Rural Social Work

ISSUE STATEMENT

Recent data suggest that rural areas are becoming increasingly diverse, with higher rates of immigration, especially of Hispanic people (Keating & Karklis, 2016). Rural communities typically experience slower employment and wage growth, lower household incomes, persistently high poverty, substandard housing, lack of Internet access, and limited access to health and behavioral health care (Rural Health Information Hub, 2018; White, 2015). Rural residents, too, tend to be older and experience higher rates of chronic disease and substance abuse (Rural Health Information Hub, 2018). Given these challenges, social workers have an important role in supporting the health and well-being of rural residents.

Rural areas comprise 72 percent of the nation’s land area (U.S. Department of Agriculture, 2017) and about 18 percent of the U.S. population (World Bank, 2018). Rural social work largely developed in the early 20th century and was influenced by local county welfare administrators, the Country Life Movement, and the Home Services Workers of the American Red Cross (Daley, 2015). Although rural social workers adapted their early methods from Social Diagnosis and the Settlement House Movement, rural social work was not immediately embraced by its urban counterparts.

The Rural Economy

Sustainable economic opportunities have increasingly been relocated away from rural America to larger cities or foreign markets. Many rural communities face the loss of traditional employment and the choice of embracing industries (such as extraction industries) that may pollute drinking water, affect drainage, cause soil erosion, or dispose of toxic chemicals into the local environment (Daley, 2015). Regional inequity is most evident in the South, with a rural
poverty rate of 21.7 percent, nearly six percentage points higher than in the region’s metro areas. On average, southern states have the lowest median household income, with nine of the country’s 15 poorest states located in the South. Nationwide, high-poverty regions are concentrated in rural southern and mountain states (New Mexico, Montana, and Idaho). Overall, rural poverty in the United States is more persistent than urban poverty with 84 percent of persistent poverty counties located in nonmetro regions (U.S. Department of Agriculture [USDA], 2017).

In addition, rural communities have higher rates of dependence on public transfers such as the Supplemental Nutrition Assistance Program (SNAP) (16 percent versus 13 percent for urban communities) and Medicaid-funded health care (21 percent VS 16 percent in urban communities) (Food Acton Research Center, 2017; Rural Health Information Hub, 2014). The past decade has continued a 30-year trend toward rising government transfer payments for rural areas predominantly when it comes to food and health care subsidies. Such funds now account for 22.7 percent of personal income, compared with 13.6 percent in metropolitan areas (USDA, 2017).

**Rural Inequality**

Approximately 60 million people reside in rural America, and 22 percent of them are minor children. Significant challenges are present for rural and remote populations specific to medical care, including behavioral health and substance use treatment, employment, education, housing, transportation, and access to technology. Rural Americans have higher rates of chronic illness, disability, injury, smoking, suicide, opioid issues, unemployment, poverty, and premature mortality. They tend to experience reduced health, limited job opportunities, lower socioeconomic status, less education, lower life expectancy, and geographic isolation. Rural
residents tend to rely more heavily on federal subsidy programs combined with less medical providers present to support health and quality of life. They are less likely to have employer-provided health care and prescription drug coverage or to be covered by Medicaid (Rural Health Information Hub, 2017). Medicaid covers a larger share of nonelderly residents in rural areas, with a noticeable trend of high child enrollment (Wagnerman, 2017). Medicare payments to rural hospitals and providers are dramatically lower than those for equivalent services in urban areas, perhaps correlating with recent data finding that more than 60 rural hospitals have closed since 2010 and 673 are vulnerable to closure (Ellison, 2016).

An increased prevalence of mental illness, substance use and overdose, and reduced mental health also exists in rural areas. With limited access to intervention and treatment services necessary for recovery (Centers for Disease Control and Prevention, 2017), possible reasons for this lack of care include greater geographical distance to access providers, overall shortage of trained health care providers (only 10 percent of physicians practice in rural America), and increased stigma of receiving help (Rural Health Information Hub, 2017). While efforts to augment health care services within rural areas with technology are encouraging, lack of access to broadband internet technology (only 69 percent of residents have access) is disconcerting (National Telecommunications and Information Administration [NTIA], 2016). This profound technology gap between rural and urban residents continues to persist (NTIA, 2016), placing additional strain on these communities while supporting the value of and need for social workers as a result.

