EVEN A CASUAL READING of the social work literature leads one to the conclusion that rural social welfare services are few and far between. Author after author recounts the scarcity of rural services and the major challenge this poses for social workers and clients. Rural people have earthy, down-home phrases that reflect scarcity: “empty as a church on Saturday night,” “scarce as grass around a hog trough,” and “scarce as hen’s teeth.” To anyone who has been in the country, these phrases capture the idea of something that is pretty meager.

This chapter examines social welfare services in small communities. Although a thorough consideration of all services is beyond our scope, the chapter does present examples of rural service programs. The services discussed here are mental health and substance abuse, health care, child welfare, domestic violence, and the emerging area of services for immigrants and migrants.

Just how scarce are these important services for rural people? At one time, an overall view of rural social welfare was that services were pretty bare. When Josephine Brown wrote her classic book *The Rural Community and Social Casework* in 1933 the argument could be made that rural services were scarce and sometimes nonexistent. But this was in the early years of the Great Depression, times were tough economically, and few of the social welfare programs of the New Deal had yet been put in place.
Most of the services that did exist were the work of private charities, but the money to support even those services had begun to dry up. So during this time, social welfare services were woefully inadequate to address the needs of rural communities.

The real question is whether things have changed so little in the more than eighty years since Brown wrote that we are still in the same kind of situation. Things have indeed changed in rural America in the twenty-first century, and it is important to assess what those changes have meant in terms of social welfare services and social work. The New Deal helped bring electricity to rural America and built a publicly funded network of social and economic support services that extended to the countryside. Programs like Social Security, Aid to Dependent Children, and child welfare services were then able to reach communities that had not experienced such support before.

Much of Leon Ginsberg’s (1976) landmark book *Social Work in Rural Communities: A Book of Readings*, which provided the modern reintroduction of rural practice to social work, deals with topics related to services. Of the thirteen chapters in the book, eight deal with service-related topics, though from a decidedly community practice perspective, and five chapters focus primarily on social work education. The book was written when the long-term trend of rural people migrating to the city had reversed, and people were again moving back to the country. There was concern that the social services and skills of social workers would not be up to the task of supporting the growth of rural communities. But even in the mid-1970s there were clearly services available in rural communities, and many of the chapters focused on expanding services and extending their reach.

Since that time the rural social work literature has diversified considerably, expanding to include topics like special populations, social work ethics, and international content. Many authors continue to write quite a bit about rural services into the twenty-first century. For example, twelve of the twenty chapters in the fifth edition of Ginsberg’s (2011a) *Social Work in Rural Communities* contain content that can be described as service related. One shift that has occurred is that much of the contemporary literature tends to focus on direct practice issues more than on community-based practice. This appears to reflect a general trend in social
work to separate practice from the community development arena (Locke & Winship, 2005). Some might argue that this kind of shift does not serve social workers well who practice in rural communities. Twenty-first-century rural authors such as Scales and Streeter (2004; Scales, Streeter, & Cooper, 2014) have added a strengths perspective that examines both existing services and informal resources as community assets.

What is clear is that in the twenty-first century social welfare services do exist and serve populations that need them. There is also general agreement that services are neither as extensive nor as specialized as may be needed. Service networks in rural areas do differ from those in the cities. The lower population densities of rural areas and the transportation networks to reach services often play out differently than they would in an urban community. Generally, rural social welfare service programs serve a larger geographic area than is typical for a metropolitan setting. This means that rural services may be further from at least some of the people who need them, and transportation to reach services could be a problem. Very few rural communities have mass transit systems, especially to reach towns that may be forty or fifty miles away.

The service and service delivery issues that face rural communities are not new. Josephine Brown (1933) wrote about how needed services may be some distance from clients and that transportation was a major barrier to accessing services. Today, the roads and communications are usually better, and there are more services available than in the 1930s. But the very nature of rural communities works against the social welfare service network being as strong as it may be in an urban area. Low population densities tend to make providing services in rural areas more expensive per capita than in a metropolitan setting. For political decision makers who are looking to cut costs and provide services economically, rural communities may not be high priorities. As governmental entities try to plan where to spend their limited service dollars, they generally turn to places where there are a lot of people, and those are the cities. There may also be some old prejudices and mythology at play if decision makers think of rural communities as idyllic places with few problems.

Services are often planned on a per capita basis, and as a result rural areas tend to receive less funding for services. Moreover, in a rural area funding has to be spread over a wider geographic area. So it is usually the
case that needed services may be available but not be found locally. Instead, services may be offered at a regional center that requires clients to travel to reach it. In some very rural or frontier areas these distances may be prohibitive, and so there are effectively few services available. This tends to be a more significant issue in regions with a lot of wide-open space, like Alaska, North Dakota, Montana, and New Mexico. An important example of this is services to veterans. Approximately 3.3 million veterans, about 41 percent of those who are enrolled in the VA health system live in rural areas, and the distance from service centers often means that they do not get access to the services and care they need (White House Rural Council, 2011).

While some of the basic social welfare services may be available, accessing specialized services may be a different issue altogether. Specialized services tend to serve a much smaller segment of the population, and they also can be expensive to deliver. Consequently, they are generally offered in a central location where they can serve larger numbers of people from several communities more efficiently. For example, inpatient mental health services are used to treat only certain types of chronic or acute conditions, and they are more expensive than outpatient services. A single rural area may not have enough people with the requisite conditions to fully utilize a facility, but several communities together might. As a result, regional service centers tend to be established to serve smaller communities. In many ways this advantages those communities that are closer to the service center and disadvantages those who are more remote.

