we need.’” These social services professionals are not unlike other social workers whose first contact with a client occurs because an existing difficulty has impaired their well-being and functioning. However, the worker-client interaction was viewed by participants as a vehicle not only to help clients cope with their present problem, but also to encourage client insight to prevent future crises.

Focusing on the Helping Relationship

The third theme that emerged related to service providers’ practices related to helping rural Appalachian elders plan for late-life needs was using the helping relationship. Specifically, participants discussed the importance of self-determination, rapport and trust, and asking open-ended questions in fostering a positive worker-client relationship to encourage planning.

Building rapport and establishing trust. A key aspect of the helping relationship that professionals used to assist rural elders in future care planning was building rapport and establishing trust with clients. Terri shared about her job: “it’s about trying to build a rapport in a short period of time and seeing if [clients] even identify as frail or needing assistance.” She went on to say, “You have to start with building a rapport, and that rapport building is a continual process.” Amy, a supervisor with Adult Protective Services, described how relationships serve as a conduit for helping older clients plan for care needs:

It’s really hard because some people don’t want to talk about it and ... they don’t want to plan for it....What happens usually is when we start developing relationships with people, those relationships develop into feeling more comfortable talking about those things.... So, you know, it’s not the first visit or the second visit. It’s down the road after we’ve been with them for a while.

Carolyn made this observation about people in her small community: “You know, people have a lot of pride – they don’t want to ask for help.” For participants in this study, attending to client engagement supported a working relationship where clients felt comfortable sharing personal information and trusted the social worker to help with issues of vulnerability and getting assistance with care needs.

Valuing client self-determination. Self-determination was also viewed as central to supporting a helping relationship that facilitated future care planning. Service providers needed to recognize when to probe deeper with clients about the need to prepare for chronic illness or disability and know when to “back off” and be less directive. Carolyn, a long-time supervisor at an AAA said this:

[It’s] a lot of it is education and knowing when to back off with people. If they are resistant and not willing to hear you out or accept the information that you’re giving – it’s fine, you know. You have to have a sense of, okay, how far can my discussion go? And it might not go very far.... They may not be ready at that point in time. We’ll follow up with them later if they want or if we think that that person might be receptive later.

Similarly, Terri, a case manager and assessor with more than 17 years of experience at an AAA, shared:

Some people just don't want you there at all and you need to just excuse yourself and say, "Here's my card and if you want to talk later, please don't hesitate to give us a call." I can't force myself or our services, because these are adults, and I have to respect them as such.

In this study, there was a recognition by participants that older clients had the right and capacity to consider the possibility of future care needs in late life and make plans for that care. Practitioners like Jacquelyn also observed that client autonomy should be viewed within the Appalachian community where they worked: "Part of what I think is hard about Appalachian culture is that we're so independent and bull-headed." Ultimately, even when clients were initially resistant to conversations about future care needs, these individuals believed that respecting clients' self-determination was central to their role in helping older clients engage in future care planning.

Asking open-ended questions. A third aspect of the helping relationship was asking open-ended questions. Terri, who worked at an Area Agency on Aging, explained how she approaches her clients: "Asking a lot of open-ended questions, seeing where they are and where they want to be and who they want to be involved, even if they're receptive to that kind of conversation....It's a lot of information gathering." Some open-ended questions that Carolyn asks her older clients are:

"Where is it that you live? How far are you from the hospital? How long does it take for the life squad to get to your home? Is your home accessible to the life squad?" Because some of our folks who live out in the rural areas and not in town you might have to be climbing a hill in trying to take somebody out of a home.... "Do you understand your medications? What kind of a relationship do you have with your primary care physician? What other physicians do you see? Are there transportation barriers to getting to where you need to go?"

Open-ended questions not only provide information needed to assess clients' situations, but can also stimulate self-reflection in clients related to future care planning. Courtney, a service coordinator trained as a nurse, uses questions to encourage hypothetical thinking from clients about their plans for care: "I usually try to ask them about what are your plans. What are you going to do if situation A happens? What are you going to do if situation B happens?"

Conclusion

The body of literature concerning social service provision in rural communities is largely comprised of narratives, case studies, and conceptual models (Riebschleger, 2007). As a result, research investigating effective practices used by social service professionals in these communities is limited, and even less is known about supporting rural older adults in planning for later life. Yet, strong evidence exists to support the notion that rural populations are underserved, disproportionately vulnerable to health-related problems, and "often invisible within discourse about social welfare programs, policy, and research" (Slovak et al., 2011, p.

429). As such, the present study is particularly relevant to social workers, adds to an evolving understanding of practitioners' experiences working in rural communities, offers implications for practice, and identifies areas for future research.

Results from this study are a first step in understanding how rural social service professionals help support older clients in planning for future care. Findings reveal practitioners perceived three salient methods as efficacious in working with rural older clients in planning for future care: providing education and outreach prior to a crisis, using initial crises to encourage clients to plan for future care, and attending to the helping relationship using specific generalist practice techniques. These findings are consistent with Riebschleger's (2007) suggestions for rural social work practice, which emphasize the centrality of generalist practice skills, in addition to the importance of community, connection, and attention to diversity. In her qualitative study of social workers serving rural areas, practitioners highlighted aspects of generalist practice such as purposeful use of self, self-awareness, flexibility, creativity, and innovation (Riebschleger, 2007). Encouraging these skills, alongside those related to the helping relationship identified in the present study, address the lack of specificity Daley (2010) asserts is missing from models of rural social work that are predominantly community-based and limited in providing guidance for direct practice with individuals and families. Further, new knowledge related to barriers and factors that promote rural Appalachians' preparation for late-life needs (e.g., long-term care preferences, housing needs, and social support) can inform social workers and health professionals as they develop strategies to facilitate planning among this population. Interventions that might influence planning among rural elders include culturally specific education and outreach efforts for aging individuals and their families and increasing long-term care options for individuals living in rural areas.

Despite a lack of consensus in how the profession of social work constructs the phenomenon of *rural social work*, the general notion that this practice area is, in fact, distinctive is widely accepted (Daley, 2010). Daley cautions against the rural/urban dichotomy due to the lack of consistent discerning characteristics between the two, so conceptualizing *rural* based upon the community of interest, rather than population threshold, may be of use in developing best practices in social service provision. The practices deemed as helpful by participants in the present study seem to be derived from the latter understanding; that is, participants discussed practices that were informed by regional and cultural characteristics of clients—both as rural clients and older clients. The perceived effectiveness of these practices may very well be tied to practitioners' apparent cognizance of the aforementioned unique characteristics of Appalachian older adults—sense of place, present-moment focus, tendency to not ask for help, and self-reliance—as evidenced by the emphasis on building rapport and trust, valuing client self-determination, and the use of open-ended questions. The importance of valuing clients' self-determination supports other research highlighting the tendency for older Appalachian women to utilize health care “on my own terms” (Brown & May, 2005, p. 10). In short, the study presented here supports the notion that a focus on community and cultural norms may serve to be a critical aspect of rural social work practice.

Providing outreach and education to older adults in their communities was also viewed as central to how these service professionals encourage and support future care planning. Providing this information on a community level, versus education tailored to the needs of individuals and families, may not be effective for older adults in small towns and rural communities. National

social marketing campaigns to encourage people to actively plan for long-term care needs have been only moderately successful. One such campaign called “Own Your Future” involved governors in 24 states sending letters to every household with residents between the ages of 45 and 65. Residents were offered a free Long-Term Care Planning Kit that could be mailed to their home. An evaluation of the effectiveness of “Own Your Future” indicates that only 8% of individuals who received the mailing made the effort to order the free kit. According to Tell and Cutler (2011), “the campaign was effective in getting individuals who already have a planning orientation to take some type of planning action” while “it was not as effective in generating requests for the planning guide among those who saw little value in planning ahead” (p. 155). Karen, a participant in this study, even mentioned the “Own Your Future” campaign and said her agency had “boxes and boxes of those darn [pamphlets] they were trying to get out.” She admitted that the information offered was very useful to older adults and their families, yet few took advantage of it. Perhaps education efforts in rural communities should consider the cultural characteristics of family-orientation and loyalty to trusted individuals. Rather than using mass mailings to encourage future care planning, identifying and training lay leaders in the community would be more effective by “leveraging the strong social networks within rural communities” (Bardach, Schoenberg, Fleming, & Hatcher, 2012, p. 6).

While the present study was somewhat limited by both a small non-random sample and with a narrow demographic range, the findings are still important and valuable to social service practitioners and educators alike. Perhaps its greatest contribution is the focus on a specific population—older adults residing in Appalachia—that may be particularly vulnerable due to multiple factors including age, geographic location, and cultural norms. As the need for geriatric social workers continues to grow (Institute of Medicine, 2008), so too does our understanding of how to best prepare social work practitioners for this work. This study adds to the growing literature related to future care planning and emphasizes the need for a strong foundation in generalist social work practice skills while also emphasizing the importance of place and culture in practice. Rural elders—particularly those in Appalachia—may be less likely to seek support and care prior to a crisis; this delay may lead to difficulties finding needed resources at the onset of a crisis. Utilizing this knowledge of situations appropriate for intervention for future care planning can help practitioners to think about opportunities to proactively plan for future care with elders and their families. The complexity of place, culture, history, and experience must be taken into consideration when crafting successful interventions and future care plans.

Study findings highlight the need for further research related to service provision for older adults in rural communities. While the present study identifies worker perceptions of helpful techniques in working with older clients in the Appalachian region who may benefit from planning for later life, a clearer understanding of the client perspective regarding needs, efficacy of services, and the helping relationship would contribute to the extant literature. Studies are needed to continue to explore the ways in which the culture of those in this region influences service availability and use, as well as how the service delivery system could more effectively attend to the needs of this population.

References

- AARP. (2007). *Are Americans talking with their parents about independent living: A 2007 study among boomer women*. Washington, DC: Author.
- Administration on Aging. (2014). *A profile of older Americans: 2013*. Washington, DC: Department of Health and Human Services.
- Alley, D., Liebig, P., Pynoos, J., Banerjee, T., & Choi, I. H. (2007). Creating elder-friendly communities: Preparations for an aging society. *Journal of Gerontological Social Work*, 49(1/2), 1-18. doi:10.1300/J083v49n04_01
- Appalachian Regional Commission. (2009). *Source and methodology*. Retrieved from <http://www.arc.gov/research/SourceandMethodologyGeography.asp>
- Aspinwall, L. G., & Taylor, S. E. (1997). A stitch in time: Self-regulation and proactive coping. *Psychological Bulletin*, 121(3), 417-436.
- Bardach, S. H., Schoenberg, N. E., Fleming, S. T., & Hatcher, J. (2012). The relationship between colorectal cancer screening adherence and knowledge among vulnerable rural residents of Appalachian Kentucky. *Cancer Nursing*, 35(4), 288–294. doi:10.1097/NCC.0b013e31822e7859
- Behringer, B., & Friedell, G. H. (2006). Appalachia: Where place matters in health. *Preventing Chronic Disease*, 3(4), A113. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1779277/>
- Black, K. (2007). Exploring case managers' advance care planning practices. *Journal of Social Service Research*, 33(3), 21-30. doi:10.1300/J079v33n03_03
- Black, K. (2011). Professional and personal factors associated with gerontological practice: Implications for training and education. *Educational Gerontology*, 37(11), 982-994. doi:10.1080/03601277.2010.495552
- Black, K., & Fauske, J. (2008). Measuring case managers' advance care planning practice: Translating focus group findings into survey development. *Care Management Journals*, 9(4), 166-176. doi:10.1891/1521-0987.9.4.166
- Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research in education: An introduction to theory and methods* (4th ed.). Boston, MA: Allyn and Bacon.
- Brechling, B. G., & Schneider, C. A. (1993). Preserving autonomy in early stage dementia. *Journal of Gerontological Social Work*, 20(1/2), 17-33.
- Brown, J. W., & May, B. A. (2005). Rural older Appalachian women's formal patterns of care. *Southern Online Journal of Nursing Research*, 2(6), 1-21.
- Buckwalter, K. C., & Davis, L. L. (2011). Rural caregiving in the United States. *Caregiving: Research, Practice, Policy*, 1, 33-46. doi:10.1007/978-1-4614-0302-9_3
- Carter, M. W., & Wang, S. (2006). *Quality of care in Appalachian nursing homes: Doing more with less*. Retrieved from <http://www.rri.wvu.edu/pdffiles/carterwp2006-6.pdf>

- Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative analysis* (2nd ed.). London: SAGE.
- Coyne, C. A., Demian-Popescu, C., & Friend, D. (2006). Social and cultural factors influencing health in southern West Virginia: A qualitative study. *Preventing Chronic Disease, 3*(4), A124.
- Daley, M. R. (2010). A conceptual model for rural social work. *Contemporary Rural Social Work, 2*(1), 1-7.
- Goins, R., Spencer, S., & Williams, K. (2011). Lay meanings of health among rural older adults in Appalachia. *Journal of Rural Health, 27*(1), 13-20. doi:10.1111/j.1748-0361.2010.00315.x.
- Haaga, J. (2004, April). *Demographic and socioeconomic change in Appalachia: The aging of Appalachia*. Retrieved from <http://www.prb.org/pdf04/AgingofAppalachia.pdf>
- Halverson, J., Ma, L., & Harner, E. J. (2004). *An analysis of disparities in health status and access to health care in the Appalachian region*. Washington, DC: Appalachian Regional Commission. Retrieved from http://www.arc.gov/assets/research_reports/AnalysisofHealthDisparitiesIntroductionExecutiveSummary.pdf
- Hartley, D. (2004). Rural health disparities, population health, and rural culture. *American Journal of Public Health, 94*(10), 1675-1678.
- Hayes, P. A. (2006). Home is where their health is: Rethinking perspectives of informal and formal care by older rural Appalachian women who live alone. *Qualitative Health Research, 16*(2), 282-297. doi:10.1177/1049732305275629
- Holden, K., McBride, T., & Perozek, M. (1997). Expectations of nursing home use in the health and retirement study: The role of gender, health, and family characteristics. *Journal of Gerontology: Social Sciences, 52B*, S240-S251.
- Institute of Medicine (2008). *Retooling for an aging America: Building the healthcare workforce*. Washington, DC: National Academic Press.
- Kemper, P., Komisar, H. L., & Alecxih, L. (2005). Long-term care over an uncertain future: What can future retirees expect? *Inquiry, 42*, 335-350.
- Kropf, N. P. (2003). Future training and education recommendations for rural gerontological social workers. *Journal of Gerontological Social Work, 41*, 287-299. doi:10.1300/J083v41n03_06
- Lengerich, E. J., Bohland, J. R., Brown, P. K., Dignan, M. B., Paskett, E. D., Schoenberg, N. E., & Wyatt, S.W. (2006). Images of Appalachia. *Preventing Chronic Disease, 3*(4), A112.
- Long, K., & Weinert, C. (1989). Rural nursing: Developing the theory base. *Scholarly Inquiry for Nursing Practice: An International Journal, 3*(2), 112-127.

- McGrew, K. B. (2000). *Impossible selves? Challenges and strategies for encouraging individual long-term care planning*. Ohio Long-Term Care Research Project. Scripps Gerontology Center. Oxford, OH: Miami University.
- Merriam, S. (2009). *Qualitative research in practice: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.
- Miles, M., Huberman, M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: SAGE.
- National Association of Social Workers. (2010). *NASW standards for social work practice with family caregivers of older adults*. Washington, DC: NASW Press. Retrieved at <http://www.socialworkers.org/practice/standards/NASWFamilyCaregiverStandards.pdf>
- Pinquart, M., & Sörensen, S. (2002a). Psychological outcomes of preparation for future care needs. *Journal of Applied Gerontology*, 21(4), 452-470. doi:10.1177/073346402237632
- Pinquart, M., & Sörensen, S. (2002b). Factors that promote and prevent preparation for future care needs: Perceptions of older Canadian, German, and U.S. women. *Health Care for Women International*, 23, 729-741.
- Pinquart, M., Sörensen, S., & Peak, T. (2004). Helping older adults and their families develop and implement care plans. *Journal of Gerontological Social Work*, 43(4), 3-23. doi:10.1300/J083v43n04_02
- Pollard, K., & Jacobson, L. (2013). *The Appalachian region: A data overview from the 2007-2011 American Community Survey*. Washington, DC: Appalachian Regional Commission.
- Pope, N. D. (2013). Female caregivers' plans for later life. *Qualitative Social Work*, 12(4), 507-522. doi:10.1177/1473325012442439
- Riebschleger, J. (2007). Social workers' suggestions for effective rural practice. *Families in Society: The Journal of Contemporary Social Services*, 88(2), 203-213. doi:10.1606/1044-3894.3618
- Slovak, K., Sparks, A., & Hall, S. (2011). Attention to rural populations in social work's scholarly journals. *Journal of Social Service Research*, 37(4), 428-438. doi:10.1080/01488376.2011.578035
- Smith, L. H., & Holloman, C. (2011). Health status and access to health care services: A comparison between Ohio's rural non-Appalachian and Appalachian families. *Family & Community Health*, 34(2), 102-110. doi:10.1097/FCH.0b013e31820de961
- Sörensen, S., Mak, W., & Pinquart, M. (2011). Planning and decision-making for care transitions. *Annual Review of Gerontology and Geriatrics*, 31(1), 111-142.
- Sörensen, S., & Pinquart, M. (2000). Preparation of future care needs by West and East German seniors. *Journal of Gerontology: Social Sciences*, 55B, S357-S367.
- Tell, E. J., & Cutler, J. A. (2011, Winter). A national long-term care awareness campaign: A case

- study in social marketing. *Cases in Public Health Communication & Marketing*, 5, 75-110. Retrieved from <http://publichealth.gwu.edu/departments/pch/phcm/casesjournal/>
- U.S. Census Bureau. (2003). *Homeownership trends*. Washington, DC: U.S. Government Printing Office.
- U.S. Department of Health and Human Services (USDHHS). (n.d.). *Long-term care: The basics*. Retrieved from <http://longtermcare.gov/the-basics/>
- Vance, R., Basta, T., Bute, J., & Denham, S. (2012). Identifying the health needs in rural Appalachian Ohio: Outcomes of a rural community-academic partnership. *American Journal of Health Sciences*, 3(2), 115-124.

Rural Older Adults and Functional Health Literacy: Testing Self-efficacy, Knowledge and Skills Resulting from Hands-on Health Promotion

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Abstract. Functional Health Literacy (FHL) involves the knowledge, skills and belief in self-efficacy to use health care information in self-care. FHL is critical for rural older adults since they are at risk of poor health care outcomes. As part of the Senior Health University project, we measured the FHL of rural older adults before and after educational sessions that included hands-on skill building. Ninety-eight participants aged 60 and older were recruited from five rural congregate meal sites over two years. Survey methods allowed for paired sample *t*-tests of FHL variables. Findings included significant post-training increases in FHL, suggesting the potential benefit of FHL training for rural older adults. Andersen's (1995) Behavioral Model of Health Services Use guided this study of the effects of health promotion on health services use, standardization of practical measurement tools, and examination of modalities in rural settings. Research is needed to test the relationship of increased FHL and use of health services by rural participants and to explore the role of online resources and service use in vulnerable older adult populations.

Keywords: health literacy, functional health literacy, behavioral model of health services use, older adults, rural health, health promotion, social work, communication

An undeniable change in the dynamic health care environment is the increased responsibility of health care consumers to understand and manage their own care. The ability to understand health information, or Health Literacy (HL), is central to self-care. As the individual's role in health care increases, there is a concomitant concern about the skills of the vulnerable aged to effectively utilize health care information (Baker & Gazmararian, 2000; Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; Zamora & Clingerman, 2011). About 62% of older adults (39% of people aged 75 or older and 23% aged 65 to 74) have significantly below average HL rates (CDC, 2009). Therefore, HL is a critical issue for older adults.

By the year 2030, the number of persons over the age of sixty-five will double to seventy million. This means that one in five individuals living in the United States will be sixty-five years and older (Vincent & Velkoff, 2010). Health promotion for older adults can include a functional dimension that may address the self-care needs of this growing population. While HL involves the study of theories and practices used to understand health information, Functional Health Literacy (FHL) pertains to demonstrating skills, such as comprehending information, asking the appropriate questions of health providers, and accessing reliable sources of medical and health information online. The addition of function brings the engagement of older adults in using health care information to explore, monitor and act on health promotion.

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In rural communities, adults aged 65 and older represent a larger proportion of the population than in urban areas (18% versus 15%, respectively) (National Rural Health Association, 2015; Hutchison, Hawes, & William, 2004). Factors that may contribute to a large proportion of rural older adults include: (a) aging in place; (b) youth outmigration; and (c) relocation to smaller communities.

Older adults residing in rural areas seem to be most at risk of having low HL and related poor health outcomes (Berkman et al., 2011). Compared with their urban counterparts, rural older adults tend to have lower income, lower educational attainment, less health insurance coverage, and less access to transportation, emergency and specialty health care services, and these barriers contribute to poorer self-reported health status (Averill, 2005; RAC, 2012). Rural older adults, in particular, underutilize health services and many wait until they are very ill before seeking treatment compared to urban residents (Hutchinson, Hawes, & Williams, 2004). Increased self-efficacy beliefs would likely empower rural older adults to make the most of the access that they do have, and request more access.

