Holistic Approach to Addressing Community Needs in Rural Communities

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Abstract. The purpose of this study was to assess health of a rural Texas community in efforts to better understand and develop a plan of action for developing community intervention for increasing availability of human resources. Researchers asked various questions to understand the availability and accessibility of resources within a rural community using a community needs assessment approach. Participants were recruited by the researchers directly within the community using purposive and snowball sampling techniques. The sample size included 361 participants in a rural community. The overall quality of life for the rural participants was slightly lower than what researchers considered to be healthy. Participants also indicated that the current resources within the rural community did not meet the needs for mental health (54%; n = 195), physical health (46.8%; n = 169), or social services (55.4%; n = 200). Implications for such findings suggest the need for strength-based collaboration and services informed by the communities themselves.

Keywords: rural community, community needs, quality of life

The cohesiveness and bonds within rural communities are often long lasting and limitless. Through the support, trust is built as well as the ability to make positive change within the community (Steiner & Markantoni, 2014). There is strength of the perceived human relationship/networking in rural communities through shared hardships and other unifying events/experiences. Rural communities are known as resilient due to some of the hardships experienced and how they carry one another through them. However, a lack of supporting services fails to further enhance the quality of life for rural residents. The disheartening reality of limited availability and accessibility to health resources surrounds rural America has been continuously reported in various scholarly reports and sociological studies. Rural communities are continually challenged with sustainable development such as limited local assets, limited local abilities, limited access (information, trade, services, and finance), limited innovation, and vulnerability to economic conditions. It has been documented that some rural area citizens travel up to 10 miles to urban areas to seek medical treatment (Pew Research Center, 2018), thus suggesting a lack of available health and mental health resources in rural environments. More so, accessibility to resources is commonplace knowledge. Access to health resources, such as hospitals and primary care, has been the focus of rural health research (Hartley, 2004). Because of these limitations in resources and accessibility, more innovative practices and access are greatly needed in such areas. However, it also difficult for rural areas to maintain a sense of autonomy due to limited services and. Rural communities are viewed through most literature as having a small-town mentality, being less progressive and sometimes less current on world

views. With these views, perspectives related to the rural communities surround negativity (Thomas et al., 2011).

According to the United States Department of Agriculture (USDA), "Rural is defined as territory outside [of incorporated entities], together with places smaller than a selected population threshold" (Cromartie & Bucholtz, 2019). That threshold is generally stated as under 50,000 people, according to the U.S. Census Bureau. Rural communities are also defined as all "non-metro counties." Roughly 15% of the nation's population occupy more than 70% of the land geographically (U.S. Census Bureau, 2010). These are clearly rural areas. The Office of Budget and Management conclude the following:

> A Metro area contains a core urban area of 50,000 or more population, and a Micro area contains an urban core of at least 10,000 (but less than 50,000) population. All counties that are not part of a Metropolitan Statistical Area (MSA) are considered rural. Micropolitan counties are considered non-Metropolitan or rural along with all counties that are not classified as either Metro or Micro. (Federal Office of Rural Health Policy, 2021, para. 4)

Because of the "geographical health inequities" in rural areas compared to metropolitan areas, the levels of "health" risks are increased for individuals (Story et al., 2016, p. 42). Various characteristics of such health risks are important in examining the quality of life of a person as well as a community. Health resources are increasingly important for social workers to explore in order to better comprehend health care measures being provided in rural communities. From physical to financial to psychological, such determinants must be taken into consideration for the likelihood of survival or healthier outcomes. Studies have been conducted on the importance of health and how it influences the quality of life. The World Health Organization (WHO) uses a Quality of Life questionnaire that has high validity and reliability to assess the holistic health of a person.

The WHO defines health in a holistic sense that is comprised of several components, not just specific to physical wellness:

> A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity [and] the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (World Health Organization, 2021, para. 1-2)

These components of physical, mental, and social health are important aspects to assess within rural areas where resources are limited or even depleted in some areas. The goal is for rural communities to have a higher quality of life. Higher quality of life is influenced by external factors, specifically resource availability and accessibility within the community.