What this may mean for rural social workers and clients is that needed social welfare services may not be available in their community. The challenge then becomes one of accessing the services that are available and addressing the barrier of distance. These are all too real, significant parts of rural social work, and sometimes it is possible to overcome them. In such instances, social workers need to be both creative and flexible in trying to help empower their clients in their home communities. In so doing, rural workers can take one of three approaches to try to address the insufficient local resource situation: (1) finding and employing informal resources, (2) developing creative combinations of services that exist, and (3) engaging in community development to enhance the supply of resources. Any and all of these are part of rural social work.
When one speaks of the assets of small towns and communities, the discussion is usually about the local people and organizations. These assets have traditionally filled the gap when formal social welfare resources were unable to do so. Some examples of informal resources include working with friends, family, or neighbors to provide services like day care or foster care, meals for the elderly, or rides for clients to keep medical or agency appointments. Churches and local civic organizations can also be mobilized around specific projects, such as a family who needs assistance because their home was destroyed by a fire or a tornado, or providing transportation to someone who needs medical treatment.

But informal services, though valuable, are usually specific to the community or even to an individual, and as such, they require rural workers to discover and learn about these resources. And there are certainly limitations as to what informal services can provide. But the use of informal, nonprofessional services is a very important part of rural work. Because of their unique nature, most informal resources are too distinct and diverse to discuss in this chapter except in a very general way. As a consequence, most of the remainder of this chapter centers on the kinds of formal services that exist in rural communities.

Despite the many service-related challenges that are found in practice, rural social workers and their agencies have found ways to adapt and provide many needed services. Rural workers have done this by being independent, creative, adaptable, and willing to look for solutions when just getting by and doing what has been done in the past would be much easier. Agencies have adapted and provided outreach to be more helpful to their communities. But most of all, in various ways rural helping professionals have shown leadership in responding to community needs. The remainder of this chapter looks at some of the types of service programs that have been developed and implemented for small towns and rural areas.

MENTAL HEALTH AND SUBSTANCE ABUSE

Although the rates of mental and behavioral health issues do not differ significantly between rural and urban areas, the experiences of the two
populations differ quite a bit with respect to treatment services. The primary difference is that it is more difficult for rural people who experience mental health or substance abuse issues to get treatment that might help them (Conway, BigFoot, & Sandler, 2011). Rural residents are less likely to receive any treatment for their behavioral disorders, and the quality of care for those who do may be poorer than people who live in metropolitan areas (Office of Rural Health Policy, 2011). Rural veterans with mental health disorders tend to be sicker than their urban counterparts, yet they receive services less often (National Association of Social Workers, 2012). However, in terms of mental health, rural people have higher rates of some conditions. For example, rural residents tend to experience more depression, suicide, and substance abuse than those in the city. They also have more behavioral risk factors such as smoking and obesity (Conway et al., 2011; Stone & Fredrick, 2011).

Similarly, substance abuse rates are also much the same in rural and urban areas, but there are fewer rural treatment resources for substance abuse. There are increasing concerns about illegal drug use in rural areas, and often these problems are addressed by the criminal justice system instead of treatment (Johnson, 1998; Locke & Winship, 2005; Rural Assistance Center, 2012b; Substance Abuse and Mental Health Services Administration, SAMHSA, 2007).

Transportation is a barrier to accessing drug treatment services, as it can be difficult in rural areas to have transportation that gets people to where services are offered. Simply, it can be many miles, sometimes over difficult roads, to reach treatment. Other barriers to receiving treatment include relatively few rural substance abuse treatment programs and the stigma of substance abuse. These all tend to reduce the likelihood that people receive treatment. There is community scorn that goes with being identified as mentally ill or as a drug user, and most rural residents want to avoid that scorn. There are many colloquial terms for someone who might be seen going to the mental health center, such as “he has a hole in his screen door,” “she’s a few pickles short of a barrel,” or “his Christmas lights are missing a few bulbs.” Substance abusers might be called “pot heads” or “speed freaks,” or be described as “drunk as a skunk in a trunk,” “smoking left-handed cigarettes,” “three sheets to the wind,” or as having “bottle fever.” These are phrases people use when they don’t
want to speak directly, and none of them is particularly flattering. Being viewed in these ways can frame a person as a community outcast or an object of pity. Indeed, there are many factors in rural areas that make it difficult to get appropriate services for substance abuse or mental illness.

There is also evidence of an increased flow of drugs into rural communities. The manufacture of methamphetamine has become a viable source of income, if a dangerous cottage industry; the cultivation of marijuana has created a new cash crop; and drug dealers, large and small, have opened up new markets in rural communities. In fact, the cultivation of marijuana has grown so extensive that some people contend that it is now the nation’s biggest cash crop (Bailey, 2006). As traditional sources of income decline, the cultivation of crops like marijuana and the production of methamphetamine provide lucrative income sources. Given the movement of drugs into rural areas and the traditional reluctance of rural people to seek formal services, it is not surprising that in rural communities a higher percentage of referrals for treatment were from criminal justice sources than from family, friends, or self-referrals (SAMHSA, 2012).

Several contemporary trends in the mental health and substance abuse field have created special problems for rural communities. The problems often stem from adopting models of mental health services developed for metropolitan areas and applying them as broad policies without first evaluating their effects on rural communities. Several policies have been implemented with the intent of cutting or containing the cost of services. Rural mental health services have traditionally been underfunded (Scheyett & Fuhrman, 1999), and further cost cutting that fails to address the needs of rural people can and does lead to lower service use and serious underserving of the behavioral health needs of people in small towns and rural areas.