Health Literacy information is the key to reducing barriers for rural older adults to recognize when care is needed. Approaches to promoting knowledge and skills include increasing older adults' ability to interact with healthcare providers and providing easy to understand reading materials. Educational interventions can increase older adults' knowledge and skills on a variety of common self-care topics, as well as on computer searches and Internet use. Improving older adults' self-efficacy skills could be achieved through the same educational interventions. With knowledge, skills, and empowerment, older adults may take a more active role in their health care.

Literature Review

Health Literacy and Functional Health Literacy

Health Literacy is defined by the American Medical Association as “the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment” (American Medical Association, 2014, para. 1). Eighty percent of older adults have limited health literacy skills (Schwartzberg, VanGeest, & Wang, 2005), and lack of HL results in fewer preventative measures, more frequent emergency room visits, higher rates of hospital admissions, and poorer overall health (Young, Weinert, & Spring, 2012). Patients with low HL are at greater risk of misunderstanding treatment recommendations and having problems in accurately taking prescription medications (Kutner, Greenburg, Jin, & Paulson, 2006; Wolf, Gazmararian, & Baker, 2005). Lower levels of HL also translate into higher healthcare costs with higher usage of health services (Schwartzberg, VanGeest, & Wang, 2005). Improving HL seems likely to improve ability to self-manage health care and perhaps prevent frequent hospitalizations (Kutner, Greenburg, Jin, & Paulson, 2006).

Some older adults face additional challenges as they have mental health issues which can compromise HL and FHL. Psychological changes in mood and self-concept can affect older adults' ability to communicate and to learn. Losses in old age, such as friends, family members, financial status, and social status can attribute to psychological problems, including depression and poor self-esteem (OSUMC, 2013, para 1). Special considerations, such as hearing loss, poor

vision, memory loss, fatigue, multiple medications, and their side effects affect older adults' ability to communicate and to practice a high degree of HL (CDC, 2009). Treating older adults with respect, by training them to be competent in communicating their health needs, is logically related to how well they navigate health care systems, and how confident they are when learning new approaches to self-care that can keep them independent.

Functional Health Literacy is likely to impact how older adults navigate the health care system even when loss and other challenges exist in their lives. To address the negative consequences of limited HL on the health of older adults, researchers have begun to explore FHL skill-building including engagement in self-care and active negotiation of chronic care and health promotion systems (Baker et al., 2002; Cho, Lee, Arozullah, & Crittenden, 2008; Nielsen-Bohlman, Panzer, & Kindig, 2004). Logically, educational offerings with hands-on skills practice are predicted to improve FHL.

Functional Health Literacy Instruction

Functional Health Literacy education for the aged population requires practical instruction and immediate application (McCray, 2005; Speros, 2009; Woodson, Adams, Timm, & Jones, 2009). Such training is hypothesized to increase elders' skills and confidence regarding interactions with providers (Resnick, Luisi, & Vogel, 2008; Waldrop et al., 2001). For example, greater confidence in talking with health care professionals can increase the likelihood that health care instructions will be understood and followed, or alternatively, questioned, which might lead to a different way for the provider to educate. The FHL approach treats older adults with respect and potentially empowers them.

Theoretical Perspective for the Present Study

The Behavioral Model of Health Services Use is central to Social Work Health Care (Gehlert, 2006). The Agency for Health Care Research and Quality (AHRQ) notes that the model is integrated into HL research, including work with vulnerable populations (AHRQ, 2011). The Behavioral Model of Health Services Use provides the theoretical perspective for the present study. At its core, the model links predisposing factors (demographics, social structure, health beliefs) through enabling resources (personal/family, community) into need (perceived, evaluated) to affect health services use (Andersen, 1995).

Regarding the first predisposing factor, *demographics*, the rural older adults in our study are a group with accompanying characteristics which can predispose them to poor FHL. The second predisposing characteristic is *social structure*. In our study this relates to the historical patronization by health providers which older adults have experienced throughout their lifetime (Brown & Draper, 2003). The third predisposing characteristic is *health beliefs*, which applies to the older adult's possible doubt of their self-efficacy in health care. The study targeted the older adults' health beliefs with hope of increasing their self-efficacy. It also challenged patronization by experts through empowering older adults with knowledge and skills formerly reserved for medical providers. We hypothesized that predisposing characteristics might be changed.

The enabling resources outlined in Andersen's model were also represented in our study: a) in the provision of training; and b) training offered in congregate meal sites—a resource of

social support. The model projects that affecting predisposing characteristics and enabling resources might influence perception of need and subsequent health service use (service use measurement exceeded the scope of the present study). In a step toward measuring impact on need perception and service use, this study measured whether self-efficacy and FHL knowledge/skills were gained from hands-on education designed for vulnerable older adults. We tested whether predisposing characteristics and enabling resources might be influenced by FHL health promotion.

Measurement of self-efficacy was represented by communication for health: questions to ask providers (we used the *Ask Me Three* from National Patient Safety Foundation, 2015), self-report of confidence talking to providers, and potential for interaction with FHL communications found online. Other measurements related to FHL were tests of knowledge and skills regarding topic areas of interest to the rural older adults. These were represented by answering questions on health information and demonstrating self-care skills.

Example of FHL Training in Rural Congregate Meal Sites

Prior to study implementation, a pilot study was conducted at five centers to determine topical interest. All centers were provided training on communication with health care providers and online sources for FHL information. In the first year, all five centers received training on blood pressure. In year two, individual centers received the communications workshop supplemented by a topic selected by that center. The aims of the study are illustrated in the following examples of the hearing health and blood pressure workshops.

Older adults with hearing loss are shown to be at increased risk of accelerated declines in cognitive function (Lin, 2011; Lin et al., 2013). However, when hearing-impaired adults 65 and older used hearing aids for three months, they experienced significant improvements in quality of life, with an increase in cognitive function and a decrease in depressive symptoms (Acar, Yurekli, Babademez, Karabulut, & Karasen, 2011). Singer and Brownell (1984) reported that older adults were misinformed or lacked knowledge about hearing health. Therefore, we explored hearing health promotion for older adults to improve communication with health providers, thereby influencing FHL.

To implement hearing health promotion, the present study used a hands-on educational workshops and a short questionnaire—Hearing Handicap Inventory for the Elderly Screening Version (HHIE-S). The skill building educational workshop consisted of a short presentation about age-related hearing loss, then older adults were coached on how to interpret hearing test results, protect their hearing and prevent further hearing loss, and seek intervention for hearing loss. Hearing aid use and care were also demonstrated. Then, the short 10-item HHIE-S self-assessment questionnaire (Ventry & Weinstein, 1983) was given to participants for quick screening of how they perceive the social and emotional effects of hearing loss to assess and interpret their own hearing handicap (none vs. mild-moderate vs. significant hearing handicap). Knowledge and skills on hearing health and associated symptoms were pre- and posttested as part of the main knowledge/skills on health topics.

Workshops on blood pressure provided health promotion training. Patterson, Morzinski, Ertl, Wurm, Hayes, & Whittle (2011) explored the use of organizations such as rural congregate

meal sites to provide training about blood pressure to older veterans. They found positive associations between location of training and the willingness to participate and engage in the workshops. Our blood pressure training included information and illustration. Pre- and posttests of knowledge and skills were paper-based, but in the process of learning, the older adults demonstrated their ability to take their own blood pressure. In year one, in each of five workshops, communications and blood pressure topics were covered. In year two, each workshop included communications and a second topical workshop from a pilot assessment of that congregate site participants' interest (e.g., hearing health/depression, cancer prevention, advanced computer search methods, blood pressure).

Methods

Study Model and Hypotheses

Andersen's model outlined a pathway to increase appropriate service use through predisposing characteristics, enabling resources and perception of need (1995). In this study, the model was applied to a FHL program to rural older adults. Predisposing study characteristics included the rural residence of the population. Enabling resources included the workshop training. Study hypotheses were: 1) FHL training would influence self-efficacy health beliefs of rural older adults operationalized as communication survey items; and 2) workshops on FHL would influence health knowledge and skills operationalized as topical survey items.

The present study explored how local, experiential education might impact FHL of rural older adults. Also studied was how education on common health topics such as blood pressure, hearing health, exercise, depression, and cancer care might impact FHL knowledge and skills. This research was conducted as part of Senior Health University, a grant-funded interdisciplinary health promotion project serving rural older adults. The study was conducted in congregate meal sites which typically serve older adults living independently in their community. Computers used in training were donated to the centers and health information stations were set up in each one.

The five rural study communities were located in three rural counties as established by their population of less than 50,000 (OMB, 2003). Two of the three counties (Polk and Taney) are also federal Health Personnel Shortage Areas (HPSAs) due to critical shortages of primary care and mental health service personnel (HRSA, 2013). The HPSA designation indicates a need for trained health care providers, and suggests that health promotion education and referral services are important community needs.

The sample was comprised of older adults ($n = 98$) who volunteered to participate in the workshops and study following their noon meal at selected congregate meal sites located in southwest Missouri. The congregate meal sites are part of a network of Area Agency on Aging (AAA) sites managed by the Southwest Missouri Office on Aging, and are designed to encourage independent and healthy living by coordinating and providing an array of services to older adults (SWMOA, n.d.). Each center that participated is located in small communities with distinctive features that attract older adults for various reasons. Forsyth and Branson are located in Taney County, which in the heart of the Ozark Mountains.

Bolivar in Polk County is a farming community and county seat, while Ozark and Nixa in Christian County are rapidly growing bedroom communities near Springfield, which is the third largest city in Missouri (USOMB, 2003). Each is considered nonmetropolitan or rural given their population is less than 50,000 (USOMB, 2003). Two of the three counties (Polk and Taney) are also designated federal Health Personnel Shortage Areas (HPSAs) due to critical shortages of primary care and mental health service personnel (HRSA, 2013). The HPSA designation indicates a need for trained health care providers, and suggests that health promotion education and referral services are essential.

The Missouri State University Institutional Review Board approval was obtained and all participants completed informed consent procedures. Instrumentation included paper surveys comprised of questions drawn from the literature on health care communication and training on health topics. The survey was neither standardized nor pretested. We elected not to collect information about the specific diagnoses or health conditions of the older adults due to inability to provide privacy. The congregate meal sites were provided a computer, printed health information, as well as a cash incentive of \$400 for the sites to encourage participation and continued use of online resources. Printed resources were also gifted to the centers. Participating older adults received a ticket for a meal at the center.

Missouri State University students (nursing, social work, audiology, and public health) involved in data collection received brief training by video in communication with older adults and research procedures toward reliability and validity of testing. Trainers and supervised students provided health education, an introduction to an online HL course, and hands-on practice of self-care skills. Student volunteers assisted program leaders with FHL assessments. After consents were explained and signed, participants were given a folder with workshop materials including a pretest. Instruments used were multiple choice and fill-in along with a skill demonstration opportunity. Students assisted with informed consent and testing so that participants had little wait time. Pretests were collected prior to training.

Researchers were concerned about total time of participation given possible stamina concerns for the older adults. A 20-minute workshop was conducted including communication and hands-on practice skills with a health topic. Students studying social work, nursing, audiology or public health assisted with skills-building with individual older adults. After the workshop, the same student administered a posttest with a matching number to the pretest collected from the older adult's folder. The instrument used for pre- and posttests of knowledge and skills had Likert scaled questions. Posttest surveys were completed in the 15 minutes immediately after the workshop. Total time for older adult participants was one hour.

In the first year, follow-up surveys were conducted by phone using the self-efficacy items as the core message measured for retention. The attempt yielded extremely low participation, and introduced hearing barriers. We realized that the older adults had no relationship with the caller or context for a follow-up occurring at 3 months after the training, so in year two the follow up-surveys were administered in person at the congregate meal sites by program leaders one month after each workshop. Follow-up surveys were collected from all congregate meal sites.

The survey measured knowledge, skills, and self-efficacy. Knowledge and skills were operationalized by items regarding specific health topics of interest to the rural older adults. Self-

efficacy was measured through communication questions such as, “How confident are you in talking to health providers?”; and “How likely are you to use the Internet for reliable health information?” Survey items are listed in Tables 1 and 2. Data were collected immediately before and after training, and then in year two some participants were contacted for a follow-up survey one month after the workshop.

For data analysis all items were transformed into a 0 – 4 point scale as follows. Survey items such as “very unlikely” were coded as 0; “unlikely” was coded as 1; “neutral” as 2; “likely” as 3 and “very likely” as 4. Items that required listing or demonstration were rated by researchers independently; ratings were compared and translated to a Likert scale of 0 - 4. The distribution of scores was tested for normality. Items measuring self-efficacy were analyzed with paired *t*-tests using the pre and post scores of individuals. Items from knowledge/skills on health topics were analyzed with paired *t*-tests using the pre/post scores. Analysis of year two follow-up of self-efficacy items utilized paired *t*-tests of posttest scores and follow-up scores.

Results

Rural participants were attendees of congregate meal sites who were aged 60 and older, the same definition used by congregate meal sites (Southwest Missouri Office on Aging, 2015). Ninety-eight surveys were suitable for use in data analysis. The communication workshop was presented at all trainings in both years. The blood pressure workshop was presented at each site in year one. Thus, the reader will note a larger number of responses for those items. A total of 27 follow-up surveys were collected.

As Table 1 shows, 25% were age 80 and older. Women comprised 63% of the sample. Participants were primarily married (54%) or widowed (21%), and almost exclusively Caucasian (66%). Of the 98 research participants, 6% had less than a high school education; 37% finished high school or their GED, and 43% completed education past high school. In addition, study participants were on average 75 years of age.

Table 2 reports the paired *t* tests of items that were associated with Self-efficacy operationalized as Communication items. Items of particular interest to this report were: (a) questions to ask health providers; (b) confidence in talking with providers; (c) recognition of reliable web sites; and (d) use of computers for health information. All items showed significant gains in communication self-efficacy between pre/post educational workshops. Table 3 reports significant gains regarding specific health topics and FHL abilities. And Table 4 reports the measures of self-efficacy when evaluated one month after the workshops in year two.

Table 1

Demographic Information

	n	Valid percent
Age		
60-64	15	15.3
65-69	21	21.4
70-74	14	14.3
75-79	14	14.3
80-84	23	23.5
85 or Above	2	2.0
<u>No Response</u>	<u>9</u>	<u>9.2</u>
Total	98	100.0
Ethnicity		
Caucasian or White	66	67.3
American Indian	1	1.0
<u>No Response</u>	<u>31</u>	<u>31.6</u>
Total	98	100.0
Gender		
Female	62	63.3
Male	31	31.6
<u>No Response</u>	<u>5</u>	<u>5.1</u>
Total	98	100.0
Marital Status		
Single	9	9.2
Married	53	54.1
Divorced	3	3.1
Widowed	21	21.4
<u>No Response</u>	<u>12</u>	<u>12.2</u>
Total	98	100.0
Education in years		
0-8	2	2.0
9-11	4	4.1
12 or GED	37	37.8
>12	43	43.9
<u>No Response</u>	<u>12</u>	<u>12.2</u>
Total	98	100.0

Table 2

Self-efficacy Pre and Post Communication Training Year 1 and 2 Total

	n	Paired <i>t</i> -test	<i>p</i> -value
What is Medline Plus?	74	6.476	.000
What are the three questions (Ask Me 3) to ask your health provider?	98	11.872	.000
Confidence talking to health providers	98	3.68	.483
Do you feel it is important to use the internet to research health and medical questions?	25	1.445	.000
Is there a computer with internet access available for use at this senior center	74	4.308	.000

Table 3

Knowledge/Skills Health Topics Pre and Post Training Year 1 and 2 Total

Knowledge/ Skills Question	n	Paired <i>t</i> -test	<i>p</i> -value
The root of a medical word is often a body part.	98	5.45	.000
Matching prefix to medical word	98	5.74	.000
What is systolic number of blood pressure?	97	5.17	.000
Grains and blood pressure	97	6.56	.000
Hearing loss can be related to depression.	15	3.05	.009
Depression is a change in the brain, not just a feeling or mood.	12	1.91	.082
Can you list some possible causes of depression that may not be commonly known?	12	2.96	.013
Can you list an activity(ies) that might be a way to help yourself stay mentally fit?	12	3.63	.004
What are some things to do before taking a blood pressure?	98	7.73	.000
What are some things to know about placing the cuff?	98	7.38	.000
All blood pressure medicine works the same.	98	2.71	.007

Table 4

Communication Self-Efficacy Post Training and One Month Follow-up Year Two

Question	n	Paired <i>t</i> -test	<i>p</i> -value
Medline Plus	27	0.000	1.000
Ask Me 3	26	-3.430	.002
Confident talking to your health provider	24	0.113	.911
Likelihood of using computer to look up health information	26	0.531	.000
Availability of a computer with internet access for use at senior center	25	0.569	.000

Discussion

Andersen's model outlined a pathway to increase appropriate health service use through predisposing characteristics, enabling resources, and perception of need (1995). In this study, the model was applied to a FHL program that provided hands-on health promotion training to rural older adults. We tested whether FHL training (enabling resource) could influence self-efficacy health beliefs (predisposing factor) of rural older adults. Findings in Table 2 support this first hypothesis as self-efficacy increased significantly between pre- and posttests. Retention of self-efficacy is supported by measures at the one month follow-up anniversary. The results suggest that predisposing characteristics and enabling resources may be influenced.

In a step toward measuring impact on need perception and ultimate service use, we tested whether FHL knowledge/skills were gained from hands-on education designed for vulnerable older adults. Significant gains were found. Measures used were sensitive enough to detect changes after one session, and it may be fruitful to further refine and standardize them. The method of assessing the interests of the older adults and providing short experiential training combined with the recruitment at congregate meal sites may be a successful implementation model.

Perhaps an increase in self-efficacy can empower rural older adults to overcome barriers to service use. A historic passive role for patients might be challenged by these rural older adults (Wolff, Clayman, Rabins, Cook & Roter, 2015). Measureable increases in self-efficacy suggest that rural older adults can be coached to make the most of provider contacts even when the contacts may be few and brief, and to develop an interest in online sources of health information. These skills may be vital in our dynamic self-care era for health care.

Only one significant change in self-efficacy (negative) was detected at the one month follow-up which indicates retention of most material. In year two, a loss of ability to recall the *Ask Me Three* questions must be noted. The researchers used the more arcane term *diagnosis* found in early *Ask Me Three*, rather than the currently suggested term *main problem* ("What is

my main problem?”), which may have increased intimidation of older adults to ask this question. Perhaps this part of the communication workshop was not as strong as other segments. Additionally, more practice may be required to travel the pathway from self-efficacy to fully empowered service use.

Findings in Table 2 support the hypothesis that FHL is malleable since knowledge and skills regarding specific health topics significantly increased. In each topical area the rural older adults learned and demonstrated health promotion knowledge and skills. The implementation and research methods may be instructive to conducting and measuring outcomes for health promotion training with rural older adults who attend congregate meal sites. As a natural enabling resource, the rural congregate meal sites may effectively offer FHL training. The Senior Health University project study demonstrated that rural older adults in this sample were interested in the FHL training and demonstrated significant post-workshop FHL gains. The program design elements likely related to success included the involvement of older adult participants in the selection of workshop topics. The project was designed to be non-intrusive on senior center staff time with financial incentives provided for staff involvement. The brief workshops and their timing (e.g., after lunch on popular meal days) appeared to improve older adult participation. Finally, student volunteers may have improved research participation because students interacted well with the older adults and encouraged survey completion.

Study limitations must also be noted, however. The design did not control for selection bias or utilize a control group. We did not compare rural and urban older adults. Participants self-selected and may have had a greater interest in FHL than non-participants. Some participants in year one may have been in year two workshops as well; however, research method and data analysis with paired *t*-tests is a stronger design than aggregated group testing. Student assistance with testing likely influenced to some degree outcomes in the positive direction. In the original FHL training plan we wanted to measure skill via their demonstration, but in practice we relied more on paper survey instruments because of time constraints.

Next Steps in Research

The perception of need variable, while not represented in this study, would be the outcome variable of an explanatory study in the future. The next steps measuring perceived need and service use will perhaps best be undertaken in circumstances where HIPAA concerns are not paramount as they were in this public setting. For example, in a health system with electronic medical records, data on training, service use, and health outcomes could be tracked after FHL training by a primary care service.

It would be important as a further step in the research to see whether participants follow through with health services and treatment once they recognized a need for such treatment. A combination of bringing the training to the older adults and accessing personal medical information regarding use might also be accomplished, for example, if online sources of FHL were linked to provider websites where use might be monitored. With technological advances, perhaps participants could demonstrate skills in research projects by virtual recognition through online health monitoring. Alternatively, the relationships established in rural congregate meal sites between older adults and staff might lend themselves to appropriate discussion, within consented boundaries, of perceived need and use of services.

Another implication for future FHL research is to further clarify and operationalize FHL skills measurement. Standardization and use of study tools and use of tools specific to hands-on skills will make it possible to test the strength of various approaches to training. Consequently, delivery of health promotion tailored to rural populations could be evaluated. We believe a direct measurement of demonstrated skills will be the best approach. It has been suggested that existing standardized tools have limited utility in some situations (Osborn et al., 2007). For example, we considered use of a standard HL measure and then realized it measured gross changes in health language abilities and was very unlikely to be sensitive to the changes we were exploring after a 20 minute training session. We accept the value of standardized tools and wonder whether a combination might be most desirable. Development of standardized FHL measurement based on skill demonstration would be ideal. With standardized tools, contrasts between urban and rural settings could be explored.

The older adults in the study represent a varied group in terms of rural location, from retirement, tourist, and farming communities. These were in large part independent older adults with mobility and the resources to attend community events, and 49% reported education past high school. Groups not captured in the current study were homebound older adults and those with minority statuses. A next step in research would be to attract more diversity. If written materials and videos in appropriate languages were distributed to homebound older adults, minority older adults, and others in their homes, FHL training would be more accessible.