Access to Health Care Services

The availability, accessibility, and acceptability of health and behavioral health services is an issue of concern in rural areas with notable shortages of professionals’ present (MacKinney
et al., 2014). As of January 1, 2018, there were 2,679 areas with shortages in rural areas, compared with 1,899 in nonrural areas (Bureau of Health Workforce, 2018). Some groups, including veterans, disproportionately live in rural areas where accessing services may be more challenging. Five million (24 percent) of veterans live in rural communities, and although they use both the Veterans Administration and private providers, access, specifically for specialty care, is often unavailable (U.S. Department of the Census, 2017).

The uneven geographic distribution of social workers in rural areas leads to inconsistency and gaps in care. Recent data sampling social workers (N = 691) who graduated from MSW programs in 2017 found that only 7.1 percent served rural areas (Salsberg, Quigley, Acquaviva, Wych, & Sliwa, 2018). Similarly, social workers with a BSW provide higher proportions of care in rural communities than in urban settings, creating a shortage of those with specialized skills and advanced professional education (Daley, 2015; Daley & Avant, 2014). Due to structural barriers (including lack of providers and long wait times for services), health and behavioral health services are often unavailable in rural communities (MacKinney et al., 2014). Rural communities may have fewer formal resources and are often taxed beyond their limits, understaffed, have limited services, and require long travel times (Beecher, Reedy, Loke, Walker, & Raske, 2016).

**Technology**

Using technology in the provision of health and behavioral health services is considered one solution to the challenges associated with providing and accessing rural health and behavioral health services. Telehealth or tele–mental health services, such as two-way video, can provide health or mental health services from off-site locations (Lambert, Gale, Hartley, Croll, & Hansen, 2016). Tele–mental health and telehealth services are considered feasible and
comparable to services delivered in person for youths and adults (Gloff, LeNoue, Novins, & Myers, 2015; Lambert et al., 2016). Developing telehealth or tele-mental health services requires important planning and consideration of technology infrastructure, staffing, training, cultural factors, community readiness, and ethical issues (National Association of Social Workers, 2017).

Despite the promise of telehealth and tele-mental health services, there are specific challenges with this service delivery model in rural communities. As with the challenges experienced in providing on-site mental health services in rural communities, tele-mental health services struggle with low reimbursement rates, difficulty in hiring and retaining providers, high rates of uninsured clients, and high no-show rates (Lambert et al., 2016). In addition, the digital divide impacts rural access to telehealth and tele-mental health services. Rural areas have historically been the last to receive telecommunication investments and as noted previously, have lower rates of internet usage. The Obama administration stated that “modern technology is critical to the expansion of business, education, and health care opportunities in rural areas and the competitiveness of the nation’s small towns and rural communities” (White House, n.d.).

Diversity

Cultural and subcultural beliefs within rural areas may be sources of strength but are also where service breakdowns can occur, particularly among African American and Hispanic populations. Ethnic minorities in rural areas tend to have higher poverty rates, specifically for Hispanic, African American, and Native American populations (Daley, 2015). Also present are persistently high poverty rates for rural children, compared with children living in urban areas. This is thought to be correlated with the rate of female-headed households, which are known to be at an increased risk for much lower socioeconomic status (National Women’s Law Center, 2017).
For some rural counties, ethnic minorities are, in fact, the numerical majority and often present with additional health disparities, including diabetes, high blood pressure, malnutrition, and obesity (Daley, 2015). Lower education levels, correlated with overall reduced health, are more prevalent in rural areas and populations, with bachelor’s or graduate degrees comprising just 10.5 percent of the population, compared to 29 percent of metropolitan populations (U.S. Census, n.d.). In addition, cultural values such as rugged individualism may stigmatize those who seek mental health services, resulting in reluctance to ask for help from health care specialists (Papadopoulos et al., 2013). Unique needs of rural youths, aging populations, socially isolated families, and small pockets of cultural groups may not be effectively distinguished from survey data reported by the broader rural community (The Conversation, 2017). This may lead to a series of homogenous assumptions and misinformation about the significant needs, services, and strengths of those living in rural areas.