For example, a trend in mental health and substance abuse treatment is the move to managed care (Scheyett & Fuhrman, 1999). The idea behind managed care is that by controlling the services delivered, increasing efficiency, and fees paid for services, cost efficiencies can be achieved and overutilization of resources reduced, thus producing significant savings. But managed care works best in urban settings where there are large and concentrated populations, coordinated service systems and information, and multiple service providers and competition. None of these characteristics describes rural communities. Rural providers often depend
more on public funding than urban services do. For example, programs like Medicare and Medicaid help fund rural services, and cutting costs associated with these programs can make it more difficult for providers to offer services, especially where there are few service providers, low population densities, and large service areas. These factors often contribute to an increased cost per unit of service. Of course, many rural people have little or no private insurance coverage, which makes it difficult for them to receive any services at all. The recent expansion of health insurance may help improve access to health care, but it is too early to tell. However, many rural people are still opposed to the recent Affordable Care Act, or Obamacare, and it may take some time for them to overcome resistance to participation in the program.

In terms of treatment, the market forces and economies of scale that are the key assumptions of managed care strategies are not rural-friendly. According to the National Rural Health Association (1999), a significant number of rural counties do not have any mental health services; thus, there is no competition or alternative service to drive down prices. Even if there were more agencies, rural communities do not have enough professional mental health personnel to provide services in those agencies that do exist. Mental health agencies in rural areas have a hard time attracting and retaining professional staff, and they are especially short of specialists (Stone & Frederick, 2011).

The move to deinstitutionalize residents of state mental hospitals and return them to the community for treatment, though commendable, has had a significant effect on rural communities. Many rural communities used state hospitals as a treatment resource because they did not have or could not afford adequate mental health services. Deinstitutionalization and the closing of state hospitals has served to keep the mentally ill in their own community, where there may not be resources to serve them. A result of nationwide deinstitutionalization of the mentally ill, for example, is that people typically end up in general hospitals, jails and prisons, and nursing homes, which may not be set up to provide the services they need (Advocacy Treatment Center, n.d.). It also means that some mentally ill people who are not elderly or do not present criminal justice or health problems may receive little or no services at all. With community mental health services strapped with declining funding, many have shifted services away from low-income clients who receive Medicare or Medicaid
to fee-generated services based on private insurance and ability to pay. As Randall and Vance (2005) indicate, cuts in public funding, staff downsizing, and an inability to keep up with current research-based treatments have all seriously impaired the ability to provide services for the chronically mentally ill in rural areas. All of these increase the possibility that mentally ill people and substance abusers in rural areas will receive less service or no services. Indeed, for people in rural areas, mental health and substance abuse services already have begun to shift from the mental health system to the criminal justice one.

Although so far this paints a pretty bleak picture of options for rural clients who have mental illness or substance abuse issues, there are things that social workers and agencies can do to help provide encouragement. A model of treatment that has been suggested as an approach for rural communities is assertive community treatment (ACT), in which multidisciplinary teams with low caseloads provide intensive case management and coordinate both treatment plans for mentally ill individuals and substance abuse treatment for the dually diagnosed (Randall & Vance, 2005). But as Meyer and Morrissey (2007) suggest, the realities of rural communities have forced adaptations of the model that tend to reduce the size of treatment teams, create a less diverse staff, and offer less intensive service that may reduce the effectiveness. In general, if treatment teams must travel a lot to reach clients, then they will be able to assist fewer clients because of travel time. Still, the ACT model can help bring more services to remote clients.

Another outreach method that holds promise is the use of telemedicine, or real-time, two-way interactive telecommunication between patients and health-care providers, to reach out to clients in distant communities. Telemedicine holds promise, but smaller communities still may not have the communications infrastructure to support it. At this point, there are still rural areas with poor connections to communications networks, and communications technology is expensive. Once again, it becomes an argument about cost-effectiveness, as to whether there are enough people who need services to avoid making their cost prohibitive. For now, telemedicine may bring services closer to clients, but they might still have to travel. In any event, some mental health and substance abuse treatment staff will still need to travel to clients.
There is also the old-fashioned outreach model, in which regional service providers establish satellite clinics or develop some type of mobile unit that can travel from community to community. Depending on the size of the population served, the facility may be staffed only periodically, perhaps two days a week or less. This provides some outreach, and depending on the schedule, a schedule of services might be predictable. This type of arrangement may provide earlier intervention than waiting for patients to travel to distant health care facilities for services. These outreach services can still be expensive, though, and clients may have to travel for specialized services.

To be most effective, mental health and substance abuse services must be adapted to the community and employ available resources. An example of this might be to develop sensitivity to the local culture and work with local people to develop culturally sensitive treatment practices, possibly even incorporating folk medicine, in addition to the traditional evidence-based approach (Conway et al., 2011). For example, Native American and Hispanic populations may benefit from the involvement of shamans or curanderos, respectively, in the treatment process. In another example, Furstenberg and Gammonley (1999) discuss the use of local companions with older people receiving outpatient mental health services in rural North Carolina. The program matched lay retired people with mental health consumers to augment traditional services, and it achieved good results. The use of community volunteers helped extend and enhance the treatment experience of the mentally ill.

Another approach that Randall and Vance (2005) suggest is to engage in service coordination. This can be effective when a service area covers several communities in a geographic region. Providers in one area may not be used to working with agencies in other communities, and basic service coordination could extend the services for the region. In any event, social workers who work across communities must establish credibility with the people in each one. In other words, just because an agency or service is accepted in one community does not mean that it will be accepted even in nearby communities.

In any event, social workers who deliver mental health or substance abuse services need to be creative and flexible in responding to the needs of clients and overcoming some of the challenges of rural practice. Some
community practice in extending, coordinating, and enhancing service may also be needed, in addition to good clinical skills in order to engage in behavioral health. But then, good rural social workers should always be creative and adaptable, and think as generalists.