Offering the workshops in a variety of locations would also increase participation and diversity. Congregate meal sites can be stigmatized and viewed by some as a place for low-income meals and where “less independent” older adults visit. Expanding educational settings to private homes, conference centers, places of worship, extension centers, and out-patient clinics would offer more venues. As computer use by rural older adults increases, many venues could become health information stations and research opportunities.

References

- Acar, B., Yurekli, M. F., Babademez, M. A., Karabulut, H., & Karasen, R. M. (2011). Effects of hearing aids on cognitive functions and depressive signs in elderly people. *Archives of Gerontology and Geriatrics*, 52(3), 250-252.
- American Medical Association. (2014). *Health literacy*. Retrieved from <http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program.page>
- Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36(1), 1-10.
- Averill, J. B. (2005). Studies of rural elderly individuals: Merging critical ethnography with community-based action research. *Journal of Gerontological Nursing*, 31(12), 11-18.
- Baker, D. W., & Gazmararian, J. A. (2000). The association between age and health literacy among elderly persons. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 55B(6), S368-S374.

- Baker, D. W., Gazmararian, J. A., Williams, M. V., Scott, T., Parker, R. M., Green, D. ... Peel, J. (2002). Functional health literacy and the risk of hospital admission among Medicare managed care enrollees. *American Journal of Public Health, 92*(8), 1278-1283.
- Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low health literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine, 155*(2), 97-107.
- Brown, A., & Draper, P. (2003). Accommodative speech and terms of endearment: Elements of a language mode often experienced by older adults. *Journal of Advanced Nursing, 41*(1), 15-21.
- Cho, Y. I., Lee, S. -Y., Arozullah, A. M., & Crittenden, K. S. (2008). Effects of health literacy on health status and health service utilization amongst the elderly. *Social Science and Medicine, 66*(8), 1809-1816.
- Gehlert, S. (2006). Theories of health behavior. In S. Gehlert & T. A. Browne (Eds.), *Handbook of health social work* (pp. 179-193). Hoboken, NJ: John Wiley & Sons.
- Hutchison, L., Hawes, C., & Williams, L. (2004). Access to quality health services in rural areas – long-term care: a literature review. In L. D. Gamm, & L L. Hutchison, (Eds.), *Rural healthy people 2010: A companion document to healthy people 2010. Volume 3*. College Station, Texas: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center. Retrieved from www.srph.tamushsc.edu/rhp2010
- Kutner, M., Greenburg, E., Jin, Y., & Paulson, C. (2006). *The health literacy of America's adults: Results from the 2003 national assessment of adult literacy*. U.S. Department of Education, Institute for Education Sciences, National Center for Education Statistics. Retrieved from <http://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/health-literacy-america%E2%80%99s-adults-results-2003-national>
- Lin, F. R. (2011). Hearing loss and cognition among older adults in the United States. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences, 66*(10), 1131-1136.
- Lin, F. R., Yaffe, K., Xia, J., Xue, Q. -L., Harris, T. B., Purchase-Helzner, E. ... Simonsick, E. M. (2013). Hearing loss and cognitive decline in older adults. *Journal of American Medical Association Internal Medicine, 173*(4), 293-299.
- McCray, A. T. (2005). Promoting health literacy. *Journal American Medical Informatics Association, 12*(2), 152-163.
- National Patient Safety Foundation. (2015). *Ask me three*. Retrieved from <http://www.npsf.org/?page=askme3>
- National Rural Health Association. (2015). *What's different about rural health care?* Retrieved from: <http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care>

- Neilsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). *Health literacy: A prescription to end confusion*. Washington, DC: National Academies Press.
- Ohio State University Medical Center (OSUMC). (2013). *Older adults and depression*. Retrieved from <https://patienteducation.osumc.edu/Pages/search.aspx?k=older+adults>
- Osborn, C. Y., Weiss, B. D., Davis, T. C., Skripkauskas, S., Rodrigue, C., Bass, P. F., & Wolf, M. S. (2007). Measuring adult literacy in health care: Performance of the newest vital sign. *American Journal of Health Behavior*, 31(S1), S36-S46.
- Patterson, L., Morzinski, J., Ertl, K., Wurm, C., Hayes, A., & Whittle, J. (2011). Engaging community-based veterans' organizations in health promotion programs. *Family & Community Health: The Journal of Health Promotion & Maintenance*, 34(4), 311-318.
- Resnick, B., Luisi, D., & Vogel, A. (2008). Testing the senior exercise self-efficacy project (SESEP) for use with urban dwelling minority older adults. *Public Health Nursing*, 25(3), 221-234.
- Rural Assistance Center (RAC). (2012). *Rural aging*. Retrieved from <http://www.raconline.org/topics/aging>
- Schwartzberg, J. G., VanGeest, J. B., & Wang, C. C. (Eds.). (2005). *Understanding health literacy: implications for medicine and public health*. Chicago, IL: American Medical Association.
- Singer, J. M., & Brownell, W. W. (1984). Assessment of hearing health knowledge. *The Gerontologist*, 24(2), 160-166.
- Southwest Missouri Office on Aging (SWMOA). (n.d.). *Who we are*. Retrieved from http://swmoa.com/?page_id=30
- Speros, C. I. (2009). More than words: Promoting health literacy in older adults. *The Online Journal of Issues in Nursing*, 14(3). Retrieved from <http://www.nursingworld.org/>
- U.S. Centers for Disease Control and Prevention (CDC). (2009). *Improving health literacy for older adults: Expert panel report 2009*. Atlanta: U.S. Department of Health and Human Services.
- U.S. Census Bureau. (n.d.b). *2010 Census urban and rural classification and urban area criteria*. Retrieved from <https://www.census.gov/geo/reference/ua/urban-rural-2010.html>
- U.S. Department of Commerce, Economics and Statistical Administration, U.S. Census Bureau (2010). *The next four decades: The older population in the United States: 2010-2050*. Retrieved from http://www.aoa.acl.gov/Aging_Statistics/future_growth/DOCS/p25-1138.pdf
- U.S. Department of Health & Human Services, Agency for Health Care Research and Quality (AHRQ). (2011). Executive summary. *Health literacy interventions and outcomes: An updated systematic review* (Report No. 199). Retrieved from <http://archive.ahrq.gov/research/findings/evidence-based-reports/litupsum.html>

- U.S. Department of Health & Human Services, Health Resources and Services Administration (HRSA). (2013). *Health professional shortage areas*. Retrieved <http://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx>
- U.S. Office of Management and Budget (OMB). (2003). *Metropolitan statistical areas, micropolitan statistical areas, combined statistical areas, New England city and town areas, combined New England city and town areas* (OMB Bulletin No. 03-04, Attachment). Retrieved from www.whitehouse.gov/sites/default/files/omb/bulletins/b03-04_attach.pdf
- Ventry, I. M., & Weinstein, B. E. (1983). Identification of elderly people with hearing problems. *American Speech-Language-Hearing Association*, 25(7), 37-42.
- Vincent, G. K., & Velkoff, V. A. (2010). *The next four decades: The older population in the United States: 2010 – 2050*.
- Waldrop, D., Lightsey, O. R. Jr., Ethington, C. A., Woemmel, C. A., & Coke, A. L. (2001). Self-efficacy, optimism, health competence, and recovery from orthopedic surgery. *Journal of Counseling Psychology*, 48(2), 233-238.
- Wolf, M. S., Gazmararian, J. A., & Baker, D. W. (2005). Health literacy and functional health status among older adults. *Archives of Internal Medicine*, 165(17), 1946-1952.
- Wolff, J. L., Clayman, M. L., Rabins, P., Cook M. -A. & Roter, D. L. (2012). An exploration of patient and family engagement in routine primary care visits. *Health Expectations*, 18(2), 188-198. doi:10.1111/hex.12019
- Woodson, D., Adams, M. K., Timm, D. F., & Jones, D. (2009). Online resources for teaching seniors to find health information on the internet: From basic computer skills to consumer health. *Journal of Hospital Librarianship*, 9(4), 391-398.
- Young, D., Weinert, C., & Spring, A. (2012). Home on the range—Health literacy, rural elderly, well-being. *Journal of Extension*, 50(3), Article Number 3FEA2.
- Zamora, H., & Clingerman, E. M. (2011). Health literacy among older adults: A systematic literature review. *Journal of Gerontological Nursing*, 37(10), 41-51.

Qualitative Experiences of Rural Postpartum Women and Implications for Rural Social Work

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Abstract. Geographic barriers and shortages of healthcare professionals in rural America have been well documented. These barriers and shortages influence rural women's access to maternity and associated healthcare services during pregnancy and mothers' postpartum period, but their perspectives about these realities have been overlooked. Semi-structured interviews with 24 mothers residing in a rural North Dakota county were conducted to understand their perspectives about both accessing healthcare services and parenting children in a rural context, with emphasis on understanding these mothers' experiences using non-rural maternity care. Thematic analysis of qualitative interview data led to the emergence of three core themes. First, mothers in the sample minimized geographic barriers they had to overcome to access healthcare despite describing significant travel and weather challenges. Second, mothers expressed concern over the lack of affordable and flexible childcare in their rural community. Finally, mothers described different experiences within rural and non-rural settings, noting specific advantages and disadvantages of each. Although our findings cannot be generalized to other rural mothers, local qualitative inquiry can inform and improve the competency of social work services within rural communities.

Keywords: rural, women's health, maternity care, healthcare access, childcare

With nearly all (99.1%) U.S. births occurring in hospitals, hospital-based maternity care is crucial to pregnant women; yet rural women often have limited access to maternity care (Martin et al., 2010; Xu et al., 2009). Rural counties continue to experience steep declines in the availability of hospital-based maternity services. While maternity services were available in 76% of rural counties in 1985, by 2002, only 56% of rural counties maintained these services. In remote rural communities, this trend has been even more pronounced. In 1985, hospital-based maternity care was available in 50% of remote counties; but by 2002, only about 20% of remote counties had hospitals offering maternity care (Zhao, 2007).

As a consequence, rural women face fewer choices in terms of their health needs. Almost half of all U.S. counties had no practicing obstetrician-gynecologists in 2005; and after accounting for population in rural communities, non-metropolitan counties had far fewer obstetrician-gynecologists than metropolitan counties (1.4 vs. 3.3 per 10,000 women) (DHHS, 2007). Family physicians who provide maternity care have also become increasingly rare. In 2000, 23.3% of family physicians provided maternity care; whereas by 2010, this percentage had

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declined to only 9.7% (Tong et al., 2013). Given that many rural maternity services are provided by family physicians, rural women are particularly influenced by this trend.

While social workers may not address the immediate medical needs of pregnant women, rural social workers certainly address many of the psychosocial needs of women during their pregnancies and as new mothers. The generalist social work model is widely used in rural settings, in large part due to the various types of social services a social worker must interact and utilize within in a small community (Riebshleger, 2007). These social services can include: the child welfare system, financial assistance, nutritional counseling, subsidized housing, domestic violence resources, substance abuse, and mental health services.

Yet, there are also shortages of social workers who serve rural areas. Over half of rural counties have no clinical social workers (Gamm, Stone, & Pittman, 2003), and 80% of MSW-level social workers practice exclusively in metropolitan areas (Gale & Lambert, 2006). Due to the comprehensive nature of issues in some rural communities, social work shortages are consequential for rural women's health because of the various supports that social workers can provide.

Besides professional shortages, rural women face barriers simply because of the geographic distance to various healthcare and social service providers in more populated communities. For example, Fordyce, Chen, Doescher, and Hart (2007) found that nearly 40% of all rural residents lived in a community over 60 minutes from an urban area. In many U.S. states, rural residents are a large proportion of the total state population. For example, in an analysis of all 2008 public birth records by Gjesfjeld and Jung (2011), 17.4% of all North Dakota mothers gave birth at a hospital over 40 miles from their county of residence.

Despite professional shortages and geographic barriers, the social work profession continues to work alongside rural women as they navigate their pregnancies and the experience of being a new mother. Given the high rates of poverty in many rural places, rural women may interact with multiple rural social service systems, including the supplemental nutrition for Women, Infant, and Children (WIC) program, financial assistance programs such as Temporary Assistance for Needy Families (TANF) program, housing subsidy programs, as well as the child welfare system. Therefore, given that rural social workers are likely to be on the front-line of providing direct services to rural mothers, there is a need for greater awareness of the rural realities and experiences of rural mothers.

Qualitative Inquiry: Moving Toward Cultural Competency in Rural Social Work

Besides a few examples of international research on the health needs of rural women, particularly from Canada (Cummins, 2005; Kornelsen & Grzybowski, 2006; Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; Leipert & George, 2008), there is limited U.S.-based research on the experiences and needs of rural women seeking healthcare in general, or more specifically, maternity care. This gap in the literature is particularly concerning because of the importance of culturally competent practice in the field of social work. Daley and Pierce (2011) note that culturally competent social work demands an understanding of the worldview of rural people. With a specific focus on the education of social workers, they write:

Students require the development of cultural competence in their educational preparation to recognize and respond appropriately to the needs of clients and communities. The development of this competence should be an important priority, especially in programs that have rural communities as an important part of their service area. (p. 131)

Further, many models of intervention were developed in urban contexts, and therefore are embedded with assumptions that may or may not reflect the rural experience. As Weinert and Long (1987) assert:

Professionals cannot successfully superimpose models based on urban experiences or professional traditions when dealing with rural populations. The environmental realities of rural living, including distances and work demands, as well as the worldview and values of rural people, must be carefully assessed. The unique aspects of each rural population must be included in any equation which is to yield a relevant, effective human service program for them. (p. 454)

Rural research can unlock greater understanding for rural social work but can also inform urban providers who increasingly work with rural residents. Without greater awareness of rural experiences, we are apt to rely on stereotypes of rural women that are inaccurate. As Kenkel (2003) writes, “by identifying concepts important to different cultural groups and to the *silenced* rural women, culturally sensitive prevention and treatment services can be designed” (p. 189).

Purpose of the Study

Rural research has documented objective barriers rural residents face when seeking healthcare services, such as distance to care, provider shortages, as well as the lack of resources and services; however, we were interested in mothers’ subjective perceptions about these barriers in their community. Thus, the purpose of this study was to qualitatively assess the experiences of 24 rural mothers as they sought healthcare associated with their pregnancy, with emphasis on how these rural women perceived geographic barriers to care. We were also interested in rural women’s perceptions of their community as they began parenting their new child.

Method

Our research was approved by the University of North Dakota Institutional Review Board. With a philosophical stance of pragmatism, we sought to consider the potential connections between these mothers’ experiences and “the outcomes of the research—the actions, situations, and consequences of inquiry” (Creswell, 2006, p. 22). Our research questions were formed with the assumption that women’s responses could be used to improve the services provided to them both within and outside their community. Ultimately, we saw our inquiry as a method for hearing the voices of rural mothers and improving the cultural competency of rural social work practice directed at these mothers.

Despite a clear focus that our conversations with mothers could improve understanding of a rural worldview, our research was also consistent with the aims of phenomenological inquiry. We sought (a) meanings behind human experiences, (b) made efforts not to predict or determine causality, and (c) described experiences rather than using measurements or ratings (Moustakas,

1994). Mothers in our sample had the shared experience of living in a rural community and travelling outside their community to birth their child.

While interviews maintained flexibility to allow for new themes to emerge from the interviews, we did create common interview probes that could provide us some “windows” into their worldviews. All interviews included the following interview questions:

- Tell me about getting to the hospital. What would have been your ideal experience? Did it go how you thought?
- What is the best part of being a mother here? What is the most challenging? What does it mean to you to be a mother?

Sample

Our research reports findings from semi-structured qualitative interviews conducted in November and December of 2010 with twenty-four “new” mothers from a rural county in North Dakota. (All mothers had an infant less than 18 months of age). These women were recruited through one WIC office. This office was within a city that had a population of roughly 4,000 individuals. WIC provides nutrition education and food vouchers to low-income women who are pregnant, postpartum, or breastfeeding, as well as infants and children up to age 5. Due to the eligibility requirements for WIC, all mothers interviewed had family incomes that did not exceed 185% of the federal poverty line.

Participating mothers ranged in age from 18-32 years, with an average age of 24 years. Approximately 70% of the mothers identified as White (N = 17), while one-quarter (N = 6) identified as Mexican-American. One mother (4%) identified as Native American. Fifteen (63%) of the mothers were married, and nine (38%) were single. More than half of the mothers (54%) indicated that they worked outside the home, either part-time or full-time (N = 13), and 38% (N = 9) described themselves as “stay-at-home moms.” Two mothers (8%) were students. All of these mothers described travelling an average of 50 miles, one-way, for delivery services for their babies. Many of these mothers also reported making frequent trips over their third trimester for prenatal visits.

Analysis

Interviews were digitally recorded with participants’ permission and transcribed verbatim. A female research assistant in the Master of Social Work graduate program conducted the interviews. This student and the lead investigator met regularly throughout the study to ensure comparable question probes were being utilized over the course of the interviews while also incorporating new information and understandings into subsequent interviews. As compensation for their time participating in the study, a \$25 gift card from a local grocery store was provided.

Thematic analysis was utilized to identify core ideas and unified impressions that emerged from the interviews. First, we began with line-by-line coding from the complete transcripts, an open-coding strategy that focuses on the specific aspects of the data by using participants’ own language and meanings (Strauss & Corbin, 1990). We then grouped codes into

larger thematic categories, or axial codes, representing common themes that emerged from the interviews. Both the principal investigator and research assistant independently reviewed these axial codes and collapsed them into core categories representing the most variation in mothers' perceptions and behavior. We engaged in ongoing dialogue over multiple months to produce a comprehensive inventory of ideas, expressions, terms, and phrases that accurately reflected these thematic categories. We also used quantifying techniques (e.g., tables) to confirm that we had reached consensus among our broad thematic categories.

Results

The thematic categories that best reflected interviews included (a) minimization of geographic barriers to care, (b) challenge of obtaining rural childcare, and (c) cost and benefit of rural parenting.

Minimizing Geographic Barriers to Healthcare: "It's Not That Bad"

Mothers psychologically minimized geographic barriers to maternity services regularly. Although women traveled an average of nearly two hours round-trip for prenatal and delivery services, they matter-of-factly described how they coped with the distance between them and their healthcare. The majority of women conceptualized maternity-related healthcare as merely one more resource not found in their specific community, akin to a large grocery store or large commercial retail store. When asked directly about the travel associated with attending prenatal appointments or the travel experienced on the day of the delivery, mothers described this as simply a rural reality. As one woman shared, "It would be nice that I would not have to drive, but that is an ideal world. But that's not going to happen, haha!" Another woman similarly noted, "I wish it was closer, but it was OK." Some women acknowledged that travelling for prenatal appointments meant they would be missing employment, yet also seemed to minimize the impact this had on their personal economic situation. For example, one mother noted, "I don't want to say it was stress. I think it was just more of a hassle from work."

Although mothers minimized the stress associated with their travel to healthcare, they admitted that travel was more complicated when their scheduled delivery was during winter. One mother simply noted it was "really, really stressful, because you run the risk of flipping over or going into the ditch." For another mother, the winter weather proved more difficult because of unreliable transportation. She shared:

It was very overwhelming and hard because it was around wintertime. It was already snowing, and the roads were all ugly. . . We actually got stranded there [while in labor]. I have a Trail Blazer and it actually wouldn't go past 45 I believe. For some odd reason, it kept turning off. It was dark. I was freaking out. I was like 'hello, we have to get out of here.'

For another mother, it appeared a health care provider had inquired about her travel to the hospital, but ultimately, she coped with the realities of winter without hospital assistance. She explained:

All my babies were winter babies so I usually got asked about the weather and how was the drive. . . . She was due [when] there was a snowstorm and we were stuck at home. Luckily she [my baby] was late.

Although respondents seemed to minimize the personal impact of travel on their healthcare, a number of conditions were required for rural mothers to use maternity care outside of their community: reliable transportation, financial resources for gasoline, and the time to make the trip. In some situations, women did not have these resources. As one woman noted, “We had vehicles breaking down and then we didn’t have a ride and sometimes we didn’t have money to go [to prenatal visits].”

Mothers and the Challenge of Rural Childcare

While we did not begin our research considering rural childcare, the challenge of rural childcare quickly emerged in our early interviews, with a particular focus on financial burden and scheduling difficulties. For example, one woman shared, “For having three kids in daycare it was gonna cost us, like, 1200 dollars a month and I just was like ‘oh, heaven’s no.’” The high cost of care also influenced decisions about employment, as exemplified by a woman who explained, “Anything that pretty much that I could get would not pay enough to pay for daycare for all the kids so it was just kind of a . . . not worth it to work at that point.”

Women who were interested in working shortly after their delivery described having to make difficult decisions about the care of both their newborn and the care of other children because of the structure of rural childcare. One woman described the struggle she faced when she was unable to find a childcare provider who could accommodate her work schedule. For this woman, leaving employment was a significant personal sacrifice.

I was working, you know, full-time. I loved my job. I worked for a farmer. Drove truck for him and stuff. . . . She [childcare provider] said she could be booked for up to 3 years. So my problem is I don’t have a daycare. So I had to quit my job and stay home.

For another woman, she found it difficult to find care for her newborn. She stated, “All the daycares are full or they don’t accept babies or children who aren’t potty-trained. I work overnights so that makes it even harder ‘cause there’s absolutely no daycare for overnights.”