Using a strengths-based approach, social workers can address strengths, examine problems, and encourage existing and new strengths. These existing and newfound strengths can be utilized as resources for growth (Teater, 2010). Considering the entire community as the

client, including both systems and citizens, the use of the WHO's Quality of Life Scale Brief Version (WHOQOL-BREF) allows participants to identify and assess the strengths within a community. Identifying strengths within a community is an empowerment-based approach and focuses on client, family, and community as having strengths and the ability to grow and develop. The main perspective that influences this study is the Strengths Perspective. Deferring away from dysfunction, deficit, and negativity, the Strengths Perspective helps facilitate the use of strengths to assist communities in developing a more positive outlook on problem solving (Norman, 2000). Using such strengths to promote increased health offers a basis for creating a positive environment within rural communities.

The Current Study

The purpose of this study was to assess health of a rural community in Texas to better understand and develop a plan of action for developing community intervention to increase resources. Compared to the year 2000, several counties in rural areas have decreased in population and have a lower rate than previous years as far back as 1990 (Hirsch, 2019; Parker et al., 2018). To serve as context for this study, the state of Texas is largely rural as more residents live in rural settings than any other state in the U.S., according to The Texas Almanac (Murdock & Cline, n.d.). Additionally, 58 counties are completely rural, and another 78 counties are 50% rural. This amounts to 15% of more than 29 million people who live in the state (Cowan, 2016). In terms of economic health, rural Texas' per capita income is just over $42,000, with a poverty rate of 17%. Twenty percent of rural residents do not hold a high school diploma (Rural Health Information Hub, 2021). These facts present a challenge for rural Texas and justifies a need for attention.

Researchers asked various research questions to understand the availability and accessibility of resources within a rural community using a community needs assessment approach. Completing a needs assessment of rural communities was essential to continuing to improve and implement social service systems that provide services to the population. For this study, surveys were used to obtain important information of resources available to community members. Each community needs assessment included demographic questions that captured the age, race, gender, marital status, and years in the community. Following the demographic section, participants rated the overall health of the community in areas such as childcare services, education systems, housing, mental health services, physical health, safety, transportation, and general social services in the community. The ratings were *healthy*, *somewhat healthy*, and *not healthy at all*. Then the participants were asked to rank the same needs as the section before. Responses were based on their experiences, ranking the needs from 1 "*being most people need assistance in this area*" to 8 "*being most people do not need assistance in the area.*" WHOQOL-BREF was the fourth section of the survey which assesses the quality of life of the participant. The last section of the survey contained seven qualitative questions pertaining to the participants views of the services in the community.

The Measure

The World Health Organization Quality of Life Brief Version Scale (WHOQOL-BREF) is a 26-item questionnaire that was developed to provide a short form quality of life assessment

that looks at the same domain profiles as the larger 100 item Quality of Life Scale (WHOQOL), which are physical, psychological, social relationships and environment. The WHO (1996) provided detailed information related to the structure of the WHOQOL-BREF:

> The four domain scores denote an individual's perception of quality of life in each particular domain. Domain scores are scaled in a positive direction (i.e. higher scores denote higher quality of life). The mean score of items within each domain is used to calculate the domain score. Mean scores are then multiplied by 4 in order to make domain scores comparable with the scores used in the WHOQOL-100. (p. 10)

These scores represent an individual's perception of their quality of life in each domain. Because the scores are scaled in a positive direction, higher domain scores indicate a higher quality of life. The mean score of domain related items is used to calculate the overall domain score.

Physical Domain

The first set of items that support the physical domain consists of seven questions that assess: "[a]ctivities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, mobility, pain and discomfort, sleep and rest, work capacity" (WHO, 1996, p. 7). This domain is concerned with daily activities and interpersonal interactions. It does not gauge specific components of sleep habits, and pain is based on the participant report regardless of whether there is a medical reason (The WHOQOL Group, 1998a, p. 58).

Psychological Domain

The second set of items consists of six questions that support the psychological domain. These questions focus on "[b]odily image and appearance, negative feelings, positive feelings, self-esteem, spirituality/religion/personal beliefs; thinking, learning, memory and concentration" (WHO, 1996, p. 7). Participants are expected to respond based on how they feel and the questions are created in a manner to also capture any "disabling psychological difficulties such as severe depression, mania or panic attacks" (The WHOQOL Group, 1998b, p. 60).