RURAL HEALTH CARE SERVICES

The availability of quality health care is important for rural people. Approximately one-third of rural residents are in poor health, and about half have a chronic health condition (Cashwell & Starks, 2011). Yet people who live in rural communities tend to have less contact with physicians and health care than city dwellers. Casey, Blewett, and Call (2004) have suggested that many unmet rural health-care needs are a result of inadequate health insurance, low income, and cultural barriers. Yet Medicare payments to rural hospitals are less than those for urban hospitals, which may be a factor in the closing of 470 rural hospitals over the past twenty-five years (NASW, 2012).

Many of the same issues that face social workers in the areas of mental health and substance abuse also apply to work in the health-care field. The main problems that rural communities face in getting health care are access, availability, image, and breadth of coverage (Cashwell & Starks, 2011). Once again, the issue of managed care, shortages of professional staff, low population density, and distance all affect the range and quality of rural services. With rural health care, unlike with rural mental health care, there is typically not community stigma associated with physical illness. But people may still have some reluctance about being seen undergoing some types of treatment, and they may not want the whole community to know the specific nature of their illness. There is, however, still some public stigma in using public funds to pay for health care, which may tend to inhibit the use of some health-care services such as public clinics or hospitals.

When we talk about health care, we are referring to services that provide prevention, primary care, outpatient care, hospital care, follow-up care, emergency care, and dental services. Rural people experience difficulties accessing these services for several reasons. For example, access may be restricted by the availability or unavailability of services
in an area. One population that has been identified as underserved by the rural health care is veterans (NASW, 2012). Forty-four percent of military recruits come from rural areas, and often they return to live there. They can have greater health needs than the average population, but they have less access to health care (NASW, 2012).

There is also a shortage of health-care professionals to serve rural areas. For example, Cashwell and Starks (2011) observed that only 9 percent of physicians practice in a rural setting. The effect of this is that health care has been moved to regional centers, typically to larger towns in a region. While this provides services for the region as a whole, the health care may still be difficult to access because of travel times or distance to the regional center. Time and distance can be critical, especially when emergency services are concerned, as extra time may mean life or death.

Access to health care may be restricted for other reasons. Local health-care centers may be small or lack comprehensive services. They may be able to diagnose, but for treatment patients may need a referral to a larger facility, which would make treatment even more difficult to access. Not having the needed range of services could cause local people to bypass a regional center altogether, thus lowering the utilization rate of the facility and increasing the operating costs even more. The smaller size of rural facilities may result in a reduced capacity to serve the local population, and people may have to be wait-listed. If the wait is too long, folks may give up seeking services and leave their condition untreated. In contrast, staying too long on a waiting list could result in serious complications and even more extensive services being needed. Neither of these is a good option for a person’s health.

Access to health care in rural communities can also be an issue, for slightly different reasons. Many rural people do not have adequate health insurance, which makes them reluctant to seek out health care. Lack of insurance and ability to pay for health care are common problems among the poor, as well as for the working poor in rural communities. Salaries and family incomes tend to be lower in rural areas than in the cities, and many jobs do not provide health insurance coverage. Many people who lack insurance coverage or use public insurance are minorities, and there are significant health disparities among groups. Also among the limited
health-care options facing smaller communities are facilities and providers who elect not to accept public programs like Medicaid. This further restricts an already-limited health-care market in a rural community.

Rural people who fear being unable to pay for health care or being denied services may put off getting health care until it is absolutely necessary. Inability to pay for services creates internal conflict because it implies that the person is not self-sufficient and needs to accept charity. This is not unique to rural people, but it is probably accentuated by the stronger emphasis on self-support value and by higher-than-average poverty rates in rural areas. So people avoid getting formal health care, or they may substitute folk remedies and just hope that things work out. However, if people wait until a condition gets more serious before seeking medical attention, it means that hospital emergency rooms often become their source of primary care. This is not uncommon among the poor or the uninsured, but it does tend to make health care very expensive and overcrowd emergency rooms. In some rural communities the emergency room isn’t an option if it is too far away.

An example can help illustrate the challenges found at the intersection of availability and access to health care. The rural county Madison has a small regional medical center, with two hospitals and several health-care providers. But many health-care resources for indigent patients and recipients of Medicaid and Medicare are limited because some providers would not treat patients unless they could pay through private insurance or personal funds. For indigent pregnant women, no provider in the community was willing to provide prenatal care or deliver children. The county hospital would deliver children in emergencies. Most cases were not considered emergency services, and thus not covered by the county hospital. So patients could not get prenatal care or delivery services if they couldn’t pay. Ultimately, the designated facility for serving those patients was 180 miles away, and the trip there took more than three hours. The basic issue in this case is payment, but obviously health complications can develop for many people in this situation.

Another reason people may not access health care much in rural areas is because of a traditional reliance on folk medicine. Some of these cures rely on roots, herbs, and oils, and they might be administered by a folk medicine practitioner. Some rural groups retain at least some folk healing
practices as an alternative to traditional medicine, such as castor oil as a purgative, catnip and chamomile for colic, tobacco for drawing out poison from insect stings, willow bark for headaches, sassafras for internal illnesses, whiskey for teething, and brown sugar and turpentine for the flu (Cavender, 2003). Some of these practices have therapeutic value, but unwavering belief in their efficacy may prevent very traditional rural people from using health care when they need it most.