It was clear that when mothers could not find daycare and did not have help from family or friends, they saw some part of their life would be compromised. This was demonstrated by one mother as she considered graduation. “They [the school] worked with me and they all tried to get me to graduate, but when he was born I did not have daycare and my mom could not stay home with him from work.” While some women described having to quit their jobs or school due to childcare issues, some described working with their partners to share childcare responsibilities while they both attempted to work. One woman said:

I don’t know, I just don’t really have a childcare. Between him and me, we try to work something out. Basically like we try to work it to where I don’t have to worry about babysitters for a long amount of time or whatever. I usually find a

way so that we don't have to put them in daycare. It's expensive anyway, very expensive.

Parenting in Rural Communities: A Mixed Picture

Respondents were asked about perceived benefits and challenges of parenting within a rural community. Mothers frequently described their connections with others and the feeling of safety as the biggest benefits of parenting in a rural community. One woman explained, "You know who your children are playing with and where they are. . . . My oldest daughter has a friend who lives right across the street so I just watch her from my window when she is going to play so that is really handy." In addition to knowing their neighbors, these mothers identified safety as a benefit of parenting in their community. One mother shared, "The town is very peaceful. I am not afraid of like leaving my door unlocked when I forget. I don't feel like somebody going to come in and like rob our house or whatever."

Conversely, these women identified the lack of resources and activities for themselves and their children as a concern in their community. One mother said, "There is not much we do around here. . . . It is a problem." Many women echoed this sentiment, suggesting their community needed more activities for kids. For example, given the cold climate and long winters, a number of mothers described the need for affordable options for indoor play. One woman simply said, "just anything indoors". Another mother suggested the need for an "indoor play area . . . but something that was affordable for moms on a one-family income". A number of women independently voiced this idea of an indoor play structure, referencing a type of playground located at a regional mall located 40 miles away from their community. One mother mentioned that their community previously had a bowling alley and video arcade that provided some community entertainment for children.

These impressions about their community also led to discussions of rural mothers' perceptions of, and contrasts between, rural and non-rural healthcare services. Mothers viewed the non-rural hospital as having more resources, such as advanced technologies and specialists. One woman, impressed at the choices and professionals available to her, shared these impressions about her postpartum time in the hospital, "I kind of liked the bigger hospital system where they do not really know you . . . all the different people had come in, you know, describing the diets. I had somebody come in and talk to me about the lactation and everything as he was having troubles latching on."

Alternatively, some mothers commented on the more personal touch and slower pace of rural hospitals. One mother explained, "They were friendlier here [local] than over there [non-rural delivery hospital]. Over there was most like rush, rush, rush, rush and I did not like that." In the larger, non-rural hospital, some of the women felt anonymous when trying to navigate care. One woman who experienced depressive symptoms after her delivery, described challenges and barriers she faced when attempting to engage with the larger hospital:

When we tried reaching out to them [delivery hospital], they were always busy or they were always booked. Like if it was not an emergency they booked you out a month from when I called. I was like, 'what am I going to do that whole month?' . . . I am going to go crazy so I never really went back to the [hospital].

Discussion

In sum, our sample of rural mothers (a) minimized geographic barriers to maternity care; (b) experienced difficulty obtaining rural childcare; and (c) saw differences between rural and non-rural healthcare and community environments.

We found rural women's minimization of geographic barriers to healthcare unexpected. Instead of frustration or anger about the travel burden to maternity care, mothers clearly placed the responsibilities of obtaining healthcare services squarely upon themselves. In fact, mothers perceived geographic distance from resources as a basic reality of living in a rural place. While the origin of this worldview was not obvious, one plausible explanation is that rural residents are acutely aware of the lack of resources available to them and adjust their expectations accordingly. Given the lack of large grocery stores and few entertainment options, these rural mothers may perceive the lack of local maternity services as consistent with the lack of other desired resources.

Another interpretation of this minimization is the "flip-side" of psychological resiliency. In the face of geographic distance to healthcare that women could not control, a stance of minimization could help these women cope with the barriers experienced with healthcare. However, it is not clear from our research the personal consequence of this coping strategy. Leipert (2006), for example, in her work with rural Canadian women, found that some rural women coped so positively with the lack of healthcare access that problem-solving about health issues tended to be overlooked. This theme requires further study because such a stance would seem to complicate efforts made by social workers to advocate for the healthcare needs, and perhaps social service needs, of rural mothers and children.

Our results also suggest that childcare issues present a substantial challenge for many rural mothers. Many women expressed how the cost of childcare impacted their decision not to work outside the home. When mothers considered working after giving birth, they often commented on low-wage jobs available to them compared with the high cost of childcare. Some mothers ultimately decided that it was more cost effective to stay home with their children. Mothers also expressed concern that many childcare providers were only open during traditional hours daytime hours that did not accommodate employment requiring early morning, evening, or weekend hours. Given the agricultural-based economy of rural areas as well as the general growth of the service sector, availability of affordable childcare in rural areas is a critical issue. This theme is consistent with rural research conducted in a northern Michigan community. Ames, Brosi, and Damiano-Teixeira (2006) documented a lack of childcare provided outside traditional daytime working hours. They speculated that childcare might be less available because rural providers are often caring for their own families during these non-traditional times.

Finally, our findings demonstrate that rural women viewed their community as having important benefits to parenting, including safety and sense of community. Many of the mothers discussed feeling safe in their community and found comfort in the idea that those in their community knew one another and cared about each other. Yet, women admitted lacking desired services and resources for themselves and their families. There was awareness that rural living meant relinquishing various health and recreational opportunities for them and their families.

From access to prenatal classes to indoor activities for their children, they were aware that these opportunities were unavailable.

While rural women appreciated the substantial resources available in urban hospitals, they also described having a more impersonal experience. Some women felt that the non-rural care reflected the faster pace of the urban environment, while their local, rural healthcare providers were friendlier and took more time with them as patients or clients. These findings suggest potentially important opportunities for collaboration between rural social workers and urban providers, including social workers. Communication and coordination of client care may provide an opportunity for rural social workers to follow up with rural women who have received non-rural healthcare and help them access necessary resources when they return to their rural community.

Due to the nature of qualitative inquiry, the findings of our research are limited in generalizability to a specific, self-selected group of mothers using WIC resources in a rural North Dakota county. Despite this limitation, we see promise in how qualitative methodologies can improve the cultural competence of social work practitioners. By studying the realities of rural subpopulations, in this case low and middle-income rural mothers with infants, rural social work practice can have greater relevance in shaping rural service delivery systems.

Implications for Social Work

With limited number of healthcare professionals serving the needs of rural mothers, social work professionals in rural environments can be a vital resource to supporting rural mothers during pregnancy and as new parents. As generalists in rural communities, the social work profession is aware of the social context of rural motherhood. As noted by one rural practitioner in research conducted by Riebschleger (2007):

You have to learn the community values and the unwritten rules . . . You've got to listen a lot . . . You've got to know people on one side of the mountain are different from people on the other side of the mountain and . . . people way up in the mountain are different from town people . . . It's the whole notion of diversity within groups (p. 210).

We see this understanding of rural worldviews as pivotal to both competent direct practice but also the advocacy of initiatives that improve rural environments. With various different intervention models directed at rural populations including telehealth, mobile health care, and rural transportation services, social workers should listen intently to how rural mothers perceive these "improvements". Historically, rural perspectives are often overlooked. Professional advocacy should consider rural perspectives before advancing initiatives, often developed in non-rural settings, that intend to improve the health and wellbeing of rural populations.

While only specific to one community, our work confirms a crisis of quality childcare in rural communities. This appears to be a critical issue for rural families; yet, community stakeholders may be relatively unaware of this crisis (Ames et al., 2006). Our findings were consistent with a report issued by the *National Association of Child Care Resource & Referral Agencies* (2010) on childcare in rural areas which notes that childcare is cost prohibitive for

many rural mothers. There are also fewer choices and the care tends to be of poor quality. We believe social workers can educate the public and policymakers about these childcare needs. Improving the access and availability of safe and affordable childcare is an important component to improving the lives of rural families. In addition, “family-friendly” policies including paid sick days, parental leave, and flextime can also help support rural mothers. Unfortunately, these policies are less available to rural mothers than urban mothers (Glauber, 2009).

We encourage more research and attention to the perspectives of mothers living in rural communities. Rural places offer both challenges *and* opportunities, yet these opportunities are often hidden from view. Social workers can use research methods to help gain greater understanding of these “insider” perspectives and help counter a deficit-perspective that attempts to explain rural places. When rural settings are only seen through a lens of deficits, it becomes difficult for the public, as well as the social work profession, to see the possibilities, opportunities, and linkages that can be leveraged to support rural mothers and their families.

References

- Ames, B. D., Brosi, W. A., & Damiano-Teixeira, K. M. (2006). “I’m just glad my three jobs could be during the day”: Women and work in a rural community. *Family Relations*, 55, 119-131.
- Creswell, J. W. (2006). *Qualitative inquiry & research design: Choosing among five approaches*. (2nd ed.). Thousand Oaks, CA: SAGE.
- Cummins, H. A. (2005). Unraveling the voices and identity of farm women. *Identity: An International Journal of Theory and Research*, 5(3), 287-302.
- Daley, M. R., & Pierce, B. (2011). Educating for rural competence: Curriculum concepts, models and course content. In L. Ginsberg (Ed.), *Social work in rural communities* (pp. 125-140). Alexandria, VA: Council on Social Work Education.
- Fordyce, M. A., Chen, F. M., Doescher, M. P., & Hart, L. G. (2007, November). *2005 physician supply and distribution in rural areas of the United States* (Final Report #116). University of Washington Rural Health Research Center. Retrieved from <http://depts.washington.edu/uwrhrc/uploads/RHRC%20FR116%20Fordyce.pdf>
- Gale, J. A., & Lambert, D. (2006). Mental healthcare in rural communities: The once and future role of primary care. *North Carolina Medical Journal*, 67, 66-70.
- Gamm, L. G., Stone, S., & Pittman, S. (2003). *Mental health and mental disorders—A rural challenge: A literature review. Rural healthy people 2010: A companion document to healthy people 2010* (Vol. 2, pp. 102). College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.
- Gjesfjeld, C. D., & Jung, J. -K. (2011). How far?: Using Geographical Information Systems (GIS) to examine maternity care access for expectant mothers in a rural state. *Social Work in Health Care*, 50(9), 682-693.

- Glauber, R. (2009, Summer). *Family-friendly policies for rural working mothers* (Policy Brief No. 15). Carsey School of Public Policy, University of New Hampshire. Retrieved from http://www.carseyinstitute.unh.edu/publications/PB_FamilyPolicies_09.pdf
- Kenkel, M. B. (2003). Rural women: Strategies and resources for meeting their behavioral health needs. In B. H. Stamm (Ed.), *Rural behavioral health care: An interdisciplinary guide* (pp. 181-192). Washington, DC: American Psychological Association.
- Kornelsen, J., & Grzybowski, S. (2006). The reality of resistance: The experiences of rural parturient women. *Journal of Midwifery & Women's Health, 51*(4), 260-265.
- Kornelsen, J., Kotaska, A., Waterfall, P., Willie, L., & Wilson, D. (2010). The geography of belonging: The experience of birthing at home for First Nation women. *Health & Place, 16*(4), 638-645.
- Leipert, B. D. (2006). Rural and remote women developing resilience to manage vulnerability. In H. J. Lee & C. A. Winters (Eds.), *Rural nursing: Concepts, theory, and practice*. New York, NY: Springer.
- Leipert, B. D., & George, J. A. (2008). Determinants of rural women's health: A qualitative study in Southwest Ontario. *The Journal of Rural Health, 24*(2), 210-218.
- Martin, J. A., Hamilton, B. E., Sutton, P. D., Ventura, S. J., Mathews, T. J., Kirmeyer, S., & Osterman, M. J. K. (2010). Births: Final data for 2007. *National Vital Statistics Report, 58*(24), 1-85 .
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: SAGE.
- National Association of Child Care Resource & Referral Agencies. (2010, July). *Child care in rural areas: Top challenges*. Retrieved from http://www.naccrra.org/sites/default/files/default_site_pages/2012/rural_top_concerns_070910.pdf
- Riebschleger, J. (2007). Social workers' suggestions for effective rural practice. *Families in Society, 88*(2), 203-213.
- Strauss, A. L., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: SAGE.
- Tong, S. T. , Makaroff, L. A., Xierali, I. M., Puffer, J. C., Newton, W. P., & Brazemore, A. W. (2013). Family physicians in the maternity care workforce: Factors influencing declining trends. *Maternal and Child Health Journal, 17*, 1576-1581.
- U.S. Department of Health and Human Services, National Center for Health Statistics (DHHS). (2007). *Health, United States, 2007 with chartbook on trends in the health of Americans*. Hyattsville, MD: U.S. Government Printing Office.
- Weinert, C., & Long, K. A. (1987). Understanding the health care needs of rural families. *Family Relations, 36*(4), 450-455.

Xu, X., Siefert, K. A., Jacobson, P. D., Lori, J. R., Gueorguieva, I., & Ransom, S. B. (2009). Malpractice burden, rural location, and discontinuation of obstetric care: A study of obstetric providers in Michigan. *The Journal of Rural Health*, 25(1), 33-42.

Zhao, L. (2007). *Why are fewer hospitals in the delivery business?* Working paper #2007-04. Bethesda, MD: The Walsh Center for Rural Health Analysis.

Shifts in Practice Based on Rapid Re-Housing for Rural Homelessness: An Exploratory Study of Micropolitan Homeless Service Provision

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Abstract. Based on interviews with rural homeless service providers, the authors examine in this practice note how policy has created shifts in practice for organizations serving homeless populations. Homeless individuals find a decreasing opportunity for assistance while awaiting Rapid Re-Housing. Some organizations, dependent on Rapid Re-Housing monies, are facing a lack of funding to pay for general homeless care provision. Organizations are creating care networks to address requirements of the new policy in addition to pooling resources in underserved areas.

Keywords: micropolitan, rural, homelessness

Although between 2009 and 2011 homelessness decreased nationwide (NAEH, 2010, 2012), policy levers that helped accomplish the decrease, including the Homelessness Prevention and Rapid Re-Housing Program funding, are often not available to rural emergency shelters which lack critical infrastructures and networks to obtain funding. The policy creates an environment where rural homeless service providers can neither fully support the persistent needs for temporary housing due to reduced emergency housing funding, nor fully rehouse individuals and families due to insufficient rural housing stock and wrap-around services.

The purpose of this paper is to better understand the context and effectiveness of homeless policy impacting rural interventions through interviews with rural and micropolitan homeless service providers. We first briefly place the study in a policy context and then provide observations from practice resulting from the federal policy shift.

Policy Background and Literature

Since the 1980s, rural communities have documented growing homeless populations (Housing Assistance Council, 2012; Segal, 1989; Wilkerson, 1989;). According to the NAEH (2010), 9% of the nation's homeless population was rural in 2007. The increased demand for skilled labor, lack of educational resources, systemic poverty, and decrease in the labor market in rural areas, coupled with recent reductions in housing availability, have moved the once urban problem of homelessness into smaller communities across the country. Rural homelessness, like many other social concerns in rural areas, lacks infrastructure to meet the need (Allard, 2009); there are fewer shelters and services available to homeless persons in rural areas. People experiencing homelessness in rural areas are more likely to live in their cars or stay with friends and family (Trella & Hilton, 2014) than seek out shelter assistance (NAEH, 2010, 2012).

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Homeless individuals generally rely on others or ask for assistance from family only in extreme circumstances (Trella & Hilton, 2014). This means that the problem is often hidden from public view and consciousness, out of sight is truly often out of mind. Confounding these facts, the most recent national data on rural homelessness was gathered in 2010 by the NAEH. Few scholarly articles have addressed the issue in recent years.

Scholarship has focused primarily on homelessness in urban areas with some exceptions, and the majority of these exceptions are dated (Burt, 1992; Cloke, Milbourne, & Widdowfield, 2002; First, Rife, & Toomey, 1994; Fitchen, 1991; Fitchen, 1992; Frank & Streeter, 1987; Milbourne, 2006; Redburn & Buss, 1986; Trella & Hilton, 2014; Vissing, 1996). The Rural Poverty Research Center (Fisher, 2007), the U.S. Department of Agriculture, Rural Economic and Community Development (1996), the National Council of State Housing Agencies (2009), and others provide much needed assessment of the problem, but our research demonstrates that currently, such information does not necessarily translate into rural-friendly policy with Rapid Re-Housing application requirements favoring urban-based solutions.

Policy development follows issue awareness. While homelessness has existed in the United States since the country's inception, it did not become a prominent national issue with policy implications until the 1970's and 1980's when the demographics and visibility began to shift from single men living primarily out of the public's view towards a more diverse population, including women and children, living on the streets. The 1983 Emergency Food and Shelter Program (P.L. 98-9) and the 1986 Emergency Shelter Grants Program (P.L. 99-591) represent initial attempts by policy makers to deal with the homeless problem, but they were limited in scope and reach. In 1987, Congress enacted the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77), later renamed the McKinney-Vento Homeless Assistance Act (P.L. 106-400), which created a number of new programs to comprehensively address the needs of homeless people (Perl et al., 2012). The McKinney-Vento Act originally consisted of fifteen programs; however, these primarily targeted the urban homeless. Since the Stewart B. McKinney Homeless Assistance Act, few federal programs and funding streams have been established to combat rural homelessness, and only the U.S. Department of Agriculture Rural Development Section 515 Program and the Rural Housing Stability Program (RHSP) appear to deal directly with the problem. Under the Section 515 program, direct loans are made to for-profit developers, nonprofit corporations, and governmental agencies to purchase, construct, or rehabilitate rental housing in rural areas for low- and moderate-income families, elderly persons, and persons with disabilities. Unfortunately, funding for this program has been drastically reduced making it even more difficult to address the disparity between rural and urban homeless (Robertson, Harris, Noftsinger, & Fischer, 2007).

Most rural homeless were not considered so by the federal government until the enactment of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 which was part of the Helping Families Save Their Homes Act (P.L. 111-22). The HEARTH Act, which also amended and re-authorized the McKinney-Vento Homeless Assistance Act, set forward criteria that better suited and described the rural homeless population. Along with altering the definition of chronic homelessness to include families with children, the HEARTH Act also modified the definition of homeless persons as those:

. . . in danger of losing their home within 14 days, instead of . . . seven, and families or unaccompanied youth living unstably. Families or unaccompanied youth fall under the definition of living unstably if they: are defined as homeless under other federal programs; have experienced a long period without living independently in permanent housing; have moved frequently; and will continue to experience instability due to disability, domestic violence or abuse, or barriers to employment. (National Council of State Housing Agencies, 2009)

The RHSP, administered by the U.S. Department of Housing and Urban Development (HUD), focusses specifically on rural areas and provides grants to assist rural communities and their homeless with

- emergency housing (short-term, non-sustainable housing such as seasonal homeless shelters);
- permanent housing (long-term, sustainable housing such as apartments or rental homes);
- re-housing (transitioning families from emergency to permanent housing including a variety of wrap around support services);
- data collection; and
- a range of supportive services.

A rural community in this case is defined to include (1) a county where no part is contained within a metropolitan statistical area, (2) a county located within a metropolitan statistical area, but where at least 75% of the county population is in nonurban Census blocks, or (3) a county located in a state where the population density is less than 30 people per square mile, and at least 1.25% of the acreage in the state is under federal jurisdiction. In 2009, the RHSP was revised to include Rapid Re-Housing activities; and, according to our interviews, funding available for emergency shelters decreased precipitously at that time with the larger portion of funds supporting re-housing efforts.

Policy assistance for rural homelessness is constrained by the ability of governmental and non-governmental organizations (NGO's) to determine how many people in the U.S. meet homeless criteria. Point-in-time counts, which count the number of homeless people during a specific point (usually a day), and period prevalence counts, which estimate the number of homeless over a given period (usually a year), have advantages and disadvantages (NAEH, 2012). A majority of the localities within the study's sample area did not track point-in-time counts, exacerbating the lack of data for these areas. Both methods tend to underestimate the true number of homeless as currently implemented, particularly in rural areas, because of the inability to count certain homeless people such as those in hidden and potentially dangerous places, and those who are in doubled-up situations when a person is staying temporarily with family or friends.

Methodology

This research studied organizational responses to policy interventions regarding rural homelessness; therefore, the research team conducted semi-structured interviews with sixteen nonprofit leaders of rural homeless support organizations and domestic violence shelters between October 2012 and August 2013. Using a snowball sampling technique, the study began with a single county in Virginia and grew to include three rural regions in Virginia, West Virginia, and Kentucky. Interviews were transcribed and coded using NVivo10 for Windows.

Research Results

Current services for rural homeless or temporarily homeless include family shelters such as the Salvation Army which restricts access to those with substance abuse issues, shelters of last resort that typically accept individuals regardless of addiction or alcohol consumption (individuals in these shelters are generally single), and domestic violence shelters which often provide temporary assistance to women and children who have had to flee their homes due to domestic violence. The communities we studied exhibited each of these types of services; however, funding for temporarily homeless service provision was considered a diminishing resource but an ongoing need by nonprofit leaders.

Organizations within the study shared several characteristics. Within the areas studied differential support exists for individuals and families. Of those shelters designed for individuals, drug and alcohol use can exclude some in need of shelter. Two emergency shelters were developed to accommodate individual drug and alcohol abusers as a result of stricter guidelines and regulations (e.g., breathalyzer tests) at other homeless service providers and in response to high profile media scrutiny resulting from lack of services for this population.