Social Relationships Domain

The third set of items has three questions that support the social relationships domain. These questions focus on "personal relationships, social support, sexual activity" (WHO, 1996, p. 7).

Environmental Domain

The last domain is the environmental domain which is based on eight questions that assess "[f]inancial resources, freedom, physical safety and security; health and social care: accessibility and quality; home environment, opportunities for acquiring new information and skills; participation in and opportunities for recreation/leisure activities; physical environment; [and] transport" (WHO, 1996, p. 7). The questions focus on a person's own feeling of safety/lack

of safety and security/insecurity in so far as these affect their quality of life (The WHOQOL Group, 1998b, p. 63).

The WHOQOL-BREF uses a Likert scoring system and reflects participant perceptions of four domains of health: physical, psychological, level of independence, and social relationships. The four domain scores denote an individual's perception of quality of life in each domain. This scale has been used in hundreds of studies and has proven to "display good discriminant validity, content validity and test-retest reliability" (WHO, 2021, para. 3).

The Study Participants and Sample

The study participants all resided within the rural area and were recruited directly within the community by the researchers by using purposive and snowball sampling techniques. The sample size included 361 participants within a rural community as defined by the U.S. Census Bureau (2010). The participants served in various roles in the community as 22% educators (n = 80), 25% medical personnel (n = 91), 23% safety (n = 82), and 30% social services (n = 108). The rural county in Texas used for this study encompasses 21 cities and over 32,000 residents. According to the USDA and the U.S. Census Bureau, this county does not qualify as an urban area because it has less than 50,000 residents. The rural community has close to 20% poverty rate and limited cultural and ethnic diversity. It consists of 25 educational facilities including public schools and higher academic institutions.

Roughly 62% (n = 224) of participants were female and 38% (n = 137) were male participants. Non-Hispanic White participants made up 86.7% (n = 313) of the population while the remainder of participants were non-White consisting of 10.8% (n = 39) Hispanic, roughly 2% (n = 6) African American, less than 1% (n = 2) Asian American, and Native American (n = 1). Most participants reporting being 22 years or older (83.66%; n = 302) and married (43.89%; n = 158).

The researchers thoroughly explained each aspect of the survey to the participants. In addition, a consent form was signed by each participant. The community needs assessment was approved by an Institutional Review Board (IRB). Utilizing differing interview processes during the distribution of the needs assessment allowed for the varying schedules and privacy preferences of the participants to be considered. Those who had spare time and preferred the face-to-face method were accompanied by a researcher throughout the duration of the survey completion process. The participants who had little spare time or preferred to complete the survey in private were given the option to keep the needs assessment in their possession and a future pick-up time was arranged before the researcher departed. Prior to distributing surveys, researchers informed participants of their right to withdraw at any time from the study.

Findings

To be considered a healthy person when assessing quality of life, the researchers used a score of 4.5 or higher which is equivalent to 90%. Researchers considered 90% rating as healthy. The WHOQOL-BREF section of the questionnaire revealed that the overall quality of life for the rural participants was only 4.01 or 80.3%, which is lower than what researchers considered to be

healthy. Of the four domains, participants scored lowest in the area of social relationships (3.89) that center around questions about personal relationships, social support, and sexual activity. Of those participants 86% (n = 193) were female and 77% (n = 105) were male. The other three domains were also lower than 4.5:

- Physical Domain = 4.09
- Psychological Domain = 4.00
- Level of Independence = 4.08

The researchers measured the strength and direction of these linear relationships between the quality of life scores and their perception based on their Likert scale rating. Although weak, negative linear relationships existed between the participants quality of life and their perception of how they rated the overall areas of "health" within the community. Six of the eight areas had weak significant relationships (education, mental health, physical health, safety services, transportation, and social services). The correlation coefficients were less than 0.20. Although the relationship between the variables were considered weak, they were statistically significant relationships. There was a negative linear relationship between the quality of life score and how participants rated the different health areas. The significance of the p-values supporting this negative linear relationship is not by chance. Since the sample size is large enough, small correlations were significant. Participants with higher levels of quality of life reported a lower level of health rating for all of the community resources, which leads researchers to inquire how participants accessed health resources for themselves based on their quality of life scores.