Today, rural health care provides quality services, and providers meet accepted professional standards. Yet the myths persist that somehow rural health care is subpar—perhaps because salaries are higher and better-known medical facilities are in urban areas. So, in general, many rural residents have the attitude that for routine health care, local facilities are fine, but for something serious, the city is the place to go. That is a realistic perspective with specialized services, because they are more widely available, but it does not reflect general opinion that rural health care is not up to snuff. They seek treatment in a larger city because of the wider range of treatment options.

In rural areas, another health-care consideration is that some health problems may be environmental in nature, and therefore a broad public health concern. For example, agricultural workers frequently work around pesticides and herbicides that may have long-term toxic effects on the body and produce a number of ailments. Some types of fertilizer and even animal litter can be toxic in high quantities. Mining and oil and gas production sites leave behind chemicals that can cause health problems through direct contact with them, breathing their fumes, or contaminated drinking water. Chemicals can seep into the groundwater and be consumed by people over a long period of time. Workers can be exposed to hazardous bacteria at meat-processing plants. Natural agricultural waste may have toxic effects that result in illness. For example, broiler litter—the droppings in chicken houses—contains a number of toxic chemicals that can lead to health problems, as well as air and water pollution. Social workers in the area of health care should be alert to cases of similar illnesses in people living in an area so that they can identify, investigate, and address possible public health issues.

In looking at rural social work practice in the health-care field, some significant ideas for improving services come to mind. A first step is to
develop knowledge of the local people, including minority and oppressed groups. Clients’ beliefs about disease and illness, their view of treatment, and their use of folk medicine are all very useful in helping workers start where the client is, in building relationships, in making assessments, and in developing interventions. Secondarily, developing knowledge of the people, organizations, and informal resources that can provide sources of support can be helpful in developing solutions. For example, knowing folk medicine practitioners who might work alongside traditional medicine could be useful for working with clients who have strong beliefs in the use of folk medicine. It is also important to identify family members who can provide personal care, do chores and other tasks, and provide transportation to fill gaps when formal resources may not exist or be limited. Churches, for example, can help address spiritual aspects of healing and also assist with transportation.

Rural social workers may have to fill many roles in providing health-related services. For example, Smith, Glasser, and Korr (2011) discussed the value of psychosocial services as important for cancer patients in rural areas, including assessment, distress screening, problem solving, cognitive behavioral therapy, and patient advocacy. Cashwell and Starks (2011) also highlighted some of the macro practice aspects of rural work, including seeking grants, coordinating formal and informal resources, mobilizing community support, and facilitating collaboration.

CHILD WELFARE

Child welfare and child maltreatment are significant social problems and the provision of services to protect children and assist families in need is a traditional arena for social work practice. According to the Children’s Bureau (2011), in 2011 there were 3.7 million children who were the subject of a maltreatment report. Not all reports were substantiated, but about one in five (19.5 percent) were found to be either substantiated or indicated (Children’s Bureau, 2011), a sign of serious issues that required intervention.

In terms of rural communities, the manner in which child abuse data have been collected has created some difficulty in making some comparisons between rural and urban areas. However, the most recent National
Incidence Study of Child Abuse and Neglect indicated that maltreatment is greater in rural communities than in urban ones (Child Welfare Information Gateway, 2012). In virtually every category of maltreatment, rural communities experience rates that exceed those of the cities. Data from prior years have been less clear, but they suggest that the rate of child abuse in rural areas appears to be at least as high as that in urban communities (Belanger, 2008; Ginsberg, 2011b; Walsh & Mattingly, 2010). In any event, child maltreatment is always a serious social problem to be addressed wherever it occurs.

Because of state and federal funding, child protection and foster-care services extend to all regions of the country, including rural areas. How well such services reach rural communities varies considerably in terms of both access and adequacy, and depends on the community and the region, but rural agencies and workers face some challenges not typically found in the cities. The consistent rural factors of distance, population density, shortage of professionals, and availability of specialized services often create barriers rural child welfare workers must address.

Information about social work practice in rural child welfare is somewhat sparse, and clearly, we need to know more about this important field to understand both the successes and the challenges, and to enhance policy and services for families and children (Belanger, 2008). One thing we do know is that rural child welfare practice is more likely to be generalist, covering a broad range of services instead of specialized ones (Child Welfare Information Gateway, 2012). There are simply not enough workers available to support workers’ field specialization. However, one area of concern for rural child welfare is the professional workforce available to provide services. Providing effective services for children in a rural setting requires professional education and training for evaluations and appropriate interventions (Leistyna, 1980). But nationwide, child welfare agencies have difficulty in attracting and retaining qualified workers to provide child welfare services (Zlotnik, 2003), and in rural communities there are fewer workers with social work degrees (Child Welfare Information Gateway, 2012). This is unfortunate, because many child welfare agencies prefer that social workers have professional training, which often generates a greater commitment to the field and longer retention (Whitaker, 2012).
Another challenge workers face in this area is isolation: many social workers are isolated in large geographic service regions (Sudol, 2009). Thus, resources are stretched over long distances, and workers have extended travel times to reach clients. This means that a greater portion of rural workers' time is spent on travel rather than directly providing services. And supervision, which is an important source of support, is more difficult to get in a rural setting (Child Welfare Information Gateway, 2012).

Another practice issue is that children in rural areas might encounter factors that affect their safety, permanence and stability in care, and well-being, but without the same access to supportive services that many urban children have. Smaller towns have few treatment options for substance abuse, mental health, and specialized placement facilities for children. Treatment options for children with special health or behavioral needs are especially limited. Support services for children and families are important resources for keeping children in their own homes and strengthening families. These supports reduce a need for foster care and shorten the length of time in care once children are placed there by building a safer home environment as quickly as possible. Support services are essential for family preservation to work effectively because they affect whether a child is placed in foster care and can remain at home once returned (Belanger & Stone, 2008). Unfortunately, rural communities often do not have enough support services to meet such needs.