Another dominant characteristic of service provision in the study locations is the importance of the faith-based community. Faith-based partner organizations are critical components of the rural homeless service provision networks in these communities. Not only were churches key partners for the shelters by serving as temporary housing locations, all organizational funding was generated from churches or faith-based coalitions.

Additionally, the majority of the sixteen organizations interviewed had limited staff resources. Over 70% of the organizations had three or fewer full time staff members and these were the organizations that focused exclusively on homeless services. Volunteers were key players in service provision for all of the interviewed organizations. Two organizations were operated exclusively by volunteers and provided seasonal homeless services.

For organizations providing services to homeless and temporarily homeless individuals in the areas studied, Rapid Re-Housing policy provides a mixed bag of positive and negative possibilities. On the positive side, Rapid Re-Housing can create some synergies between organizations that previously did not work closely together. Because the application process encourages participation in the Coalition of Care or other network of providers, greater levels of cooperation even beyond the application process are being reached by some, thus achieving a legislative goal. In these cases, communities of service providers have come to work more closely in terms of providing references and bundling services for individuals.

One director of a battered women's shelter described how federal policy changes were driving collaborative practices that are indeed improving service for those in need of permanent housing solutions and creating conversations around this issue that were not taking place prior to the policy shift. However, in an adjacent community, the domestic violence shelter director lamented the fact that the new Rapid Re-Housing legislation hamstrings providers from serving those in emergency homeless situations by decreasing federal monies for emergency services in favor of monies for re-housing. One interviewee said, "Maybe some communities have more resources to get people into housing right away; it's not [this one]." Since it takes time to conduct assessments and process paperwork involved in getting someone into permanent housing, some shelters are struggling to provide both types of service.

Other interview themes include attitudes regarding the impact of Rapid Re-Housing on accessibility of funding, the importance of available housing stock and additional support services, and the classification of homeless individuals.

The first identified theme was accessing funding. Nonprofit leaders report that Rapid Re-Housing funds are difficult to access for rural service providers who lack needed infrastructure such as required amounts of housing stock in their communities. One respondent noted, "housing stock is certainly a problem – in a number of different ways. One is just the number of units that are available, the second is decent units, and third is cost of the unit." In terms of housing stock, the areas had little available housing suitable for Rapid Re-Housing placement. More problematically, housing for temporary emergency needs are being defunded in light of emphasis on funding Rapid Re-Housing. Those indirect service providers in micropolitan areas, urban areas with less than 50,000 and at least 10,000 people, who can access Rapid Re-Housing funds, are frustrated by a gap in service between those in need of immediate homeless services and those in need of Rapid Re-Housing services.

Support service infrastructure was the second theme identified. A high point in the study is the consistent report of strong support from law enforcement and social services as in helping give rural homeless service providers additional support and legitimacy, which is critical since these organizations lack financial and human resources. However, critical infrastructures missing for rural areas include adequate housing stock (e.g., "There is no such thing as low-income housing in [this] city") as well as needed wrap-around service such as health, employment, transportation, and substance abuse services (e.g., "50%-75% of our women come in with substance or alcohol abuse issues").

All direct service providers interviewed are part of their continuum of care coalition. These support systems generally do not come with funding attached. Emergent homeless service providers feel they lack capacity to access state and federal funds as well as time and capacity to identify private and foundation funding possibilities, while state and federal funders encourage coalition-building for greater fund access. Such constraints led one temporary shelter in the study to close after only two years of operation, with no other temporary shelter available for approximately thirty miles.

Finally, nonprofit professionals identified a recurring theme regarding the classification of homelessness. The policy shift can artificially impose a reclassification of individuals to make them fit the policy's guidelines. For example, one domestic violence shelter director noted,

we have a convergence, then, of people in the house that come with different issues in that the main [concern] is around safety. The homeless folks that come in – now of course we’re trying to make them domestic violence . . . ‘at some point in your life, wasn’t somebody mean to you’?

In another case, the interviewee described barriers to classifying those needing service as

. . . the type of people we would work with is going to be the main barrier. They say somebody who is local doesn’t [fit the definition for Rapid Re-Housing], so they can amend some of the things. So sometimes we’re a square peg trying to go into a round hole, which doesn’t fit the type of people we work with. We work with a higher barrier people (those who have high barriers to access housing), medium- to high- barrier. We’ve got very few low barrier (individuals who have low barriers to access housing). So until they come up with a solution to help those, we’re going to be on the outside looking in.

Practice Implications

As a whole, homeless services are emergent providers with associated liabilities of smallness, newness, and resource dependence (since private contributors are crucial). The organizations that focused exclusively on provision of homeless services were the leanest in terms of staff and overall infrastructure. Noted earlier was the general paucity of staff. The domestic violence organizations were the exceptions each with over ten staff members. At least one staff member in each of the domestic violence organizations had grant writing responsibilities as part of their job description.

The problem of homelessness is increasing in rural and micropolitan areas. Interviews indicate that rural homeless often migrate into micropolitan areas for access to services, particularly in colder months, taxing the resources (human, fiscal and space) of the micropolitan entity. Smaller communities are seeking collaboration and consultation with others for ways to address this growing need.

Practitioners cite many challenges presented by the shift in Rapid Re-Housing policy. Small, community-based homeless service providers providing shelter alone are pressed even more so for financial support; yet, the need for some form of emergency shelter is not entirely eliminated by the new policy environment of Rapid Re-Housing since it often takes time (sometimes one to two weeks) to place individuals and families in permanent housing. The transition period between emergency shelter needs and transition to permanent or semi-permanent housing is a gap in service not currently addressed through legislation. Although states are still supporting emergency shelters in some cases, this support is dwindling and in danger of being phased out entirely.

Along with the gap in funding for emergency services, emergency shelters may be ill-equipped on their own to support increased levels of service mandated by Rapid Re-Housing. Emergency shelters can choose not to seek Rapid Re-Housing funding and therefore not provide those services; however, this source of funding is significant and often financially struggling organizations feel pressed to seek this option. Smaller organizations often may not have the time

or capacity to seek the funding which can require considerable time, effort, knowledge, and collaborative skills to obtain. If organizations do receive funding, the demands of the federal requirements can strain on other services, causing a shift in mission in some cases, or discontinuation of services once offered. In some cases, individuals with criminal charges cannot qualify for re-housing; and in some cases, these individuals, through little fault of their own (a spouse did not pay bills or damaged property, for example) are often stuck without housing assistance under the new provisions. In small communities, where housing stock is limited, individuals who may have gained a reputation for unruly or irresponsible behavior in the past may have difficulty finding landlords willing to work with them.

Yet, along with these challenges and difficulties lie opportunities for community organizations and funding agencies. Organizations obtaining Rapid Re-Housing monies report that once they understand the federal requirements and obtain funding, they are working more collaboratively with other community service providers. Such collaboration can reduce redundancy and overlap of services and create stronger networks of service professionals in micropolitan and rural areas. The opportunity for federal funders is to re-examine re-housing to close the gap between emergency and permanent housing and take the needs of rural emergency service providers into greater consideration.

References

- Allard, S. W. (2009). *Out of reach: Place, poverty, and the new American welfare state*. New Haven, CT: Yale University Press.
- Burt, M. R. (1992). *Over the edge: The growth of homelessness in the 80s*. Russell Sage Foundation Press.
- Burt, M., Aron, L. Y., Lee, E., & Valente, J. (2001). *Helping America's homeless: Emergency shelter or affordable housing?* Washington, DC: Urban Institute Press.
- Cloke, P., Milbourne, P., & Widdowfield, R. (2002). Partnership and policy networks in rural local governance: Homelessness in Taunton. *Public Administration*, 78(1), 111-133.
- First, R. J., Rife, J. C., & Toomey, B. G. (1994). Homelessness in rural areas: Causes, patterns, and trends. *Social Work*, 39(1), 97-108.
- Fisher, M. (2007). Why is U.S. poverty higher in nonmetropolitan than metropolitan areas? *Growth and Change*, 38(1), 56-76.
- Fitchen, J. M. (1991). Homelessness in rural places: Perspectives from upstate New York. *Urban Anthropology and Studies of Cultural Systems and World Economic Development*, 20(2), 177-210.
- Fitchen, J. (1992). On the edge of homelessness: Rural poverty and housing insecurity. *Rural Sociology*, 57(2), 173-193.
- Frank, R., & Streeter, C. (1987). Bitter harvest: The question of homelessness in rural America. In A. Summers, (Ed.), *Social work in rural areas: The past, charting the future, acclaiming a decade of achievement. Proceedings of the 10th National Institute of Rural*

- Areas* (pp. 36-45). Columbia, MO: University of Missouri at Columbia, School of Social Work.
- Housing Assistance Council. (2012). *Taking stock: Rural people, poverty, and housing at the turn of the 21st century*. Retrieved from http://www.ruralhome.org/storage/documents/ts2010/ts_full_report.pdf
- Milbourne, P. (2006). Rural housing and homelessness. In P. J. Cloke, T. Marsden, & P. Rooney (Eds.), *Handbook of rural studies* (pp. 427-444). Thousand Oaks, CA: SAGE.
- National Alliance to End Homelessness (NAEH). (2010, January). Questions and answers on homeless policy and research. In *Fact Sheet: Rural homelessness*. Retrieved from www.endhomelessness.org/content/article/detail/1613
- National Alliance to End Homelessness (NAEH). (2012, January). *The state of homelessness in America 2012*. Retrieved from <http://www.endhomelessness.org/library/entry/the-state-of-homelessness-in-america-2012>
<http://www.endhomelessness.org/content/article/detail/4361>
- National Council of State Housing Agencies. (2009, June). *McKinney-Vento Homeless Assistance Reauthorization enacted*. Retrieved from <https://www.ncsha.org/blog/mckinney-vento-homeless-assistance-reauthorization-enacted>
- Perl, L., Bagalman, E., Fernandes-Alcantara, A. L., Heisler, E. J., McCallion, G., & McCarthy, F. X. (2012). *Homelessness: Targeted federal programs and recent legislation*. Congressional Research Service (7-5700, RL30442). Retrieved from <https://www.hsdl.org/?view&did=710962>
- Redburn, F. S., & Buss, T. F. (1986). *Responding to America's homeless: Public policy alternatives*. New York, NY: Praeger.
- Robertson, M., Harris, N., Noftsinger, R., & Fischer, P. (2007). Rural homelessness. In *Toward understanding homelessness: The 2007 national symposium on homelessness research* (Vol. 4). Retrieved from: <http://www.huduser.org/>
- Segal, E. A. (1989). Homelessness in a small community: A demographic profile. *Social Work Research & Abstracts*, 25(4), 27-30.
- Trella, D. L., & Hilton, T. P. (2014). "They can only do so much:" Use of family while coping with rural homelessness. *Contemporary Rural Social Work*, 6, 16-39.
- U.S. Department of Agriculture, Rural Economic and Community Development. (1996). *Rural homelessness: Focusing on the needs of the rural homeless*. Washington, DC: Author.
- Vissing, Y. M. (1996). *Out of sight, out of mind: Homeless children and families in small-town America*. Lexington, KY: The University Press of Kentucky.
- Wilkerson, I. (1989, May 2). As farms falter, rural homelessness grows. *The New York Times*, pp. A1, A14.

Teaching Students to Write Book Reviews

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Abstract. This teaching note argues that one value associated with preparing book reviews for publication is the increased capacity to develop this skill in undergraduate and MSW-level social work students. A book review assignment is presented that has been effective in developing student authors. After graduation, student authors ($N = 21$) agreed that acceptance for publication improved their self-confidence, increased attention to their studies, and enhanced their practice.

Keywords: book reviews, teaching

The production of descriptive book reviews to summarize new scholarly work and scientific findings has been traced back to the 17th century Enlightenment. As the number of new titles increased, attempts to provide comprehensive catalogs of new books ceased in favor of selectivity and critical appraisal in the 19th century leading to the contemporary academic standard of objective evaluation by a qualified scholar (Orteza y Miranda, 1996). Appeals to consider the dissemination value of high quality reviews as an important academic contribution (Gibbs, 2013) have not prevailed in an academic marketplace that categorizes reviewing as service (Felber, 2002; Toor, 2012) or self-education (Lee, Green, Johnson, & Nyquist, 2010). Accordingly, only 16 of the 41 social work journals included in the *Journal Citation Reports Social Science Edition* published book reviews in 2011. Understandably, social work educators may avoid investing the time necessary to develop into competent reviewers. This Teaching Note argues that there are ample reasons for social work educators, especially those serving smaller rural programs, to reconsider their reluctance to develop reviewers.

Reasons to Write Book Reviews

The scholarly stature of academic books is established primarily by the quantity and quality of published book reviews (Worsham, 2012), which leads to substantial author and publisher support for reviewing. Gibbs (2013) argued that the book reviewer may contribute substantially to the dissemination of high quality work, and Lee et al. (2010) added that it is equally important to inform potential readers to avoid low quality work. *Print* (2011) reported that traditional publishing was up 47 percent and reprints/print-on-demand up 8400 percent from 2002 to 2010, highlighting the magnitude of the challenge associated with maintaining currency in research, theory, and practice trends.

Some might suggest that social work educators may maintain currency by simply reading new literature; but as Kahn and Holody (2009) argued, “the real work of writing [is] the organization, synthesis, and integration of ideas” (p. 88). The process of preparing a high quality book review is especially recommended for the developing writer (Lee et al., 2010; Worsham, 2012) as it helps the writer discover voice, frame arguments, analyze content reflectively and critically, and relate that content to self and social issues (Waller, 2000). A final reason for reviewing books is quite simple: One who does not develop this skill will be hindered in passing this skill along to students.

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Faculty serving smaller rural social work programs may find these suggestions particularly suitable for their teaching focus and limited research resources for the reasons noted above; however, it may be even more important for rural social workers to be heard. Smalley and Warren (2012) have argued convincingly that rurality is an unrecognized cultural diversity issue in its own right. To the extent that social work educators allow workload demands, time constraints, and resource scarcity to minimize their potential contributions to the professional literature, they may be in violation of their own professional values and ethics. Moreover, writing book reviews is a modest, but meaningful way to raise one's voice.

Using Book Reviews to Improve Student Writing

Amidst the larger literature concerned with improving student writing on all program levels, there is a small thread encouraging social work students to submit manuscripts for publication. Support for submission of MSW student work is scant, perhaps because as much as one-third of MSW students may not possess adequate writing skills to be successful in graduate school (Alter & Adkins, 2006). Kane (1978) described a team-based research project where MSW students produced a manuscript after graduation. And, some evidence suggests that improvement in the students' ability to master academic prose is linked to better writing in practice contexts (Rai & Lillis, 2013). Linsley (2002) wrote about encouraging her MSW-degreed peers to speak up, advocate, and establish expertise through writing. There is generally stronger support for doctoral student submissions as part of their academic preparation (Bender & Windsor, 2010). Page-Adams, Cheng, Gorgineni, and Shen (1995) even tested the productivity of a doctoral student writing group and found that in-group productivity exceeded out-group student productivity by more than three times.

Outside of social work, Prat-Sala and Redford (2010) found that deep and strategic undergraduate student learning was determined by self-efficacy beliefs in reading and writing. A follow-up study linked improvements in perceived self-efficacy to higher quality manuscripts in the second year of college (Prat-Sala & Redford, 2012). Writing for the American Association of Colleges and Universities, Kuh (2008) described writing intensive courses as one of the high impact educational practices that significantly influence student engagement, retention, and graduation.

Guidelines for Writing Book Reviews

As an instructor working with both graduate and undergraduate social work students, this author developed a book review assignment that has resulted in 24 book reviews accepted for publication in the last three years. Graduate students are provided detailed review notes on a first draft of the review and required to submit the review after revisions. Undergraduate students are provided more general feedback and awarded bonus credit if they choose to submit the review. In addition to general review notes on undergraduate first drafts, the second draft goes through a one-to-two hour final revision where the instructor and student work together. This assignment has been used in social policy classes on both program levels and in an undergraduate mental health elective.

Selecting a Book

The first step to getting a book review published is to select a good book. Academic journals are usually most interested in considering reviews on books published by a university press. Amazon's Advanced Search tool makes it easy to locate recently published books. It is very hard to get an editor to consider a book that is older than two years, so stay current. The selection should be nonfiction published in the last two years from a substantial press. Self-published and fiction books should not be selected.

Selecting a Publication Outlet

Finding a journal that will consider your review can take time. The first problem is that some journals do not publish book reviews. The second is that some journals that publish book reviews will not accept unsolicited submissions. If the journal's webpage is unclear about considering unsolicited reviews, contact the book review editor by email for permission to submit. If there is no book review editor listed on the editorial board roster, it is safe to assume that the journal does not publish book reviews.

Match the mission of the journal with the content of the book. Read one or two reviews in the journal to get an idea of the journal's expectations. University libraries tend to have electronic access to a list of journals that can be quite useful in locating prospective publication outlets.

Preparing the Review

Read the entire book. Make sure to take a few notes while reading. Know why the author(s) wrote the book and to whom it is addressed. Clearly identify and understand the central arguments and key ideas expressed in the book. Reviews that are mildly positive have a better chance of being published than reviews that are highly critical of the book. Focus the review on describing accurately and succinctly the book's content, not your opinions. Personal information or extraneous connections should be minimized.

However, it is essential that a book review be written in a manner that demonstrates that the reviewer has processed the content deeply and reflectively. Read the book from a critical perspective. Students tend to have too much respect for anything in print. An argument is not valid because of an author's credentials or the stature of the publisher. Even the best book can be improved, and even the most laudatory review should be able to suggest improvements. This outline may be useful in structuring a review:

- Opening paragraph – Describe the author(s), to whom the book is addressed, and its central argument(s). One thing that works very well here is to comment on the degree to which the author has accomplished his/her goal and what else the book really offers. The easiest way to get published is to have a *hook* here that grabs the reader.
- Middle paragraph(s) – These paragraphs can be the most difficult to craft appropriately because of the necessity to convey the content of the chapters in only a few words. Provide enough detail to enable the reader to understand the

author's perspective on the subject matter. Do not simply list the topics covered. "This chapter is about proposals to privatize Social Security" does not convey any information about what the proposals are. "The author proposes to privatize Social Security by diverting half of the current payroll tax into individual private retirement accounts" is better.

- Next to last paragraph – Provide a brief list of suggestions for improving the book or provide a mild criticism of something specific. This should not be comprehensive of every flaw, but clearly demonstrate the depth of understanding developed in the review process. Specific suggestions are customary, but be sure to consider the book's message in a broader social context such as a social issue or usefulness for practice.
- Last paragraph – Describe who will benefit most from reading this book and what they will gain. Speak specifically to the journal's audience.
- Reviewer identification – Somewhere, the journal will identify the author of the review. Provide this information in the format that previous reviewers have used.

Three double-spaced pages in APA format are approximately 800 words which will be acceptable to most journals. Do not exceed 1,200 words. Always spell- and grammar-check and eliminate all errors noted before submitting. Always check the instructions for authors on the journal website for rules to follow. If they exist, follow them exactly.

Submitting the Review for Publication

Submit the review strictly in accordance with the journal's instructions for authors. In some cases, this will be as a MS Word document attached to an email. In other cases, an electronic manuscript submission system will require registration.

Acknowledgement of receipt of submissions usually occurs within 30 days, perhaps a little more if it is over the holidays. Feel free to contact the book review editor by email if you do not receive an acknowledgement within 60 days.

In general, book reviews are not peer-reviewed, although this is beginning to change for some journals. Rejection is the most likely response, but a submission by a student will almost always receive some form of review comments if the review is accepted for publication. Respond to these quickly and thoroughly.

A well-written review of a book relevant to a journal's audience will often be accepted for publication in a matter of days, but publication can take many months. Some form of publication or copyright agreement is almost always required. Expect an email asking for a signed release when the review is being prepared for publication. Respond to this quickly as well. Failure to respond quickly to review notes and requests for signed publication agreements will delay or cancel the publication.

Benefits Associated with this Assignment

According to national polling data, the general reading habits of Americans have declined over the last three decades even when new electronic access to books is included. Almost one-fifth of Americans did not read a book in 2011, up from 8 percent in 1978; and heavy readers of more than 50 books a year declined from 13 percent to 5 percent (Rainie, Zickuhr, Percell, Madden, & Brenner, 2012). Requiring students to select, read, and review a high quality book is one possible approach to reversing this trend among social workers. From the perspective of a social work educator, this assignment may also help develop career-long learners; nurture student skills in discovering, appraising, and attending to social trends and social change; and improve the critical thinking skills of students, especially skills related to reviewing and synthesizing content (Council on Social Work Education, 2008).

In order to determine student perceptions of the benefits associated with this assignment, an IRB approved online survey was conducted ($N = 21$, response rate of 75%) with those students whose reviews had been accepted for publication. All had graduated by the time of this survey. Nineteen of the student authors provided open-ended responses to describe their feelings about the assignment before submitting. Most were excited, although five did comment that the assignment was intimidating. Likert responses to six questions indicated that acceptance of the student authored manuscripts *improved their self-confidence* (85.7%), made them *more serious about their studies* (71.4%), and *helped them in their practice* (57.1%). Less than half concluded that the acceptance *helped them accept other challenges in their life* (42.9%), and very few felt that the acceptance *changed their career aspirations* (19%).