A closer observation of the 26 WHOQOL-BREF answers revealed additional insight into the understanding of the participants living in this rural community. These results indicated that 18% (n = 65) of residents had difficulty accomplishing daily living activities, 27% (n = 51) responded that medical treatment was needed to function in daily life, and 36% (n = 129) did not feel they had enough money to meet basic needs. When observing the participants' perception of the healthiness of the community, less than half indicated the community was healthy when it came to financial health (25.7%; n = 94), mental health (29.5%; n = 108), and physical health (31%; n = 118). Almost half of the participants (47%; n = 170) indicated financial health as the greatest need in their rural community which included access to social service resources such emergency food, shelter, financial assistance, and clothing.

Data for the rating portion are analyzed for the health of the following areas: safety services, childcare services, physical health services, housing services, mental health services, transportation services, and social services. The ratings are identified on a scale of 1 (healthy), 2 (somewhat healthy), and 3 (not healthy). Participants rated the overall health of the community pertaining to each area. All of the areas indicated more than 40% of each of the areas was either somewhat or not healthy at all. Only a little over half of participants rated education services in the rural community as healthy (56%; n = 161) with remaining areas being rated as somewhat healthy or not healthy at all: safety (53%; n = 168), childcare (55%; n = 161), physical health (70%; n = 108), housing (69%; n = 110), mental health (70%; n = 108), transportation (73%; n = 96), and social services (74%; n = 94). These results support long-standing research on the limited access of resources within rural communities.

Data using the same sample size also analyzed which areas the participants identified as needing the most assistance in their rural communities. Based on the participants' experiences, the needs of the community were ranked from 1 (needs most assistance) to 8 (needs the least assistance). Results indicated social services was identified as the area with the highest need for assistance (35%; n = 126). Overall, the remaining areas were all identified to a certain extent as an area that needed the highest attention within rural areas: childcare (26%; n = 94), transportation (24%; n = 89), housing (23%; n = 82), mental health (23%; n = 82), education (21%; n = 76), physical health (18%; n = 66), and safety (14%; n = 53). These results support the need for additional resources within rural communities at all levels.

Although no differences by ethnicity were indicated, other differences between groups based on gender and age were observed. Using an independent samples t test, the mental health rating was statistically significant across age groups (p < .01; p = .007) with 82% (n = 153) of participants between ages 31 to 70 years expressing more concerns about mental health in rural areas compared to 61% (n = 104) of participants 18 to 30 years of age. The gender of participants showed statistically significant differences (p < .01; p = .015) in how they ranked physical health with a third of the males (26%) indicating physical health as an area that needed the highest attention compared to the 16% of the female participants. Lastly, results also indicated statistically significant differences (p < .05; p = .042) of physical health across the different age groups with 38% of participants 18 to 30 years of age indicating physical health as an area that needed the highest attention compared to 27% of participants above the age of 30 years.

The older population aged 51 years and older was more likely to rate childcare services and safety services within the community as either somewhat healthy or not healthy compared to participants 18 to 21 years of age. Almost 58% (n = 45) of older participants indicated childcare services were not healthy compared to 40% (n = 24) of younger participants and 55% (n = 43) of older participant indicated safety services were not healthy compared to 47% (n = 28) of younger participants. These findings emphasize the perceptions between older and younger participants are different as it relates to particular areas within rural communities. Age yielded statistically significant correlations with social services (p = .016) and mental health services (p = .005). There was a positive linear relationship between the age and social services (r = .128, p = < .05), and there was a positive linear relationship between age and mental health (r = .147, p = <.01). Overall, participants indicated that the current resources within the rural community did not meet the needs for mental health (54%; n = 195), physical health (46.8%; n = 169), or social services (55.4%; n = 200). In general, women seem to be more satisfied with their health than men. However, both groups reported experiencing negative emotions such as anxiety and depression. Females had a larger experience of such emotions compared to their male participants, which is not surprising since "rural females possess higher risk of anxiety and depression social and environmental problems" (Sharma & Mahajan, 2015, p. 19). For the question that asked participants to rate their feelings of such emotions, both scored less than 4.5 (average male score was 3.97; average female score was 3.83).