When rural children are placed in care outside of their homes, they often are placed far from their home communities, and so they have more limited family contact and family preservation efforts suffer. For example, parents with mental health issues may have children removed and placed out of the home because there are insufficient treatment services available to them. Neither children nor families benefit from this, and the community suffers because of the extra expense of maintaining children in foster care. One way to maximize limited resources for rural children and families is for smaller communities and agencies to coordinate activities, services, and resources (Leistyna, 1980; National Child Welfare Resource Center, 2003; Sudol, 2009). Through coordination and cooperation, small communities can work together to share existing resources across geographic boundaries, make limited specialized resources more available, and extend the reach of their services.
Undoubtedly, another factor that works against families, children, and rural communities is the higher-than-average rate of poverty (Belanger, 2008). Child maltreatment rates are generally higher among poor families. Poor families have fewer resources with which to support their families, which potentially increases the likelihood of some types of child maltreatment, especially neglect. For example, poor families are more likely to live in substandard housing, to have difficulty clothing and feeding their children, and less likely to provide parental supervision. For working parents with marginal income, it is unlikely that they will be able to afford either child care or babysitting during work hours. Day-care centers are more limited in rural areas, and people are more likely to work nontraditional hours, further limiting access to day care (Friedman, 2003). In some small communities, quality day care may not be available at all. Thus, working parents may have to sometimes leave children unsupervised while they try to make ends meet.

A significant issue in foster care nationwide is the disproportionately high rate of minority children who are placed there. For example, African American and Hispanic children tend to be placed in out-of-home care at higher rates than Caucasian children. Rural communities that face high poverty and do not fully accept members of minority groups face an especially high risk for foster-care placement of poor and minority children. Family and community resources also seem to be a factor in such placements, and poor families with limited resources may not be able to provide assistance to their relatives in need.

In rural communities, some characteristics and traditional values may make child welfare services more difficult to provide as well. Ginsberg (2011b) suggests that domestic violence, including child maltreatment, may be more hidden in smaller communities because of a lower concentration of housing. These conditions make it less likely that people will observe and report cases of suspected maltreatment. In addition, people might fear that a family’s rights will be violated by outside organizations, and so they are deterred from reporting maltreatment (Sefcik & Ormsby, 1980). Many rural communities still believe in “sparing the rod and spoiling the child,” and they interpret it literally. This is another factor that may make people reluctant to become involved in what they see as essentially a family matter. The trend in several states to centralize the reporting of child maltreatment may also reduce reporting maltreatment in rural
Social Welfare Services in the Rural Community

areas, especially if community members do not trust calling a toll-free number in a distant, often urban community. Traditional values that reinforce the idea that family problems, including maltreatment, belong in the family can be quite strong, producing reluctance to make a formal report, except under extreme circumstances. Moreover, law enforcement and medical personnel may be reluctant to intervene because they know a family or expect family matters to be handled internally. Child welfare workers may face pressure to avoid intervention with some families because of who the families are and their relative power in a community. Without enough information or available services, rural agencies may end up leaving more children in potentially dangerous situations (Child Welfare Information Gateway, 2012).

Despite all these challenges, rural child welfare agencies have shown an ability to adapt to local realities and enhance their services. Rural agencies have used coordinated wraparound services to improve what they do (Child Welfare Information Gateway, 2012). Developing wraparound services and integrating child welfare with health care and other human services is one solution. Rural services have also benefited from decentralization of services at the local level, allowing delivery of education and preventative services and work with community resource centers (Child Welfare Information Gateway, 2012). Examples of this include the RURAL program in California, which provides competency-based training to workers in managing barriers to service access, in strengthening families, in improving access to faith-based and community services, and in working with state, local, and tribal governments (Denniston, 2008). Also, the HERO Project in Hale County, Alabama, works to coordinate community services and provide a forum for identifying community issues and devising solutions (National Child Welfare Resource Center, 2003). To reduce problems of distance and access, some pilot programs in rural child welfare have used virtual home visits via Skype connections (Family Center on Technology and Disability, 2010).

How to effectively deliver child welfare services to rural communities is a challenge that many small towns and rural areas face today. It is clear that at least some effort must be put into the community aspects of practice to develop ongoing collaborations and communication with local social welfare agencies. Creative solutions for outreach for services and
supervision also must be devised. Child welfare agencies must also recruit, attract, and retain workers who are multiskilled and have a professional background in generalist approaches. It is also essential that workers are sensitive to the rural culture and able to learn the local culture. Given the isolation of many rural social workers, it is a plus that they have a degree of autonomy, creativity, and flexibility. There are many formidable challenges, yet many agencies and communities successfully find a way to adapt and provide high-quality services.

DOMESTIC VIOLENCE

Domestic violence is a serious social problem in the United States, yet there remains much to be learned about it. Much of what we know about domestic violence comes from case studies and anecdotal reports. Reliable figures on the extent of domestic violence are difficult to pin down, as public reporting to a central source is inconsistent. Much of what we know of the prevalence of domestic violence comes from social surveys that rely on different methodologies and definitions of the problem. Thus, figures on domestic violence vary considerably. For example, one source indicates that 22 percent of women have been assaulted by a partner at some point in their lives, and that 1.3 million women and 835,000 men are physically assaulted in the United States annually (Rural Assistance Center, 2012a). Another source estimates that between 4 million and 6 million women are affected by domestic violence each year (Turner, 2005). It is clear that more research is needed on the topic of domestic violence, especially in regard to rural areas (Rural Assistance Center, 2012a).