Conclusion

Social work educators who have not published book reviews may wish to consult Hartley (2010) and Lee et al. (2010) for additional suggestions and guidance. Developing this skill and passing it along to students may effectively target specific practice behaviors as mentioned above, increase student self-confidence which may be a prelude to improved writing (Prat-Sala & Redford, 2012), and encourage students to be more serious about their studies.

Skeptics will note that students are unlikely to produce reviews that meet the general expectation of a qualified expert (Gibbs, 2013; Worsham, 2012). Hartley (2005) explored the usefulness of book reviews among educators and found that the highest ranked value associated with book reviews was “a straightforward overview of what the book was about” (p. 1200). These findings were confirmed with a larger group of academics in the humanities, social sciences, and natural sciences (Hartley, 2006). Apparently, a descriptive book review once again has value.

References

- Alter, C., & Adkins, C. (2006). Assessing student writing proficiency in graduate schools of social work. *Journal of Social Work Education, 42*(2), 337-354.
- Bender, K., & Windsor, L. C. (2010). The four *Ps* of publishing: Demystifying publishing in peer-reviewed journals for social work doctoral students. *Journal of Teaching in Social Work, 30*(2), 147-158. doi:10.1080/08841231003697999

- Council on Social Work Education. (2008). *Education policy and accreditation standards*. Retrieved from <http://www.cswe.org/Accreditation/41865.aspx>
- Felber, L. (2002). The book review: Scholarly and editorial responsibility. *Journal of Scholarly Publishing, 33*(3), 166-172.
- Gibbs, A. (2013). What would a scholarship of publishing look like? *Higher Education Research & Development, 32*(4), 687-689.
- Hartley, J. (2005). Book reviewing in the BJET: A survey of BJET's referees' and writers' views. *British Journal of Educational Technology, 36*(5), 897-905.
- Hartley, J. (2006). Reading and writing book reviews across the disciplines. *Journal of the American Society for Information Science and Technology, 57*(9), 1194-1207. doi: 10.1002/asi.20399
- Hartley, J. (2010). The anatomy of a book review. *Journal of Technical Writing and Communication, 40*(4), 473-487. doi:10.2190/TW.40.4.g
- Kahn, J. M., & Holody, R. (2009). WAC: A strengths-based approach to student learning. *Journal of Baccalaureate Social Work, 14*(1), 83-94.
- Kane, R. A. (1978). Encouraging MSW students to write for publication: A realistic goal of the research curriculum. *Journal of Education for Social Work, 14*(3), 78-85.
- Kuh, G. D. (2008). *High impact educational practices: What they are, who has access to them, and why they matter*. Washington, DC: American Association of Colleges and Universities.
- Lee, A. D., Green, B. N., Johnson, C. D., & Nyquist, J. (2010). How to write a scholarly book review for publication in a peer-reviewed journal: A review of the literature. *Journal of Chiropractic Education, 24*(1), 57-69.
- Linsley, J. (2002). Put it in writing: Tips on writing for professional publication. *The New Social Worker, 9*(4), 7-9.
- Orteza y Miranda, E. (1996). On book reviewing. *Journal of Educational Thought, 30*(2), 191-202.
- Page-Adams, D., Cheng, L.-C., Gorgineni, A., & Shen, C.-Y. (1995). Establishing a group to encourage writing among doctoral students. *Journal of Social Work Education, 31*(3), 402-407.
- Prat-Sala, M., & Redford, P. (2010). The interplay between motivation, self-efficacy, and approaches to studying. *British Journal of Educational Psychology, 80*(2), 283-305. doi:10.1348/000709909X480563
- Prat-Sala, M., & Redford, P. (2012). Writing essays: Does self-efficacy matter? The relationship between self-efficacy in reading and in writing and undergraduate students' performance in essay writing. *Educational Psychology: An International Journal of Experimental Educational Psychology, 32*(1), 9-20. doi:10.1080/01443410.2011.621411

- Print isn't dead, says Bowker's annual book production report.* (2011, May). Retrieved from Bowker's website:
http://www.bowkerinfo.com/pubtrack/AnnualBookProduction2010/ISBN_Output_2002-2010.pdf
- Rai, L., & Lillis, T. (2013). "Getting it write" in social work: Exploring the value of writing in academia to writing in professional practice. *Teaching in Higher Education*, 18(4), 352-364. doi:10.1080/13562517.2012.719157
- Rainie, L., Zickuhr, K., Purcell, K., Madden, M., & Brenner, J. (2012). *The rise of e-reading: Part 2 – The general reading habits of Americans*. Retrieved from <http://libraries.pewinternet.org/2012/04/04/part-2-the-general-reading-habits-of-americans/>
- Smalley, K. B., & Warren, J. C. (2012). Rurality as a diversity issue. In K. B. Smalley, J. C. Warren, & J. P. Rainer (Eds.), *Rural mental health: Issues, policies, and best practices* (pp. 37-47). New York, NY: Springer Publishing Company.
- Toor, R. (2012). Why bother writing book reviews? *The Chronicle for Higher Education*, 58(31), A30.
- Waller, M. A. (2000). Addressing student writing problems: Applying composition theory to social work education. *Journal of Baccalaureate Social Work*, 5(2), 161-166.
- Worsham, L. (2012). The endangered scholarly book review. *The Chronicle of Higher Education*, 58(31), A29.

Integrating Service, Community, and Teaching: Inspiring Students While Building a Mentoring Program for African American Youth

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Abstract. This teaching note describes how the author used various social work practice skills to design and effectively implement a community-based local mentoring program for African American adolescents. This program served as a case study for social work students who practice in rural areas to learn about community development since our program lacks formal rural community practice training module in its curriculum. This article details the process and provides practical examples and recommendations for social work faculty on how to infuse community service experience into the classroom.

Keywords: Teaching, mentoring, African American youth

Social work education can support the academic development of students who work and live in rural communities by providing models of effective, experiential community development programs. This essay outlines how the development of a mentoring program for African American youth in a rural state has enhanced both instructor development and graduate student learning outcomes. This is of particular importance since I teach in a school of social work in a rural state that does not have a specific rural component in our curriculum. This essay reviews my experiences in integrating various social work practice skills within the community, and how those skills were translated into the classroom.

Like many tenure-track faculty, I was encouraged to incorporate service into my scholarship when I arrived at the University of Arkansas at Little Rock. I decided that I wanted my service to align with my research which focuses on African American identity development, particularly among youth. To that end, I joined the 100 Black Men of Greater Little Rock, Inc. (100 BMOGLR) as a member the following year. The 100 BMOGLR is a national non-profit service organization based on the four tenets of Mentoring, Education, Economic Development, and Health and Wellness programming, and the Greater Little Rock chapter of the organization is one of 118 chapters worldwide. Upon joining, I was honored to be a part of the group and looked forward to contributing in any way I could as a social worker and educator. Membership requirements are a minimum of two hours of service per month, and my intention upon joining was to simply participate as a way to get involved in the community.

The 100 BMOGLR lives by two mottos: *Real Men Giving Real Time*; and *Who They See is Who They'll Be*. Our chapter had a good, established record in the community of being a group of caring men. However, member turnover and attrition began to affect the chapter after some organizational turmoil. We went through a two-year period where the chapter struggled to provide effective programming. We had become stale and stagnant, and our reputation declined. Years of un-impactful programming had led to this, and we found ourselves on the precipice of collapse.

At that time I faced a personal, professional, and ethical dilemma. Should I join the effort of improving a fledging non-profit by offering my social work background and experience?

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Could I personally dedicate the time and effort required to take on the mantle of leadership to try to turn the organization around? Or should I abandon ship and focus on the number one priority of all junior faculty, upping my research productivity so that I could secure tenure and promotion (Gose, 2011)? After much contemplation, I decided to run for president of the 100 BMOGLR and was elected later that year. We needed climate change both within our organization and within the city, and that was the first order of business in my new leadership role. If our community non-profit was going to survive, I had to model to our members our motto *Who They See is Who They'll Be* by providing effective leadership and direction. To accomplish this goal, I had to assume the many roles of a micro- and macro-level social worker: advocate, broker, community-change agent, counselor, mediator, and researcher. I found that assuming these roles and using their accompanying practice skills, significantly improved my teaching skills and learning outcomes related to macro and micro social work.

Roles Used in the Community

Researcher

Often, when we think of mentoring programs for African American youth, we tend to think of large urban centers. Although many African American youth do live in urban centers, a significant number of youth are from cities in rural states such as Knoxville, Tennessee, Charleston, South Carolina, and the place where I currently reside, Little Rock, Arkansas. One classic saying among Little Rock locals is that, "it only takes a ten minute drive in any direction to have you in a rural area outside of the city." In Pulaski County, and the entire Central Arkansas area, where Little Rock resides, many families that have moved into the area are from more rural areas of the state. Many of the students I teach and young people I mentor are from small towns with charming names such as "Rose City," "Sweet Home," and "Roland." And all are within a fifteen minute drive of Little Rock's city center. In a recent review of the student enrollment of the MSW program in which I teach, approximately 60% of admitted students the past two years live in rural areas of the state outside of the Greater Little Rock area. I have spent the majority of my life in southern rural states, and what I've observed is that issues of school delinquency, low expectations, and risky, sometimes criminal, behavior in which many African American youth participate is not exclusive to more traditional urban centers such as Philadelphia, Baltimore, New York City, and Dallas (O'Donnell, Richards, Pearce, & Romero, 2010). Arguably, children raised in rural areas are at an increased risk for delinquency due to the lack of community resources and afterschool programs (Taylor, Merritt, & Austin, 2013).

African American teenagers face many obstacles (Witherspoon, Speight, & Thomas, 1997). Aronson & Steele (2005) point to the achievement gaps between African American males and their racial and ethnic counterparts. In Arkansas specifically, 40 percent of African American males do not graduate from high school (Schott Foundation for Public Education, 2012). In addition, African American high school students in Little Rock experience the inappropriate use of school-based arrests as a disciplinary tool (Kennedy, 2014). Many African American students are funneled out of the public schools and into the juvenile and criminal justice systems. Zero tolerance policies with regard to school discipline have significantly increased the number of arrests made at school. Pulaski County, where Little Rock is located, has the highest arrest rate, 44 per 1000 students, and the majority of those arrested are African

American. African American students comprise only 21 percent of the K through 12 student population in Arkansas, but 57 percent of recorded school arrests (Kennedy, 2014).

100 BMOGLR concluded that there were a sufficient number of programs within the city to target the top African American high school students; therefore, we specifically sought teenagers irrespective of grade point average to participate in the program to underscore that we believed all youth are worthy of good role models and quality mentoring relationships.

Program Developer

In the spring of 2012, I led the charge for us to design a mentoring program to mentor African American teen boys specifically between the ages of 13-17. We designed a program called the 100 Academy Mentoring Program (100 Academy). The 100 Academy is an eight week mentoring program that led participants through the Success, Motivation, Academics, Respect, and Trust (SMART) model. SMART was designed to provide various mentored life lessons to program participants. Youth who enrolled in the 100Academy met with 100 BMOGLR members in a group setting for 90 minutes every Saturday for eight weeks. During each mentoring session, mentees were taught the principles of the SMART program by various chapter members who were trained in the SMART program guidelines.

Counselor and Group Leader

To “graduate,” participants must have attended 80 percent of the sessions and actively participate in Academy activities such as essay writing, group discussion, and community service projects. During Academy sessions I primarily play the role of group leader. During the eight week program, each 90 minute session was designed to teach the young men the benefits of effectively building relationships and working together toward a common goal. From an educator and clinician viewpoint, helping the young men excel in a quasi-educational environment is of specific emphasis due to challenges that many African American youth face while in school. As Williams, Greenleaf, Albert, and Barnes (2014) posit in their exploration of the role of counselors in the lives of African American at-risk students, it is imperative that structural support mechanisms (e.g., family, school, and community) are developed and enhanced whenever possible for disadvantaged students to excel in school despite of the adverse situations that many face. Providing a safe space for the young men has taken additional significance given the recent rise in self-harm, high-risk behavior, and depression among African American adolescents (Compton, Thompson, Kaslow 2005). Matlin, Molock, & Tebes (2011) investigated the role of connectedness and social support, specifically peer support, in suicidality and depression among African American adolescents. In their study of over 200 African American adolescents, they discovered that increased family support and peer support are associated with decreased suicidality. They concluded that peer support and community connectedness played a key moderating role in the relationship between depressive symptoms and suicidality (Matlin, Molock, & Tebes, 2011). In short, they found that programs which use group activities such as the Saturday morning 100 Academy sessions have the potential to help reduce depression among African American adolescents.

Subsequently, I use many of the same group development and cohesion strategies while leading the 100 Academy sessions as I do while teaching my Advanced Group Psychotherapy

graduate course. The same group dynamics of the classic forming, storming, norming, performing, and adjourning that occur in therapeutic group work also happen among the young and older men who participate in group sessions (Tuckman & Jensen, 1977). While facilitating the groups, I use the skills of effective group leadership. All of the tools that I teach my students to use while effectively leading groups are put into practice; everything from encouraging the group to become comfortable with everyone for their own benefit to empowering group members to effectively deal with *problematic* group behaviors such as the classic “Help Rejecting Complainer,” to effectively using silence to allow the young men time to process their thoughts, attitudes, and emotions that come to the surface during the program (Corey, Corey, & Corey, 2014; Yalom & Leszcz, 2008). Several of the young men are quite hesitant to participate at the beginning of the program. When asked about their hesitancy, several 100 Academy participants readily admitted that the only reason they were participating was because their parent or guardian insisted that they needed mentoring. With this in mind, it was necessary to, and quite helpful that I could, work in multiple roles of educator, practitioner, and community organizer during our time together.

Community Organizer and Educator

At the conclusion of the program, we were encouraged that the initiative went relatively well, but we wanted to increase our impact by recruiting more young people to participate in the 2013 class. Therefore we: (a) increased our social media presence; (b) promoted the activities and accomplishments of 2012 participants; (c) visited schools and community service events to increase our service imprint; and (d) volunteered at various community events. As mentioned, the chapter’s *100 Black Men* brand had name recognition in the city, but people did not really know us or our program. Our goal was to change that popular perception through active community engagement and media appearances to promote the upcoming class. I realized early that my role had expanded from a community member who took on a leadership role in the community civic group, to that of an experienced social work professional who was changing culture through community non-profit organization leadership.

I often implore my students to believe that the best social work practice isn’t either *micro* or *macro*, as they so often believe in this false choice dichotomy, but a combined effort of all of the skills that we strategically plan to give them during their time in our undergraduate and graduate level programs. According to Dreuth and Dreuth-Fewell (2003), students and practitioners should be exposed to more real world examples of community-based training. My experiences in the community were a good grounding in real world examples that I could share in my classroom. Specifically, the experiences I shared with my students and colleagues underscore the importance of understanding organizational functioning and the ability to deal with associated challenges. At every turn, including my role as a professor, I was using social work practice skills to facilitate change.

Program Evaluator

With regard to the 100 Academy, 90 percent (45 of 50) of the young men who participated in the program have graduated since 2012: 4 of 6 (66%) in 2012, 18 of 18 (100%) in 2013, and 23 of 26 (88%) in 2014. The average age of participants is 15, and of those who have matriculated through high school, one mentee has enrolled in college, one mentee earned his

GED, and the remaining young men are still enrolled in high school and matriculating to their next grade. Due to the program's popularity and exposure, we expect a full class of 30 young men to apply to be participants for the program this fall. As a part of our ongoing program evaluation, for the past two years we've asked parents and guardians to complete a brief electronic satisfaction survey of the impact of the program on their sons. Thirty nine percent (14 of 36) of the parents or guardians completed the survey which was a combination of five questions that gathered parental views of the program's operation and success. Parents and guardians were asked about their perception of how the program was implemented, and its mentoring on their sons. We also gave the parents room to provide any recommendations they had for improving the program. Respondents have been overwhelmingly positive, and the following are common response themes:

- The program filled a void in the lives of their son that was much needed;
- Many 100 academy mentees did not like attending weekly program sessions at the beginning but grew to look forward to attending towards the end of the eight week period; and
- Small improvements were beginning to show up in the academic success of the mentees.

In addition to the satisfaction survey, we also charted the general interest and growth of the program as a part of our overall program evaluation. In addition to the support and interest of parents who wanted their sons to participate, sponsorships and donations to the 100 BMOGLR have grown by 400 percent since the initial launch of the program in the fall of 2012. As mentioned, sponsor support has been enough to not just support the 100 Academy Mentoring Program, but it has also spawned a series of annual *Mentoring Across a Lifetime* leadership conferences that the organization has hosted the past two springs. Lastly, the general interest and support of the organization has grown significantly via word of mouth of community members. In all, we view the program as successful with more room for future growth.

From Community to Classroom

Each year I receive a new group of first year social work graduate students, and upon day one of the program, the majority already know if they will be a micro specialist focused on therapeutic work with clients, or a macro professional who will lead, and ultimately own, their own social service enterprise someday. In my social work practice course that I teach in two parts, one each semester of the foundational year of our graduate program, I have annually given my students the same mantra that "the best social workers do both, so don't limit yourselves." Despite my best efforts, the students seem to philosophically understand my point, but they also observed that the majority of my in-class examples came directly from the clinical perspectives that drew upon my experience as a social worker in a behavioral health center where I had worked as a therapist several years ago. Each year I would give my speech but not necessarily personally see any movement in the students' reaction to my charge. That began to change, however, once I began to share more of the lessons I've learned during my experience leading the 100 BMOGLR in the various roles that have previously been described. Here are three tangible ways that my classroom experience has changed since I began sharing more of my community work with students.

Classroom Activities: Better Real World Role Play

I use role plays in each of my classes. Through the experiences I've had in my various roles with the 100 BMOGLR, I was able to craft better-designed scenarios that stretched the learning experience of my students. For example, in my Practice I class I have students conduct role plays with each other to improve their basic social work interviewing skills. One of the role plays involves a 15-year old African American male, 'Joey,' who presents many of the same attributes that some of the young men of the 100 Academy program present: being uncomfortable with sharing in a therapeutic setting, lack of trust of authority figures, and the need for peer support. My community experience enhances the learning environment via my ability to help provide a more nuanced approach to both the design of the role play as well as the classroom discussion I facilitate following each.

Course Content: Reshaping My Own Expertise

My work with the 100 Academy taught me two lessons that I quickly realized and then infused into the course content of each class I teach, particularly my Diversity and Oppression and Juvenile Delinquency courses. The first lesson was that I'm not as young, hip, and culturally competent as I assumed. The second lesson was that some of the same anxieties experienced by adolescents entering the 100 Academy were very similar to the anxieties of many of my students. With regard to lesson one of cultural competence, without my experience of working with 21st century millennial adolescents, I may not have ever realized the extent to which my worldview lens was that of a late 20th century child and adolescent of the 90s. The realities, challenges, and obstacles faced by the population I was serving in the community were beyond the boundaries of my life and content expertise. I assumed that my scholarship on conditions that affected the lives of African American adolescents made me an expert on said population. The lessons I learned over the course of three 100 Academy program classes has made me more aware of my own blind spots and presumed/over-assumed ownership of relevant cultural competence. Now, when I teach the two aforementioned courses, I give the story I just described to my class as a case study on the number one rule of cultural competence in my opinion: the moment that you *think* you know everything there is to know about a group and stop learning, you are no longer culturally competent.

With regard to the second lesson, having a better understanding of the impact of anxieties associated with a new group environment, the community experience I had with the young men I mentor has given me more understanding and patience with anxious students who also struggle with this issue. Many have written about the very real experiences of collegiate student anxieties and their influence on student learning (Jiao & Onwuegbuzie, 1998; Green, Bretzin, Leininger, & Stauffer, 2001). Although I was aware of those challenges, it wasn't until I re-launched myself back into community work with the 100 Academy program in 2012 that I saw the parallel in the actions and thought processes of the adolescents I worked with and some of the graduate students I taught. Many program members are *nontraditional* students in the sense that many are later returning to school, decades later in some instances, seeking their post undergraduate graduation. It's hard to explain exactly why this happened, but I have become much more patient and understanding of student needs since my experience with the youth. I still challenge them and teach as well as I can, but now I also take the same effort to be tuned into the pulse of the students of my classes and check in much more often to see how they are doing inside and

outside of the classroom. This is no different than the typical check-in process that I would do with the young men when I put my clinical cap on always made sure to follow the basic principle of being tuned into the pulse of the group prior to each session (Corey, Corey, & Corey, 2014; Leszcz & Yalom, 2005).

Course Content: Teaching

With regard to teaching students who are from rural areas and will most likely ultimately practice in rural areas, I believe that my service experiences have helped those students by giving them a detailed account of how we can use various social work roles to lead quality interventions in various settings. Social work students should be prepared to be independent practitioners and skilled in relating to various socioeconomic classes and ethnic groups. They also appear to benefit from a combined generalist educational and rural field instruction experience (Helton, 2010). In short, the integration of what they get in their field experiences are undergirded with in-depth exploration of various aspects of issues within the classroom setting. I hope that my students have received valuable insight from the lessons I've shared with them during classroom instruction. Particularly, I hope they recognize that through the use of social work skills that have been shown to be particularly effective in rural communities—such as living and working in the same community where you practice, reflection of the impact of the community on the practitioner, as well developing a deeper understanding of the group you are serving—it is possible to conduct quality practice that not only is applicable to rural settings, but any setting where they eventually may practice as social workers (Green, Gregory, & Mason, 2009).

Arkansas is a rural state in which many of my students are born and raised, or currently live. We do not have a specific rural component of our curriculum but my colleagues and I find ways to weave our rural work experiences into our teaching.