Discussion of Findings

These study findings suggest that this community needs support as the community scored lower in all four domains than the WHOQOL-BREF authors consider healthy with social

relationships having the lowest rating below four. Social relationships are valuable and other studies have shown the influence they have on the overall health of communities (Umberson & Montez, 2010). Socially, rural communities are viewed as friends who are similar to family. There are usually a few congregations located in the area with one to two financial institutions, and one educational school district to represent elementary, middle, and high school. Families and children thrive from social relationships and use them as a strength over the years. Also, economic shifts take place within rural communities once families place their resources back into the community (Carrington & Pereira, 2011). There is limited literature on the social impacts of families within rural communities. Therefore, there is a need for further research to explore this population and topic.

With only a little over half of the participants rating education services in the rural community as healthy, researchers met with community members to begin a discussion of educational improvement within the county. The observations of education within this community were satisfactory compared to past perceptions of the educational access, but more needs to be done to increase financial resources.

> Education is tied to the economic prosperity of rural people and places. The educational attainment of people living in rural (nonmetropolitan) areas has increased markedly over time but has not kept pace with urban (metropolitan) gains, especially in college and postgraduate education. (USDA, 2021, para. 2)

Enhanced educational awareness, improved communication between systems and communities, and adequate delivery of services among system representatives can influence a healthy community's perception of the available services. These discussions also included the remaining areas rated as somewhat healthy or not healthy at all. The concerns about mental health resources within this rural community yielded additional discussions from community members about how to increase funding for the service provisions of mental health professionals. Several barriers exist within rural communities regarding the treatment of mental health, which emphasizes and "rural areas must consider strategies to address these barriers in order to create more sustainable programs that provide for community needs (Rural Health Information Hub, 2019).

These findings are consistent with various studies and have implications for services, particularly in areas of physical and mental health (Story et al., 2016). Additionally, based on findings that community members' health impedes daily activity and that the community does not have the resources to help in areas of physical, mental, and social quality of life, attention should be given to this community and, likely, other similar communities. Another challenge based on these findings is limited financial stability. All of these findings are consistent with Hirsch (2019), who argued non-metro communities are less healthy and have less wealth than metro areas. Consistent with El-Amin et al. (2018), mental health and mental health services are of significant concern, and are often manifested in substance use/abuse, substance-related illness, and suicide/suicidal ideation.

Implications for Social Work Practice in Rural Communities

The results of the study support the need for increased advocacy to obtain resources in rural communities, including funding for additional social services. The findings also support the need for increased communication among and within community organizations to form effective partnerships. Social work implications for future research include community development strategies. The results will be utilized to improve communication efforts between and within systems, avoid duplication of services between and within systems, improve QOL (Quality of Life) and "health" for overall community, and to support proposals for potential internal and/or external funding for systems serving families in rural communities.

It is increasingly important for social workers to explore rural communities in order to gain a better understanding of their struggle with sustainable development such as limited local assets, limited local abilities, limited access, limited innovation, and the vulnerability to economic conditions. Because of these limitations, more innovative practices and access is greatly needed in such areas. Continued discrepancies and disparities take place within rural populations specifically as it relates to "health care access, social services, and other goods and services needed for healthy living" (Averill, 2002, p. 450). Rural communities have access to fewer resources compared to urban areas (Hirsch, 2019; Dean & Sharkey, 2011), making it critical to ensure rural areas function adequately. For years, scholars have acknowledged the importance of finding innovative ways to "link limited social service resources with established community institutions like schools and churches" (Lewis et al., 2013, p. 102). Research has come to include far more resources that fail to be utilized because of access.

One way of facilitating social work partnerships is for community leaders and social work practitioners to partner with social work educators and schools of social work. In this way, faculty and students can collect data that validates the need for services, identify leading edge interventions, facilitate community forums, meetings, and "listening sessions" that allow leadership to hear community members, and advocate for needed changes. Social work practitioners and schools of social work can partner to create grassroots organizations for the purpose of leading change. One example is when a community's leadership attempted to eliminate afterschool programs that were being held at recreation centers. A group of community members rallied to advocate on behalf of the families who would be hurt by the decision. That group sought a nearby school of social work that helped the community group collect and analyze data. Together, with faculty and students, the group held a meeting with decision-makers to discuss findings and implications for not just the afterschool programs but the recreation centers and possible bond issues. Additionally, the field of social work has the unique skill of locating natural leadership within a community as well as the skill of identifying and maximizing community strengths, such as creativity and collaboration, by using such models as the Asset Based Community Development approach (ABCD) (Kretzmann & McKnight, 1993). Also, there are courses focused on community engagement that are designed to partner students with community systems. The purpose of this course is to help with serving the community through creating programs and conducting needs assessments which could include community members. Social workers play a large role in defeating rural barriers to needed services by educating community stakeholders and members of disparities while assuming leadership roles in the