**Social Work Practice in Rural Communities**

In many communities, social workers may be the only helping professionals who develop, identify, and implement models of practice to reduce disparities across vast geographic areas. Rural social workers may struggle with workforce challenges, often caring for increasing numbers of clients without sufficient numbers of allied professionals. Lack of social work supervision, high caseloads, low salaries, hiring of non-social workers to fill positions, and complicated ethical challenges are issues that rural social work professionals face (Daley, 2015).

Professional recruitment and retention issues are, in part, by-products of a social work education system that developed largely from urban roots and most social workers receive little content on rural social work in their professional education. This may lead to a social work discipline unprepared to address the needs of rural communities. Knowledge of rural social work
is important for all social workers, given patterns of migration and immigration to urban zones, specific economic opportunities, employment, conflict, and even natural disasters. The expansion of distance education programs has increased access to social work education for rural students; however, barriers for rural social workers continue to exist (Daley, 2015; Daley & Avant, 2014).

Rural social work practice requires a sophisticated understanding of values and ethics and highly developed skills in their application. In many respects social work in rural communities is similar to urban social work, but a refined focus on social relationships, nuanced cultural practices, and sheer geography are important (Daley, 2015; Mackie, Zammitt & Alvarez, 2016). Rapport and connection are crucial given that the strength of community and interpersonal relationships directly correlate with the ability to create quality service delivery (Starks, Jones, Cashwell, & Stokes, 2016). Ethical issues, such as lack of anonymity due to low population, are present and worthy of additional training postgraduation (Daley, 2015; Davis, 2014).

Effective rural practice often involves locality-based community development that may make maintaining professional distance something that is considered inappropriate and may limit effectiveness. Protecting clients from any negative consequences of dual relationships in rural settings has less to do with setting clear boundaries and more to do with effectively managing professional relationships. A potential challenge for the helping relationship, many rural communities share close community ties, which may also be a grand strength in empowerment and change (Daley, 2015).

Similarly, recent work has highlighted the need for social work and religiously affiliated organizations to work closely in accessible service delivery (Moore, Pearson, Rife, Poole, Moore & Reaves, 2016; Yancey & Garland, 2014). Faith-based organizations may positively affect service delivery while concurrently may be less inclusive of those in nondominant groups, such
as people of color; women; or lesbian, gay, bisexual, trans, or questioning individuals. Residents of rural areas may be judgmental toward clients and services that reflect cultures and lifestyles different from community norms. Social workers not from the community may also find it challenging to establish effective working relationships due to the close-knit nature of the residents and is an area that requires further dialogue.

The overall understanding of rural people and cultures is a pressing issue of cultural competence in the social work profession. All social workers should have an awareness of the unique challenges associated with practice in rural communities. It is critical that the issues identified in this statement be addressed, not only in undergraduate and graduate social work curriculum, but through ongoing educational training, research, and professional development.

**POLICY STATEMENT**

NASW supports

- Recognizing the importance of rural populations to the nation’s economy and cultural identity, and society as a whole
- Legislation and policy initiatives that improve infrastructure, economic development, transportation, education, comprehensive strengths-based social services, and access to high-speed Internet, and also promoting environmentally sustainable practices
- Advocacy efforts that address the unique needs of rural clients, particularly those who are at risk, vulnerable, or oppressed
- Culturally competent strengths-based practice, research, advocacy, and education specific to rural diversity at all levels of study
- Developing and applying ethical principles of social work practice with rural populations
• Promoting workforce development and retention through incentives, training opportunities, mentorship, and supervision

• Continuing education opportunities on a range of topics, including clinical and health practice, advocacy and organizing, administration and management, public welfare, ethics, and community-based services for rural people and communities.

REFERENCES


*Policy statement approved by the NASW Delegate Assembly, Month 2018. This policy statement supersedes the policy statement on Rural Social Work approved by the Delegate Assembly in August 20011. For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 800, Washington, DC 20002-4241. Telephone: 202-408-8600; e-mail: press@socialworkers.org*