One of the roles I've had the pleasure of fulfilling during my university work is that of a Field Liaison. Each semester I help a group of eight to 10 students who are placed in rural social work field sites navigate internship challenges. In each class we discuss how our course content affects their classroom and experiential learning while in the field. Research has shown that first person accounts of rural stories help students become more sensitive to needs of a community (Kropf, 2003; Lavan, 2008). Therefore, I'm confident that by modeling various roles used in program development I helped grow and lead via the 100 BMOGLR the educational experience of my students was heightened.

Learning Outcomes

So, how exactly have the learning outcomes of my students been effected by the work I have done with the 100 BMOGLR, specifically the 100 Academy program? In short, my experiences have, at minimum, inspired a few more students. There haven't been significant changes in the number of students who take, pass, and move on to graduate from our program. There has been a qualitative shift, however, in the depth of discussions held in each class. This depth has been exhibited in students providing more in-depth responses on exam questions as well as demonstrating a willingness to take more nuanced perspectives when writing community assessments and other written assignments. This has led to a more relaxed classroom setting, one where the students receive the necessary rigorous education to earn their graduate degree while

also learning the importance of having flexibility in their approach to what constitutes effective social work practice. Oftentimes we don't fully express the value of trial and error learning as a professional. By having shared both the ups (e.g., the success of the mentoring program) and downs (e.g., the struggle to get more community members and parents involved) of my experience I think that value has been added to the learning experience of my students.

By being able to share the experiences of working with my mentoring organization, I have been able to provide students with real world examples of community social work practice and I have also been able to provide students with the opportunity to gain their own experiential learning experiences by participating in some of 100 BMOGLR's community events. Specifically, eight graduate and two undergraduate students from my social work program attended the 2014 Mentoring Across a Lifetime conference and the number who have registered to attend the 2015 conference has more than doubled. The feedback I received from their experience was very positive and many of the students shared that not only did they enjoy seeing social work community advocacy in action, they also were now inspired to "give back" via mentoring in the future. One of the sayings that we often give voice to in social work is "going where the client is." By being able to see community members come together as a participatory learning experience, I strongly believe that my students who attended the event will use their experience to better relate to their future clients and other community members who they may work with in the future.

Final Thoughts: Chasing the Learning

Leading the 100 BMOGLR has afforded me a wealth of experiences to share weekly with my students. One mantra that I have given all of my students and advisees over the past decade has been to "Chase the Learning, Not the Grade." I am proud to report to all who have heard my message that I have taken my own advice on this life course. The learning that I've received, and continue to receive daily, throughout this process of focusing my university service work on the greater community at large is worth more to me than any letter grade in any class. I encourage all of my fellow social work practitioners and educators to expand how we reach outside our comfort zone to practice and educate by actively applying the skills we teach our students in our local communities. This is of particular importance in rural settings where our unique ability to work closely with our clients has prepared us to be more cognizant of the issues that our community populations face. When one does this, not only will one enrich one's community, one will also enrich one's teaching and the classroom experience of students by having more to give them with regard to pertinent, current, real world issues (Skilton, 2011).

"Communicating the goal of social justice as part of both the social work code of ethics and the profession's person-in-environment perspective has been a challenge for social work educators in the classroom" (Rocha, 2000, p. 53). One of the best ways to enhance our ability to do this as educators is to take the student outside of the classroom to actually examine and feel for themselves the benefit of effective social work practice to individuals, groups, and communities (Goldstein, 2001).

This past December, during the graduation of the 3rd 100 Academy class of mentees, included in the crowd were several of my current and former students. I didn't reach out to them to solicit their attendance, and no extra credit or any course incentive was offered. They reached

out to other members of my organization because after hearing my stories about the program, and the young men who matriculated through it, they wanted to attend the ceremony to see for themselves the impact the program has had on the young men, their families, and the greater community. After the formal part of the graduation was over, two of my students approached me to thank me for showing them a different side of social work that they hadn't seen put into practice before.

I'll close by sharing a quote from the American author, William Arthur Ward, "*The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires*" (William Author Ward Quotes, n.d.). This quote represents the lofty goal that many junior faculty, myself included, embrace as we enter the world of higher education. That said, the realities of balancing teaching, research, and service, in the pursuit of tenure sometimes makes it difficult to bring that same drive to the classroom after a couple of years in the academy, and the desire to inspire may be replaced with the desire to just survive. My hope in having penned this manuscript is that social work instructors feel compelled to take chances and fully thrust themselves into their roles of teachers, researchers, and community servants and then bring all of the valuable lessons from that experience with them back into the classroom to teach students. What I've found most rewarding in my experience is that, contrary to popular belief, excelling in one of the three areas doesn't take away from the others, it actually enhances them.

References

- Aronson, J., & Steele, C. M. (2005). Stereotypes and the fragility of academic competence, motivation, and self-concept. In A. J. Elliot & C. S. Dweck, (Eds.), *Handbook of competence and motivation* (pp. 436-456). New York, NY: Guilford.
- Compton, M. T., Thompson, N. J., & Kaslow, N. J. (2005). Social environment factors associated with suicide attempt among low-income African Americans: The protective role of family relationships and social support. *Social psychiatry and psychiatric epidemiology*, *40*(3), 175-185.
- Corey, M. S., Corey, G., & Corey, C. (2014) *Groups: Process and practice* (9th ed.) Belmont, CA: Brooks/Cole
- Dreuth, L., & Dreuth-Fewell, M. (2003). Emerging themes in community-based training. *Academic Exchange Quarterly*, *7*(3), 189-193.
- Goldstein, H. (2001). *Experiential learning: A foundation for social work education and practice*. Alexandria, VA: Council on Social Work Education.
- Gose, B. (2011). Junior professors: Juggling teaching, research, and advice. *Chronicle of Higher Education*, *57*(42), B42-B43.
- Green, R. C. , Bretzin, A., Leininger, C., & Stauffer, R. (2001). Research learning attributes of graduate students in social work, psychology, and business. *Journal of Social Work Education*, *37*(2), 333-341.

- Green, R., Gregory, R., & Mason, R. (2009). Preparing for social work practice in diverse contexts: Introducing an integrated model for class discussion. *Social Work Education*, 28(4), 413-422. doi:10.1080/02615470802109999
- Helton, L. R. (2010). Faculty perceptions of differences between teaching rural Appalachian and urban social work students. *Contemporary Rural Social Work*, 2, 66-74.
- Jiao, Q. G., & Onwuegbuzie, A. J. (1998). Perfectionism and library anxiety among graduate students. *The Journal of Academic Librarianship*, 24(5), 365-371.
- Kennedy, H. (2014, December). *From playgrounds to prisons: An updated look at school-based arrests in Arkansas*. Arkansas Advocates for Children and Families. Retrieved from <http://www.aradvocates.org/wp-content/uploads/Playgrounds-to-Prisons-December-2014.pdf>
- Kropf, N. P. (2003). Future training and education recommendations for rural gerontological social workers. *Journal of Gerontological Social Work*, 41(3/4), 287-299.
- Lavan, A. (2008). Community social work and the learning circle. *Journal of Teaching in Social Work*, 28(3/4), 310-319. doi:0.1080/08841230802160068
- Leszcz, M., & Yalom, I. D. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books.
- Matlin, S. L., Molock, S. D., & Tebes, J. K. (2011). Suicidality and depression among African American adolescents: The role of family and peer support and community connectedness. *American journal of orthopsychiatry*, 81(1), 108-117.
- O'Donnell, P., Richards, M., Pearce, S., & Romero, E. (2010). Gender differences in monitoring and deviant peers as predictors of delinquent behavior among low-income urban African American youth. *Journal of Early Adolescence*, 32(3), 431-459. doi:10.1177/0272431610397661
- Rocha, C. J. (2000). Evaluating experiential teaching methods in a policy practice course: The case for service learning to increase political participation. *Journal of Social Work Education*, 36(1) 53-63.
- Schott Foundation for Public Education (2012, November). *The urgency of now: The Schott 50 state report on public education and Black males*. Retrieved from <http://sparkaction.org/content/urgency-now-schott-50-state-report-public->
- Skilton, C. J. (2011). Involving experts by experience in assessing students' readiness to practice: The value of experiential learning in student reflection and preparation for practice. *Social Work Education*, 30(3), 299-311. doi:10.1080/02615479.2010.482982
- Taylor, M. J., Merritt, S. M., & Austin, C. C. (2013). Negative affect, delinquency, and alcohol use among rural and urban African-American adolescents: A brief report. *Journal of Child & Adolescent Substance Abuse*, 22(1), 69-84. doi:10.1080/1067828X.2012.729923
- Tuckman, B. W., & Jensen, M. A. C. (1977). Stages of small group development revisited. *Group and Organizational Studies*, 2(4), 419- 427.

William Arthur Ward Quotes. (n.d.). *Quotes.net*. Retrieved from <http://www.quotes.net/quote/6655>.

Williams, J. M., Greenleaf, A. T., Albert, T., & Barnes, E. F. (2014). Promoting educational resilience among African American students at risk of school failure: The role of school counselors. *Journal of School Counseling*, 12(9), 1-32.

Witherspoon, K. M., Speight, S. L., & Thomas, A. J. (1997). Racial identity attitudes, school achievement, and academic self- efficacy among African American high school students. *Journal of Black Psychology*, 23(4), 344-357.

Yalom, I. D., & Leszcz, M. (2008). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.

Book Review

by Peter A. Kindle

Rural Social Work in the 21st Century

Michael R. Daley

2015

Chicago, IL: Lyceum Books

309 pages

Paperback, \$49.95.

ISBN-13: 978-1935871613

Anyone who has taken on the challenge of completing a dissertation will understand how valuable a good synthesis of prior research can be. Michael Daley has provided just such a gift to rural social workers and social work programs focusing on the preparation of rural social workers. This folksy, accessible, and sometimes quaint synthesis of the most recent scholarship on rural social work, almost two-thirds of the 420 chapter endnotes are dated since the turn of the millennium, was enriched by Daley's decades of experience as a rural social work program director and educator coupled with his leadership experience as president of the National Rural Social Work Caucus and Association of Baccalaureate Program Directors. Intentionally avoiding the more common edited book approach to rural content, Daley's ten chapters speak with a singular and wise voice. Every social work educator teaching a course on rural social work needs to quickly get a copy of this book.

The historical roots of the social work profession were urban, and to some extent, contemporary social workers are more likely to be educated and employed in an urban or suburban context as Daley demonstrates in his introductory chapter. Preferring a sociocultural understanding of *rural* to geographical or population density definition helps the reader grasp one of Daley's central arguments – that rural social work practice requires the same kind of targeted cultural competence as any other kind of cross cultural social work practice. Pockets of rural culture may survive even in urban contexts, extending the relevance of this book for any social worker. Although rural practice may be more isolating and less specialized than urban work, deeper community involvement, stronger interpersonal relationships, and enhanced autonomy may be ample rewards to social workers focusing on rural people.

To understand rurality as a diversity issue requires Daley to walk a careful line in chapter two. Rural cultures do share general tendencies, but Daley also wanted to avoid stereotyping and oversimplifying the variability that exists. He finds a good balance when he describes how rural values are attached to the land, family, churches, schools, and informal helping networks. He suggests that rural people, in comparison to urban dwellers, prefer the personal in relationships and cherish community which can lead to greater openness in communication and greater respect for tradition. The mythology of self-reliance is often quite alive in rural areas. Acculturation to any rural community will be demonstrated by learning the language spoken, the outdoor nature of rural recreation, appreciating rural gun culture, and embracing the food, music, arts, and even folk remedies frequently practiced. Daley's picture of rurality is not rose-colored. He also mentions how closeness can fuel a basic distrust of outsiders, the complex influence past

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generations may have on one's reputation today, the dominance of hidden power structures in most rural communities, and the absence of diversity of employment opportunities.

In case the second chapter did not sufficiently address rural diversity, Daley certainly compensates for that with chapter three. His basic understanding is that social work practitioners cannot effectively practice without a clear understanding of the individual in context. When that context involves the intersection of rurality with race, aging, or sexual orientation, greater understanding is required. Daley specifically addressed African American, Hispanic, and Native Americans, showing not only that their rural presence is often dominant regionally, but also some of the unique challenges they face in rural areas. Heterosexism and religious opposition to alternative lifestyles can be a challenge for gay, lesbian, bisexual, and transgendered people in rural areas; and the health concerns of rural elders contribute greatly to their service needs.

Having described the diverse service needs of rural peoples, Daley then moves on in chapter four to address rural social welfare policy. He understands social welfare policy as "an objective and standardized approach to a course of action designed to help those in need" (p. 105) which apparently conflicts with the personal relationships valued by rural peoples. Because most policies are established by outsiders who are unfamiliar with the local context, unintentional barriers to access for rural residents can be created. Requiring delivery of an application for services at a central, urban location or through an online system will leave many rural needs unfilled. Daley is especially critical of national policies that have a disparately negative effect on rural health care delivery such as lower fee for service rates in Medicare and Medicaid. The chapter closes with identification of organizations addressing rural policy issues such as the Rural Policy Research Institute and the need for action and advocacy to improve social welfare policy for rural areas.

The delivery of formal social welfare services in rural areas is challenged by access, availability, inadequate funding, scarcity of professional staff, and rural reluctance to embrace formal services. How these challenges are approached in the delivery of mental health, substance abuse, healthcare, child welfare, domestic violence, and immigration services are discussed in detail, but the themes tend to recur showing that distance, stigma, and increased costliness of rural service delivery present challenges.

In chapter six Daley confronts the rural mythic idyll by providing a short history of rural North America and the incipient rise of rural social welfare in Freedman's Bureau services for former slaves, Country Life Commission initiatives under Theodore Roosevelt, and the extensive increase in rural social welfare services that were funded by the Federal Emergency Relief Administration in the 1930s. Interest in rural social welfare tended to wane and remain quiescent from the outset of the Second World War until the 1969 Annual Program Meeting of the Council on Social Work Education that included a workshop entitled "Education for Social Work in Rural Settings." By 1976, the first edition of Leon Ginsberg's *Social Work in Rural Communities* was published and the National Rural Social Work Caucus began. Today, the Caucus' work continues with a summer National Institute each year and a new open-access online journal, *Contemporary Rural Social Work*, that help address the professional isolation of generalist social work practice in rural areas through a strength perspective that builds on community.

The tone changes a bit in chapters seven through nine with a more explicit practice focus. In chapter seven, Daley presents the Down-Home Model for rural social work practice that is a blend of practice theories. He combines problem solving theory, systems theory, the strengths perspective, and social exchange theory within a generalist model along with discussion of a specific case study to enhance the reader's understanding. The next chapter addresses professional ethics for rural practice. He uses the term *fishbowl* to emphasize the absence of anonymity that often accompanies rural living. Rural practitioners are provided specific advice for dealing with the unavoidability of dual relationships, the challenges associated with maintaining confidentiality, and the competency issues that may arise when other helping professionals are unavailable. The scarcity of consultation requires a degree of circumspection by rural practitioners that may not be required in urban contexts with regard to personal behaviors and anticipation of potential ethical conflicts which places a premium on preemptive informed consent and documentation of services. In chapter nine Daley describes practical implementation of his Down-Home Model and the personal characteristics that appear best suited for rural practice.

In the concluding chapter, Daley mulls over the possible future of rural communities and rural social work. His vision of rural life makes much of the hard work, honesty, and thrift often associated with rural peoples and sees much hope for these traits sustaining the resilience of communities threatened by globalization and agricultural policies that promote consolidation of agribusiness. Rural life is changing as Daley asserts, but one is left wondering whether he has understated the degree of change that has taken place. Iowa, after all, was one of the first states to legalize same-sex marriage. Telecommunications, television, and travel have improved substantially, eroding the isolation borne by distance. The fact that rural communities as a whole survive economically only because of redistribution of resources from urban areas makes their continuation potentially problematic.

Daley did not intend this book to be a critical analysis of rural social work, and it is not. Readers with a more critical orientation might find themselves asking many questions, but his intended audience of social work students and social workers preparing to work with rural people should begin their education here. This synthesis of the literature on rural social work is accessible for undergraduates and will provide a strong foundation to develop culturally sensitive practice with rural people.

Book Review

by Karen Harper-Dorton

Rethinking Rural: Global Community and Economic Development in the Small Town West

Don E. Albrecht

2014

Pullman, WA: Washington State University Press

232 pages

Softcover, \$17.09

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In *Rethinking Rural*, D. E. Albrecht, Director, the Western Rural Development Center, Utah State University, eloquently and concisely guides the reader in revisiting the evolution of the American West as a vast, isolated, and unsettled region rich in natural resources that attracted fairly self-sufficient settlers to remote and previously unsettled areas. In Section One, the author presents the challenges of early settlement of the rural West up to the mid twentieth century in the first three chapters. The reader is reminded of various federal land acquisitions and resource management efforts germane to so many parks and recreation areas that support tourism. Human dependence upon the biophysical environment is no better depicted than in the settlers' early struggles to establish homes and communities amid forests, mountains, and plains regions that were mostly devoid of water. Arid plains and great distances would eventually be crossed mostly by rail. Rich in minerals and their mining, the lack of water proved to be a significant obstacle despite eventual development of dams and irrigation. Indeed, as much as fifty-five percent of the land of thirteen western states came under federal jurisdiction protecting some remote regions and harnessing resources to better serve arid territories.

Growth in transportation, manufacturing, newspapers and television partially fueled transitioning from the early Small Town in Isolation Era to the Mass Society Era of the 1950s to 1980s. The rural west experienced less dependence on natural resources and agriculture as communication and manufacturing increased. Changes such as reducing open range areas for livestock grazing, increasing pesticide usage, conserving water through various dams and irrigation projects, clear-cutting forests, and mining minerals such as uranium provided employment and protected some natural resources, but also produced negative ecological consequences. Furthermore, sparsely populated areas isolated by distance only continued to be at great disadvantage for employment as well as resources.

Moving to Section Two, the remainder of the book, Albrecht notes that location becomes less relevant as the transition to a Global Society Era gathers momentum. Internet, online employment, changing communication and change processes for goods and trades may bring new avenues for growth to rural areas.

Chapter four continues discussion of resource management by the U.S. Forest Service, National Park Service, Bureau of Land Management, and U.S. Fish and Wildlife Service. While resource and wild-life preservation are important goals, there are both positive and negative

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implications of ecological protection in view of political issues and inadequate funding or in stances of public demand for purposes of new or different land usage. Based on strategic roundtable sessions with thirteen states in the western region, Albrecht identifies three major concerns for families and communities in the rural West in anticipation of opportunities the Global Society Era may or may not hold. First, appropriate uses of natural resources need to be addressed. Second, employment opportunities for place-bound persons and vulnerable communities must be identified and developed to mesh with changing technologies. And third, rural development to improve leadership, reduce inequalities and enhance human capacities is essential. Place-bound rural people need to build local communities in order to experience meaningful participation on any other level.

Chapters five, six, and seven address resource concerns of Western water, energy, and biodiversity respectively. Important to agriculture, water continues to be at the core of concerns and demands as population and consumption increase raising issues of harnessing water power without adequate protection for salmon and other food sources or allowing contamination from chemicals and invasive species. Water and energy are interdependent in producing and cleaning processes. The rural West is rich in coal, oil, and natural gas that while abundant, carry the risk of contamination from greenhouse gases as well as the depletion of resources for future generations. Resource utilization and protection are critical concerns to the balance of life forms in our ecosystem. Preserving biodiversity requires attention to issues such as pollution, extractive industries, population growth, and protection of noninvasive species for the future of the West as part of the era of the global society. Easy and immediate solutions for this mix of resources are not readily available in the obligatory and ongoing effort to protect natural resources.

Place-based economic and rural development are addressed in chapters eight and nine and include creative recommendations for growth. Being part of an increasingly global society, the rural West is confronted with changing and inadequate employment opportunities as agribusiness adjusts to rural, place-based economies either because of large-scale operations elsewhere or due to out-sourcing to international entities. Larger population centers offer specialization opportunities on a much broader scale. One example given in *Rethinking Rural* is the concentration of health care specialists in metro areas versus the small-town doctor. Indeed, rural residents in need of specialized care must seek such help in larger population centers.

Nevertheless, the Global Society Era includes those who seek community connections and can contribute to improving employment opportunities. Specific recommendations include: (1) increase local production such as fresh, nutritious, organic foods; (2) encourage entrepreneurs who have special skills and interests; (3) attract workers who value rural living and perhaps work at home via internet; and (4) develop regional clusters for development such as partnering with rural development centers and local universities. Capitalizing on the region's beauty and resources, some high-end developments offer exquisite views and are markets for many in search of relocation in advantaged, less metropolitan communities. Disadvantaged communities lack amenities, may be home to undocumented immigrants, and have language and education disparities. The West is home to many Native Americans, stripped of their land that is now owned by the Department of Interior. Disadvantaged by lack of ownership, financial security is not really within their reach. Education is one avenue to explore toward better employment and security.

Chapters ten and eleven raise issues of retaining and increasing human capacity as out-migration of the brightest and best is a resource lost. Community development and leadership programs and opportunities are needed but are costly and challenging for rural community participation in the global society. Rural poverty with accompanying lack of education, employment, single parenthood, isolation, and lack of opportunities continues since the days of the Great Depression and the War on Poverty. Albrecht sites research findings confirming increasing levels of inequality and poverty. Cultural and structural changes are called for but without strong political and financial support are unlikely.