community. Collaborative partnerships between rural churches, schools, and community leaders prove to be an effective way to combat the lack in adequate resources throughout the community.

A few rural community programs and/or initiatives are provided through the Health Resources and Services Administration. However, they are primarily grant based. The Community-Based Division (CBD) offers funding to increase access to care in rural communities and to address their unique health care challenges. Most of these programs want the organizations to "share resources and expertise using evidence-based models of care" (Health Resources & Services Administration, 2019, para. 1). Within the few programs that are geared for rural communities, only two focus primarily on the overall health of the community: The Rural Health Network Development Program and the Rural Health Care Services Outreach Program (Health Resources & Services Administration, 2019). The Rural Health Network Development Program only focuses on "mature" social networks within rural communities, which are few and far between, while the Rural Health Care Services Outreach Program supports "utilizing evidence-based or promising practice models in order to address community-specific health concerns" (Health Resources & Services Administration, 2019, para. 6). A guide for collaboration and coordination was developed so rural service providers have information on how to work together in addressing the health needs within their communities (U.S. Department of Health & Human Services (DHHS), 2019). The collaborative action steps seek "to maximize resources and efficiencies, with a common goal of ensuring access and providing services to rural populations" (p. 3).

> No single organization can address all needs of its community. However, by collaborating and coordinating with other organizations, rural health care providers can extend their reach and capabilities, which can lead to healthier communities and more vibrant, relevant, and financially stable organizations. (U.S. Department of Health & Human Services (DHHS), 2019, p. 4)

Although DHHS provides a detailed initiative for collaboration and coordination that includes a community needs assessment, their solution to improving the health of rural communities is missing a critical player: the community. The important concept of community development as it relates to systems is being intentional about transparency and including the community at the decision-making table. Historically, systems have tried developing programs for the community without the inclusion or feedback of the community. So often these same systems will ponder about the reasons certain programs continue to reap disproportionate and disparate outcomes.

The implications of this research focus on filling awareness and educational gaps within rural communities primarily rooted in the voices of the community. Too often programs and practices are developed that do not include the voices of the people it intends to help. The results of this research support additional efforts of developing solutions for increasing quality of life that involve community participation. Intentional efforts of investing in rural America is a sentiment in which helping professionals need to take part despite the obstacles. As community efforts toward social change persist and young people are leaving with no intention of returning (Hirsch, 2019); ensuring they have a voice in community development is vital. The perspective of younger people is beneficial to research as it suggests that certain community aspects will have a trickle-down effect on the children of the community. Goodwin and Young (2013) stated

that community development should utilize a bottom-up approach by including children and younger people as opposed to a top-down approach when working with communities. The population including children and younger people are generally overlooked, having little contribution to community development. Collaboration that includes the community voice is paramount in assuring acceptance and participation in the intervention. Such cross systems collaboration enhances the strengths of partnering agencies/programs to promote a continuous system of services (Stewart, 2013), lending itself to community organizing efforts that encourage communities to advocate on their own behalf (Beckwith & Lopez, 1997).

> Although community-based agencies play an important and vital role within the community, many times you do not find collaboration with community members themselves–the very same people you are trying to help. Community member participation may be relegated to advisory positions and only included after the program has been designed. Ideally, a diverse mix of people from the community and those representing related community agencies should be present from the conception of the program. In addition to researchers, each group can bring to the table a number of valuable perspectives and resources. (Franco-Paredes et al., 2007, p. 2)