The extent of rural domestic violence is particularly unclear. We do know that in the rural context, there are several barriers that need to be addressed in providing domestic violence and related services to clients. Turner (2005) indicates that rural victims of domestic violence confront unique barriers to leaving an abusive situation, including geographic isolation, lack of transportation, and lack of community resources. Chiarelli-Helminiak and Bradshaw (2011) identify essentially the same barriers for rural women, and they add high rates of poverty. In writing about indigenous women in Alaska, Shepherd (2005) identified additional barriers,
including few law enforcement officials, lack of transportation, severe
winters, extended family networks, language barriers, ties to the land,
cultural history, and even availability of weapons. What can be concluded
from this is that there are a variety of contextual factors that keep rural
victims of domestic violence in a relationship and may impair their moti-
vation to seek services, as well as their ability to receive and benefit from
services. Just which barriers exist depends somewhat on the individual,
the community, geography, culture, and the family network.

There are domestic violence services and shelters in rural communi-
ties across the country, but shelters and domestic violence services face
major challenges in terms of access. Low population densities combined
with geographic isolation often result in considerable separation between
people and the services they need. Given the need and geographical
expanses, rural domestic violence shelters and services often end up serv-
ing multiple counties in a region. To access services, domestic violence
victims need to get to service centers, which are typically located in a
larger town in the region. Consequently, they often need reliable transpor-
tation to access the services. Distance, road conditions, and even weather
can affect just how easy that access might be. Severe winters and storm
conditions can shut down travel for a considerable time, and the combina-
tion of long distances and poor roads can make travel very difficult. For a
shelter that serves a large geographic area, considerable community out-
reach is often necessary, especially in outlying areas, to inform people
that services exist, what the services are, where they are located, and how
to access them.

In some small communities people are isolated and uncertain about
reaching out for help. Victims might be surrounded by family members
and friends of the perpetrator. There is little confidentiality because every-
one knows everyone, and there is reluctance to reveal family problems.
Rural communities are often not supportive of victims, and they often
deny the existence of domestic violence (Johnson, 1998). There may be
few law enforcement personnel in rural areas, and response times may be
exceedingly slow. Law enforcement may also tend not to take domestic
violence seriously, perhaps viewing it as a family problem. Or law
enforcement officials may know the perpetrator and call on the “good old
boy system” to protect him.
Domestic violence tends to generate stigma and embarrassment for victims in small towns, which makes victims reluctant to reach out for help. There may also be cultural factors that keep victims from getting informal support from family and friends. The attitude “you made your bed, now lie in it” may come into play.

Realistic concerns about confidentiality and safety may arise about domestic violence services. Many shelters keep their locations confidential for security reasons to keep perpetrators from tracking victims down and harassing or hurting them. Such locations are rarely confidential in small towns, and if victims do not feel secure about being in a safe place, they are often reluctant to reach out for help. For example, in two rural communities in which I lived, locals could give most anyone directions to the shelter safe house even though its location was “confidential.”

Seeking services from a rural domestic violence shelter may mean that a person would have to leave his or her home community and relocate to another, and this is where the rural value of connection to the land comes into play (Shepherd, 2005). If the person has strong roots in his or her home community and believes that services involve moving to another, that person will be less likely to seek out services. Low incomes and poverty in rural areas may also constitute a barrier to services. A victim of domestic violence with low income may have fewer resources, such as transportation, for seeking out services. The availability of options for family income if the victim leaves the perpetrator may be much more limited in a rural setting, depending on the area’s economy. Language can certainly be a barrier to seeking services, as victims may have difficulty communicating their situation and needs, and/or they may be uncertain as to how outsiders view or understand their culture.

So, what kinds of services can rural social workers expect will be needed to serve domestic violence victims? Turner (2005) indicates that for many rural communities, having a shelter is ideal. But not all rural communities can support a shelter, and the need for one would have to be assessed by each community. If a shelter is needed, then community development could be used to establish it. Shelters are costly, and a needs assessment would have to be undertaken with the full understanding that even if a shelter were to exist, some rural people might be reluctant to use it. However, many rural communities could benefit from supportive services, if not a shelter, for domestic violence victims (Turner, 2005).
At a minimum, domestic violence services might include a twenty-four-hour crisis line, information, case management, coordination of community services, temporary emergency housing, services for batterers, and community education (Chiarelli-Helminiak & Bradshaw, 2011; Shepherd, 2005; Turner, 2005). Rural social workers might have to engage in advocacy with existing service agencies to address the many barriers that domestic violence victims face in receiving services. Workers might need to engage informal community resources, such as concerned individuals, civic organizations, and churches.

SERVICES FOR IMMIGRANTS

As discussed earlier, a primary area of growth in rural communities is a result of in-migration. Much has been written about services to Hispanics, especially migrants and immigrants in rural areas, although they are by no means the only group migrating to rural areas. At this point, there is little written about social welfare services programs addressing the needs of immigrants other than Hispanics, such as Asians.

Hispanics account for one of the fastest-growing populations in the United States. As of the 2010 census, they accounted for about 16 percent of the population (US Census Bureau, 2011). The past ten years have seen dramatic increases in rural areas of Hispanic residents—many of whom are undocumented immigrants—which has been a major contributor to the increased rural population. Between 2000 and 2006 alone, the Hispanic population of rural communities experienced an estimated 22 percent growth (Mather & Pollard, n.d.). Many communities that previously did not have Hispanic residents saw significant in-migration. As job opportunities opened up in construction, agriculture, services, and other sectors, Hispanics began to move past traditional southern border regions of the United States into the middle of the country.