Concluding remarks call for appropriate use of natural and sustainable resources, increasing employment opportunities through development and innovation, and building human capacity through education and growth. Tending to community development at home is important to the future of the rural West. Participation in the Global Society Era may very well foster new insights and strategies for quality of living in small towns and rural areas in the West as well as other areas of the U.S.

As a social worker with Appalachian roots and experience in delivering services funded by the 1960s War on Poverty, I would enjoy using this book as a text for a doctoral seminar. The succinct history of rural policy development in response to natural resources utilization and preservation provides rich information for policy debates, economic research, and recommendations for leadership in so many small towns and rural areas. The final chapter could have addressed the importance of rural relationships, interconnectedness of people and places, and the importance of understanding a rural culture. However, this comment likely reflects my social work values more than the economic and policy concerns that are central to *Rethinking Rural*.

Book Review

by Claudette L. Grinnell-Davis

The Last Best Place? Gender, Family and Migration in the New West

Leah Schmalzbauer

2014

Redwood City, CA: Stanford University Press

224 pages

Paperback, \$24.95

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This ethnography on Mexican migrants to southwest Montana fills a gap in the immigration literature by examining the role of gender and geography in a previously unexplored relocation zone for migrant families. In addition, this ethnography also provides a rigorous understanding of the ethnographer's own position in relationship to space, place, and privilege as a part of the ethnographic research process, and as such provides a robust model of deconstructing one's own position of epistemic privilege in the opportunity to conduct this research in the first place.

The New West is a sociological designation for the transformation of places like southwest Montana from a predominantly agricultural area to a desired relocation spot due to the influx of "lifestyle migrants." These lifestyle migrants move to the area either for the opportunity to enjoy outdoor leisure pursuits on a regular basis, or for an idyllic lifestyle free of concerns related to violence and corruption. As a part of this migration, these new migrants have brought more fiscal capital and higher expectations for quality of life than that which previously existed in the area. As a result, in addition to the traditional demands for migrant labor in the ranching and agriculture sectors, the need for skilled and unskilled construction labor has resulted in an increased influx of Mexican workers and their wives and children into southwestern Montana. Together, these couples form survival teams with complementarian divisions of labor to meet the needs for the entire family.

For some of the families, this division of labor mirrors what life was like for them in their home regions of Mexico, where men worked agrarian jobs and women took care of domestic duties. This comfort in turn supports their own self-defined sense of an idyllic lifestyle. However, these families are also more self-reliant than they may have been in the regions in Mexico from which they come, as they live in isolated locations separated from each other by many miles. For the women, many of whom speak no English or have no access to transportation while their husbands work, their lives revolve around their homes and their children. Some women in these families embrace this similarity to the lifestyles they lived before coming to the United States, embracing what the author calls *survival femininity* as a means of providing for their families and assuring their ongoing existence. However, for others, this rigidly domestic lifestyle is a prison where even contact between others of the same ethnic community is limited, both in terms of fiscal and social independence.

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At the same time, this isolation is part and parcel of their survival. The author identifies southwest Montana as a location in which anonymity is impossible; there is no way for migrants to blend in with a predominantly White culture and as a result they perceive themselves as being perpetually scrutinized. In addition, given strong anti-immigrant sentiment in the area (which is also an area in which white supremacy has a strong history), these families live in perpetual fear of being pulled over during a traffic stop, held on immigration status, and then deported. This combination of marginalization and geographic isolation frequently results in a complete lack of community on which to fall back should something as catastrophic as a deportation happen. Thus the isolation of the geographic terrain in Montana also provides a measure of security as they can stay out of the public eye and minimize potential involvement with Immigration and Customs Enforcement (ICE).

The Great Recession, which took place during the author's research, disrupted both the practice of gender norms and the stability of the families. As frequently happens in recession periods, high-paying traditionally male-occupied positions rapidly decreased while low-wage traditionally female-occupied positions—positions which had not been readily available to Mexican migrant women in the past—increased. This resulted in a form of survival femininity that not only involved maintaining the complementarian role traditions as much as possible but also simultaneously becoming transgressors of these traditional norms, brought on by having to work outside of the home. Combined with the physical isolation and the in-home presence of unemployed and economically disenfranchised husbands whose own well-being is threatened, this brought on physical and emotional exhaustion.

This same complexity of negotiation between traditional ways and new ways has always been a way of life for the second generation (children born in Montana) and the “halfway generation” (children born in Mexico but who experienced part of their childhoods in Montana). Similar to other children of migrants in other locations, these children have and exercise power by being interpreters for their parents. At the same time, they internalize the threat from their parents' documentation status. In addition, because of a lack of geographic proximity to others, these children are frequently socially isolated even while being in school. This isolation becomes harder for boys than for girls, but with it comes a paradox: while the bullying that these boys receive encourages them to reinforce their fathers' traditions of masculinity, the ability to function in their school settings makes the younger girls transgressors of the family roles. What promotes survival away from the family has the potential to create threat within it. So while school and social settings for children in Montana may result in role congruity for the boys as they become young men, the same settings produce a situation in which young women have to do more gender and ethnic identity work as they negotiate their own multifaceted identities in relationship to their families.

Overall, while some of the experiences of Mexican families in Montana mirror other migrants in the United States, the geographic isolation of Montana leads to other complications. The notion of community is a matter of weak ties with minimal relationships, except for passing encounters in local stores or at the monthly Spanish Catholic Mass. So in effect, this is not an ethnography of a community per se, but of an aggregate of individuals scattered in an area who share like characteristics outside a community.

In a twist of irony, it is precisely this aggregate nature that allowed for this research to be done in the first place. The author identifies that it is precisely her position as a scholar who spoke fluent Spanish and who had young children that allowed her to complete this ethnography. Being a mother created a common identity between the women in these migrant families and the researcher, allowing her entrée into these families' lives. Because of her bilingual language ability, she was a participant observer in her work as she would occasionally provide herself as a resource for women who needed her language skill as well as a volunteer in a food bank whose target population was predominantly the families she was studying. Despite writing about isolation in the lived experiences of these women's lives, it was through her intersection with these shared identities - and the relationships that developed as a result—which allowed for this work to take place at all. So in the end, while this book may be about isolation among Mexican migrants in the New West based on gender, it is also ultimately about relationships—because without relationships, the research could not have been completed. How this is framed in terms of privilege and oppression is left for interpretation.

A Poetics of Place: The 2nd Annual Poetry Section of CRSW

Danielle Beazer Dubrasky,
CRSW Poetry Editor
Southern Utah University

Editorial Comments

Geri Giebel Chavis, a long-time practitioner of poetry, states “Poets achieve a vivid compactness unlikely to be found in any other literary genre. A few well-chosen words and literary metaphors can tap a well of deep feelings, thoughts, and associations” (2). The primary purpose of poetry therapy is to facilitate healing from emotional, physical, or mental trauma. The purpose of *Contemporary Rural Social Work* journal is to provide a professional forum for social workers to share research, practices, and pedagogy in their field. The goal for this poetry section is to become a site for poetry that addresses an intersection between rural identity and human services. The poetry can be written from the perspective of the social worker, the client, or someone who is an observer. Social workers witness the human experience at its most challenged times and stand as advocates for those who can’t protect themselves. Can this same witness be expressed in poetry without being didactic, cliché, or too abstract, with all the nuances that poetic language is capable of creating? What kind of poetics develops from this intersection? What additional perspective do these poems give to the social work field? What happens at the crossroads of poetry, rural experience, and human services? The poetry that stands at this unique intersection needs to be strongly grounded in rural experience, yet be able to “tell it slant” to quote Emily Dickinson, allowing “a few well-chosen words” to convey a connection to the field of human services. This very narrow criteria allows for a unique forum, not only for the social work field, but also potentially in the area of contemporary American poetics—especially poetics of place.

Rural identity is often strongly rooted to a connection to place that can be complicated by both a sense of belonging as well as the challenge of economic or social disparity. With that idea in mind, the poems in this issue present a spectrum with regards to place. Abandoned structures—a house, a church or even a college—stand as landmarks of a fading past; in the midst of these structures are the memories of people who have left or the struggles of those who remain and endure. Thus, a subtle motif for these poems would be that of ghosts—of historical events, of past relatives, or even of a younger self. The traces of the past that intersect the present are perceptible to only those who understand their context—a storefront with a memorial to Emmet Till or a line of trees planted as a legacy. Sometimes the notion of human services is only implied by virtue of how abandonment has changed the vitality of a rural place. But there are other poems that address the experience of social work head on. Barbara Cecelia Harroun’s “What I Left, Unknown” describes a young social worker’s well-intentioned naiveté as she visits homes in Appalachia while Libby Day Merrill’s “Doublewide” gives voice to those struggling with rural poverty.

Within this range are other depictions of rural experience through a nostalgic memory of climbing a silo as a child or the poignancy of a daughter caring for her aging mother. However, what I hope the reader will also take note of is the craft of these poems, how images can weave a

connection between land and people as in these lines from Zara Raab's "That Is to Say": "The mill stands beneath the looming/Mayacamas, smoke rising/over the town where the highway/seams the land of the San Andreas/and brings only tourists passing/to Redwoods or House of Mystery." This section conveys a unique form of poetics—poems that stand as witness and advocates for those who are vulnerable but at the same time allow a few words or gestures to create nuanced moments of resilience in the midst of adversity.

One way to get to know a place is through their poets. The literary world of South Dakota (the location of the 2015 Rural Social Work Conference) has just transitioned from one Poet Laureate to another. Lee Ann Roripaugh has been appointed Poet Laureate, replacing David Allen Evans who has held that position since 2002. Their distinctively different writing styles give a diverse portrayal of both their relationship to language and to South Dakota. Their linguistic difference can be seen by looking at two of their poems that portray images of nature.

David Allen Evans has published eight collections of poetry. In "Sixty Years Later I Notice, Inside a Flock of Blackbird" Evans juxtaposes the memory of cleaning Venetian blinds with the image of a flock of blackbirds. The effect of seeing the world through Venetian blinds as a boy is described as "[pulling the] cord a few/times just to watch the outside/universe keep blinking." This memory is brought to the present as a flock of blackbirds "suddenly/rises from November stubble,/hovers a few seconds,/closing, opening,/blinking, before it tilts,/then vanishes over a hill." This short poem uses ordinary language yet spans time and distance with a sweeping overview. The simplicity of the language allows for the complexity of the "time travel" to happen almost unnoticed—the effect is as a "blink of an eye."

Lee Ann Roripaugh is the author of four volumes of poetry and the editor of *South Dakota Review*. The idea of meeting the past is explored in her poem "Chambered Nautilus" in which she describes the effect of relocating to various apartments, shedding places when they become unnecessary. A series of lines deftly weaves the notion of time travel with the metaphor of the nautilus shell:

Other times looking out the wider operculum of a new front
window, I think it's all a fantasy of space travel,
even though I'm never really sure where, exactly,
I think I'm going—although the cold, dark, and quiet deep
preferred by the shy and enigmatic nautilus is,
I suppose, an inner if not an outer space. What do
they see down there with their primitive lens-less eyes—making

their images through tricks of light like old, pinhole cameras?

Do they see the coelacanth and recognize a stranger
from their past—chambers rewinding, pinwheeling backwards into
prehistory like reel-to-reel tapes clattering on their spools?

To read these poems in their entirety, please refer to the websites of The Poetry Foundation and Coconut Magazine, respectively.

The 2016 Rural Social Work Conference will take place in El Paso, Texas. Two poets whose work relates to that area are Ray Gonzales and Ben Saenz. More information about all the above poets can be found through The Poetry Foundation.

References

Chavis, G. G., & Weisberger, L. L. (2003). *The healing fountain: Poetry therapy or life's journey*. St. Cloud, MN: North Star Press.

Coconutpoetry.org <http://www.coconutpoetry.org/roripaugh1.html>

The Poetry Foundation <http://www.poetryfoundation.org/>

Jennifer Soule

Border Town

Mobridge—like its name—two parts:
 Missouri River and the bridge
 that straddles two countries—
 Indian and White—cut off from the world
 and each other by the Mighty Mo.

On the west side—Standing Rock Reservation:
 Sitting Bull's fenced grave,
 and a monument to Sakakawea
 where wind and horses play.

On the east, deserted
 shutters-banging-in-the-wind parochial
 Central Indian Bible College overlooks
 a riverbank and cottonwoods.
 A second rate motel has million dollar
 views of water and sunset on the Plains.

Residents cross back and forth
 to gambling at the casino
 on reservation dirt-roads or
 shopping and Burger King in town.

City hall—the old high school—
 houses fading murals by Oscar Howe, painted
 during the Depression—public works for artists—
 a treasure in a town where recently

a young Lakota man was found
 stuffed dead in a trash can. Reconciliation groups
 now meet to bring the two sides together—
 with more in common than they will admit:

poverty, joblessness, isolation.
 All who can desert
 this border place
 at the edge of the earth.

Tony Reevy

Emmett

Tutwiler, Mississippi

was dressed
here, sent on home.

The storefront,
collapsing under
its own weight,
bears a new
historical marker.

Rain floods down;
scattered, fallen bricks
glisten.

At the corner
by US 61,
the last gas
station
open in town

is crowded with folks
sitting
under the awning.

Beyond it, tracts
of abandoned houses,
then the flat fields

where a huge tractor
rumbles,
working the crop.

Christopher Schmersahl

Rusty Stone Silo

Stone cracked silo circled by ruddy iron band—
I made it halfway up the orange rusted ladder
as a child, gripped with fear of where I'd land.

Whether it was phobia or reason dictating the matter,
my small white-knuckled hands descended from rung
to rung. I didn't look down: just hands and thumping patter.

As fear began to leave, senses returned—horse dung:
the fragrance of a yellowed pasture at the base
of the stone cracked silo to which I'd clung.

I took the fourth bar from the bottom at a gentle pace,
but when I had three more to go, I jumped on down.
There was relief there and childish, earthly grace.

Now that I've left the pasture and silo, and grown,
I don't wish for the climbing but the cracked silo of stone.

Lucien Darjeun Meadows

Out What Was the Kitchen Window

Spearmint lifting itself into a bush
that falls on the skirt of a Virginia Pine
Grandfather planted in the first summer
of his marriage, the July my mother

was born. Only three are left, the remnants
of diagonal rows that filled the field
between home and forest. Nothing like his
telephone line of Sweetgum down the drive,

planted a few years later, my aunt's year,
days of dollar-bags of loam, the feeling
that anything he could plant would grow—

all those trees are still there, even after
my grandparents' house became my parents'
house, then my aunt's house, trembled, and burned down.

Barbara Cecelia Harroun

What I Left, Unknown

One client chain smoked, her oxygen tank
standing sentry at her stooped shoulder.
Cigarettes and urine,
so I breathed through my mouth
as I did the assessment.

She could not tell me the day or month
or year, but as she stabbed her butt out
in the heavy glass ashtray atop her afghan
covered lap, she called for her husband to help.
When I explained he had died four years ago
the grief swallowed her face, and she sobbed
until I turned on her television to Maury
and made her soup and a grilled cheese
in a kitchen filthy enough to frighten me.

I was an hour behind by the time I left her
asleep in her wheel chair, certain her last smoke
was not smoldering. The trailer a tinderbox,
and her isolation within it, haunted me.

I was 23. I knew nothing, nothing
about the back roads that trailed
like tributaries through rural poverty—
houses within my own county
made of plywood, insulated by newspaper.

Before cell phones, a son sat with a shotgun
on his lap as I asked for his mother's last bank statement.
He snorted, and then motioned with his bald head toward the door.
I drove, chain smoking, my hand shaking so bad
the ash dropped in my flower-printed lap.

I was 24. I knew nothing, nothing. I bobbed
my long, blonde hippy hair, and wore ankle
length dresses and sensible shoes that lent
me the air of a social worker. On the way home
to my new husband, I would stop for booze
and a fresh pack of smokes. Once home,
before I did anything, I'd shower off the old people.

Once I sat in my car, in the parking lot
of the saddest nursing home in the county,
weeping. Once he had played piano for silent films.
In his tuxedo, his slicked back hair, he
was more devastatingly beautiful than Valentino.
He had shown me his photographs in a yellowing
scrapbook. He had lived down the block from me, would place
Strawberry candies into my palm and wink before walking
me out. Dapper and quiet, a life of chosen celibacy,

he was now dying alone, too sick to answer any questions
or place me. I sat in his foul smelling room on a hard
backed chair, held his hand, then watched him sleep,
seeing how he would look in two days upon his death.
In my weeping, I mourned him, but I mourned even more
that my parents would someday die, my husband, even
the children we were imagining—we would all grow old,
(if we were lucky), our bodies failing us, and we would die.
I leaned my seat back, spent, and took a nap in early
spring sunlight until a nurse knocked on my window,
her cartoon scrubs absurdly cheerful, relief on her face
when I came fully awake, and reassured her I was fine.

I was 25, and I knew nothing, nothing
about how to explain that I loved driving
farther out, on a road no one knew existed,
around a bend of white gravel, where a fog lifted
in the sultry August around me; and then beneath
a massive tree that seemed to bend down to protect
a small, white cottage, so kept and tidy

I would slow to blink, look again, blink—
the glider swing, measured flowers,
an old push mower leaning against
a pristine shed, so crisply white.
It was a pleasure to look at, to walk through
the deep silence that lived there with her, my client.

I felt a longing and a loss before she stepped
to the front porch. Her gray cotton dress
pressed with an iron she heated on her
ancient stove. Her yellow white hair braided,
then bunned tightly under her koppa. Her bare
feet naked and clean. Blind and alone, she offered
me respite in the cool dark of the drawing room,
well water in an aluminum cup, so cold my eyes

watered with gratitude. Grateful too that she could not see me, so moved by her gift. She touched my face with such gentle grace. I would close my eyes, silent as she saw me. And when I revealed

I was leaving, going back to school, she clasped her hands in her lap, and smiled, saying plainly, "I am so pleased for your happiness." Her own tears tracking down the fine creped wrinkles of her face.

On the porch we held each others' hands, in the way I had only ever done with my mother. Perhaps she prayed for me, and then I let go, stepped off the porch, already gone.

I was 25 and knew nothing, nothing but that my skin was too thin, I had no professional distance, and this place and its people were my own and I had to leave them.

Raymund P. Reyes

The Old Church Bells

The bells of the old church still ring,
throwing their echoes to the wind.
Not to call for mass. No more.
When the wind is strong,
it sways. To delight the birds
that gather in the eaves of the belfry.
It tolls for the rust, moss, dust
and cobwebs that have claimed
the deserted church.

Only the doves seek sanctuary now
to the forgotten god (or Holy Virgin it was)
that people once worshipped there.

But the bells still ring—
listen on quiet hours:
echoes of the *barrio* gone.

Day Libby Merrill

Doublewide

She sat at the dinette and watched snow blow through the crack in the trailer wall.
Damn! Matt had promised to fix those holes before winter,
but it had snowed early this year.

Since the factory shut down,
he was off every day God-knows-where in his truck,
at least for now—
they had already repo-ed the flat screen,
so she had to watch *Ellen* on the little portable.

At least he hadn't taken to drink
like her sister Jean-Marie's husband.
She had stopped going over there, tired of seeing the bruises
and hearing about the latest "accident."

She looked down at her swollen feet.
Everything was so expensive, and that before the baby was born.
They'd lost their insurance when Matt lost his job,
and she didn't work enough hours at the grocery store to get benefits.
How would they pay the doctor bills and the hospital?

She thought about her other sister in Canada—
everything covered and a year-long maternity leave, protected by law.
She was no Commie but that seemed to be a better way.
Everyone she knew here was down on Washington.

Uncle Fred said he was sick and tired of them politicians
putting their hands in his pocket every time he turned around.
Saw Obama-care as the latest scam,
said he wasn't about to pay for benefits for the indigent poor.
Live free or die—that was his motto.

Indigent poor—guess that was what she and Matt were,
unemployed and uninsured.
Live free or die. What exactly did that mean?
Nobody she knew lived very free these days.

Gail Folkins

Upstream

Coho salmon return—
silver scales on stones
in streams that whisper,
home grows near.

Tumors, budding quiet,
spread inside you,
your feet swollen
from their reach.

No remedy exists
for upstream journeys,
each foot soaking in a bath
of tepid rivers.

I look at your toes, a
mother's nails grown long,
thick white scars of the
rock-bruised salmon

thrashing under
Douglas firs that beckon
toward the place
of birth and death.

Your smile reaches
down your feet,
warmed from bathwater
and wrapped in towels;

under Mt Rainier's pink light
I trim your toenails,
silver coho scales,
all of us returning.

Zara Raab

That Is to Say

Like a volcano, the sawmill
burns and smokes above my village.
Jostling for place on a pebbled street
stretching out almost a mile
to unfenced pasture and forage,
houses hide behind their shrubbery.
Yards might drop of a sudden
to embankments and rushing creeks,
where berries grow thick and jumbled.
At dusk the mill hands come in
to sleep unwashed on tousled sheets
and dream of fire and blade.
The mill stands beneath the looming
Mayacamas, smoke rising
over the town where the highway
seams the land of the San Andreas
and brings only tourists passing
to Redwoods or House of Mystery.
In the rain-drenched glen, I tent
my umbrella and peer from the rim
spoked as a high spinning wheel.
Each nod of greeting is a codicil
begun by codgers in the old-time,
some quite kind, some less so,
name and lineage at every entry,
the lot bound by milk and semen,
and the sticky, viscous, untapped sap
of pine growing high in the valley—
bound by these and mulish conviction
that comes of roots set deep.