Using a strengths-based approach, social workers must address strengths, examine problems, and encourage existing and new strengths. These existing and newfound strengths can be utilized as resources for growth (Teater, 2010). This approach seeks to assess strengths and resources in order to promote individual, groups, and communities. Clients who need services from social workers are seeking a better lifestyle that is more productive, without stress of life circumstances surrounding legal, mental, and/or financial strains. Clients usually want to live without constant obstacles surrounding everyday living. For instance, they want basic needs to be provided in a self-sufficient manner. When social workers use the strengths-based approach, they are looking through the micro, mezzo, and macro lens with an emphasis on positivity. With some families, communities, and individuals, this is not a simple task. However, this is one of the best skills of a social work professional. This approach helps with rebuilding belief and growing courage to succeed in various aspects (Saleeby, 1996). Therefore, when engaging with a social work professional, the strengths-based approach is necessary to ensure the client reaches their intended goal. The core work of social work is strengths based and therefore leads to client empowerment (Pulla, 2017). The strengths-based approach is effective with various populations in the manner that relationships are built and populations are supported in a holistic manner. When focusing on the positive, a community grows and believes deeper in oneself. For instance, with indigenous families' using a strength-based approach, it provided a restoration in security and assets, as well as re-building the community (Askew et al., 2020).

According to Van Hook (2019), the strengths-based approach helps with identifying resiliency. Although rural communities consist of low populations, food deserts, health disparities, and poor infrastructures, there is a piece of resiliency. In previous research as well as in current studies, it is evident that rural communities are under-served. Strengthening health and mental health services is vital to the overall health of the community. In order to combat mental health challenges in rural settings, some states, including Texas, have implemented Mental Health First Aid (MHFA), which is an evidence-based training program that equips community members to support individuals in their communities who may face mental health challenges (El-

Amin et al., 2018). The MHFA trains community members to detect possible depression and anxiety, and substance abuse. Community members are taught how to listen and encourage continued professional services. Area practitioners should consider being trained and training others to implement MHFA locally. It also relieves the need for professional resources so they can attend to those who need it most. Having area practitioners trained to help carry some of the mental health burden, it would allow for professional resources to focus on those with more urgent needs.

As stated in the National Association of Social Workers (NASW) Code of Ethics, "social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people" (NASW, 2017, Ethical Principles section, para. 3). For this reason, social workers must actively participate in allocating adequate resources regarding rural communities. Enhanced awareness, improved communication, and adequate delivery of services amongst agency system representatives will allocate for a healthy community perception of the available healthcare services. Additionally, when a community is healthy, all members are working together. In an effort to build and increase the quality of life for all, there needs to be inclusive methods. For instance, systems such as advisory committees should include community members in the decision-making processes for essential needs.

As previously stated, these findings suggest a need for advocacy. According to Eisenberg (2020), rural communities have fallen victim to policy changes in favor of innovation and ease of living at the expense of rural communities. Social workers placed in and near rural communities should communicate and collaborate with social work lobbyists who daily advocate for communities who are not being heard. Social workers would benefit from gathering the voices of the members who live within the community. Those voices will provide an experiential perspective that will lead the charge of adequate services to rural communities. Similarly, policy practitioners should remember to look back to the communities where marginalized citizens live, many of whom reside in rural settings, and advocate for the specific needs of rural society.

Conclusion

Amid findings that suggest the need for further study and service delivery as well as a need for cross-systems collaboration and political advocacy, it may be the temptation of social workers to forget the rural communities' efficacy as it is. Many rural communities face disparity when compared to the, at times, abundant resources accessible in urban settings. One's perception of rural communities must not be deficit-based. Rural communities have historically proven their ability to sustain themselves; however, we recognize that there are ways the field of social work can provide additional support and empowerment for resources inherent in rural settings that include the voice of the community. This belief is reality for rural communities who are most impacted by the social determinants of health and have a lower quality of life than their urban counterparts. According to Vance (2017), rural communities need social workers to be a conduit rather than taking over or enabling dependence. A study by Fletcher et al. (2020) found in a discussion concerning the importance of social capitol that rural communities have a history of mobilizing in times of need. They spoke of a community's "bonded networks and existing adaptive capacity" as skills in combatting crisis. Schultz et al. (2021) discussed the ways rural

communities utilize informal sources of support. In creating avenues for service delivery and advocacy, it is also the role of the social work field to listen, aid, and then allow the community to do what it needs to do. Social workers can continue a commitment to the promotion of a holistic approach to health.

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