On the basis of recent trends in Hispanic immigration and projections of future immigration, rural social workers have increasingly identified Hispanic immigrants to the United States as an underserved population and have begun to focus on providing services to meet their needs. For example, since 1990 there has been a trend toward decreasing social integration of immigrants as in rural communities that appears to correspond
to the number of recent arrivals (Koball, Capps, Kandel, Henderson, & Henderson, 2008). In other words, the greater the number of immigrants to a rural community, the less likely they are to be integrated into that community. Much of this appears to be about language, as many communities who experience high immigration have few people fluent in Spanish or other languages to work with those who might not speak English well. It is also difficult for existing residents to understand or appreciate the culture of new immigrants if they cannot communicate with them well. And then there is the fact that rural communities are not noted for their tolerance of newcomers or outsiders. There is also the fear that recent trends in state laws identifying undocumented immigration as a crime and the exclusion of Hispanics from the traditional service delivery system will further disadvantage them in society.

For migrants and immigrants who do not have a legal immigration status, there is fear of detention, deportation, and possible separation from their family. In addition, they are often barred from receiving public benefits. All these things discourage the use of services and health care in small towns and rural areas. But there are examples of programs specifically designed to help reduce these kinds of barriers. For example, Dollar, Reid, and Sullivan (2009) discuss a multistage health program called Salud para la Vida (Health for Life) that was developed in rural Missouri. The program provided education to health profession students about rural and Hispanic cultures, and helped them develop medical Spanish skills and cultural competency. It also delivered culturally appropriate preventative health and clinical follow-up for low-income Hispanics. The program used a multicultural approach to bridge the language and cultural gap between new immigrants and rural residents (Dollar et al., 2009). Such an approach also provides for better outreach and follow-up services, and the program reported successful results in providing health care to this underserved group.

In another program example, Rodriguez, Cooper, and Morales (2004) outline the use of community practice to organize residents of a colonia in rural Texas to form an ongoing community spokesgroup to engage in advocacy for underserved community residents. The program, Hispanic Alliance for Community Enrichment (or HACER, which means “to make” or “to do” in Spanish), a voluntary coalition of churches, law
enforcement, education, and social service agencies organized by a social worker, helped address issues like road maintenance, restoration of school bus service, work with stores to carry culturally relevant items, and work with city government to better address the needs of this population.

In the twenty-first century it no longer is clear, as it was once, where one might find significant groups of immigrants who may need services. The Salud para la Vida program is in an area near the middle of the country, and the HACER program is in a region of Texas that had traditionally not experienced significant Hispanic immigration. Even in rural areas of the US South, services for immigrants are being established. For example, in my county in Alabama, services are being established for both Hispanic and Southeast Asian immigrants.

Many of the newly established programs to serve immigrants and migrants are either funded through grant funds or established by churches and not-for-profit agencies. For example, in my county, rural services for Hispanic immigrants originated with the Catholic Church, Catholic Charities, and a Catholic hospital. There is also a rural health clinic that serves many people of Southeast Asian descent. Given that there still is societal bias against new immigrants, states and local communities, especially rural ones, are unlikely to offer much to help until they can no longer ignore the presence and needs of immigrant populations within their communities. This means that rural social workers will need to be alert to new minority groups entering the area and their needs. And workers may need to spend a portion of their time on community education and advocacy on behalf of immigrants. Community practice skill may need to be used to solicit grant funding, coordinate existing and develop new resources, and mobilize informal sources of support. It certainly appears that developing culturally appropriate services for new rural immigrants will be an important field for practice in the future.

CONCLUSION

Popular beliefs to the contrary, social welfare services are present in rural communities in some form, but that certainly does not mean that the available services are ideal. Rural communities frequently face a number
of barriers to providing services that reach people who need or benefit from them. Small towns and rural areas tend to have significantly lower concentrations of people than one would find in a city. The result is that providing services in rural areas tends to be more costly, services are spread over a wide area, and they often are not found where clients might need them.

The common problems encountered by rural social workers, agencies, and communities typically fall into one of five categories. The first problem is access to services. The expanse of the countryside and a service area can mean that needed resources are located some distance from those who need them. Rural services tend to be found in larger towns that serve as regional centers, but people in rural areas have to find a way to get there. Travel over country roads, long distances, and weather and geographic barriers for people who have less-than-reliable transportation may mean that services are effectively unavailable. A second problem is availability of specialized services. Rural people who have special needs may not find service available locally. Children who have behavioral or mental health problems may find services locally, but perhaps not the service that best addresses their need. Getting specialized treatment can require long commutes, perhaps hundreds of miles, to get the appropriate treatment.

A third problem facing rural services is funding. In today’s society, where social welfare funding is a target for budget austerity, money flows more readily to communities where the most people live and where services are delivered more efficiently. With lower populations and higher costs per unit of service, rural agencies are often chronically underfunded. A fourth problem facing rural services is attracting and retaining professional staff to deliver services. Often larger communities offer more opportunities, better salaries, and a different lifestyle, which makes it difficult to build and maintain appropriate levels of professional staff. A fifth and final service barrier is the traditional value base of many rural communities, which emphasizes personal responsibility, self-reliance, and use of informal resources. These values make people reluctant to access formal services for a variety of reasons.

These challenges for rural social workers and services can be formidable. Yet social workers, agencies, and communities have adapted to serve people in need. New technology offers some promise for outreach,
but there is no substitute for good community work to coordinate and build on what is available to build support for needed services. Generalists can provide direct services as well as leadership in community development. Instead of focusing on what is not in a community, successful workers and programs concentrate on the assets available, are creative in developing new approaches, and are culturally responsive to the community. More creative approaches to services are needed to face the challenges of service delivery in the twenty-first century.

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