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Reinventing Social Work Education and Service Delivery in Rural Areas: An Interprofessional Case Study

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Abstract. This article presents an interprofessional case study approach to serving the social service and health needs of vulnerable persons living rural communities. This project, the Congregational Social Work Education Initiative (CSWEI), is funded by a health care foundation. Persons in rural areas are often at risk for poverty, homelessness and lack of access to needed health and social services. The case study demonstrates the opportunities for collaboration between professional social work, religiously affiliated organizations (RAOs) and nursing in order to reduce health and mental health disparities among residents in rural areas.

Keywords**:** social work internship, elderly, social work and rural religious affiliated organizations, congregational nursing, collaboration, interprofessional practice

The economic and social effects of the great recession of 2007 continue to negatively impact rural areas today. Persistent levels of high unemployment, homelessness, and health care disparities, coupled with plant closures and falling infrastructure funding, have been the reality for many rural communities. In North Carolina, 1.8 million people living in rural areas are on the edge of poverty. Job creation has been slow and the number of family farms continues to decline. Perhaps of greatest concern is that the number of manufacturing operations in many rural communities and counties has decreased since 2007 and continues to do so presently (Berner, Vazquez, & McDougall, 2016; Huskins, 2014). This has led to higher levels of poverty and lack of access to needed health and social services.

These factors have prompted the need for new and innovative approaches to serving people in need. Of importance, the relationships between rural churches and the social service community have been highlighted in recent research (Colvin & Bullock, 2015; Harr & Yancey, 2014). Recent reports have also highlighted the need for social work and religiously affiliated organizations to work closely to promote access and service delivery (Boddie, 2002; Davis, n.d.; Yancey & Garland, 2014). The purpose of this article is to present a case study of an interprofessional model of collaboration between social work education, nursing, and religious organizations in one North Carolina county to serve vulnerable rural residents.

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Review of the Literature

Despite recent research on social work practice in rural areas (Davenport & Davenport, 2008; Ginsberg, 2005; Lohmann & Lohmann, 2005), university-based social work education has not traditionally provided specialized training in rural practice or in concert with religious affiliated organizations (RAOs). Perhaps the history of social work as an urban-based profession, and the desire for specialization as opposed to generalist practice, has contributed to this trend. In rural areas, social workers are generalists (BSW) and advanced generalists (MSW) because they are called upon to address multiple and complex client and family needs in environments having challenges with access to services, transportation, service gaps, and persistent poverty (Farley, 1982; Ginsberg, 2005). Roles of the social worker in rural areas include not just direct service but also community collaboration with existing agencies and RAOs, capacity building among agencies, and community advocacy and education (Colvin & Bullock, 2015; Lewis, Scott & Calfee, 2013; Scales, Streeter & Cooper, 2013).

These challenges require social work education programs to continue developing new working relationships with vulnerable rural communities and RAOs (Moore & Collins, 2002). The social work profession has often missed opportunities to join with these organizations in the delivery of services (Abbott, Garland, Huffman, & Stewart, 1990; Elliott, 1984). This has been particularly true for social work practice in child and family settings, mental health, and schools (Paul, Hussey & Arnsberger, 2002; Polson & Rogers, 2007; Taylor, Ellison, Chatters, Levin & Lincoln, 2000).

Through history, religious organizations have provided social services for members while also acting as a voice for the poor and oppressed (Garland & Bailey, 1990). Faith-based social service delivery has long been an important system of care (Cnaan, Sinha & McGrew, 2004). This is especially true in rural areas where the rate of attendance and membership in RAO's is higher than in urban areas nationally (Garland & Bailey, 1990).

Despite the importance of RAOs in the delivery of social and health services, professional social work has often missed opportunities to join with these organizations in the delivery of services. While social workers in settings such as hospitals, hospice, and long-term care have been leaders in recognizing the spiritual needs of patients and collaborating with clergy, social workers in child and family settings, mental health, and schools have been less active in this collaboration. As Manthey (1989) noted, during the modern development of the social work in the 20th century, there has been a drive for professionalization and a separation from volunteerism and religious-based service delivery.

When experiencing personal health or mental health difficulties, individuals and families often seek help from their pastor or church staff. However, church leaders may not always be skilled in recognizing or meeting the mental health needs of members. This can be especially true in rural areas where churches often are smaller, independent non-denominational, and have fewer clergy who hold additional qualifications (e.g. degrees in psychology, social work, pastoral counseling, counseling or related fields). Furthermore, many American clergy have little to no formal higher education or seminary training. They are not prepared to collaborate with community nursing, social work, psychology, or health practitioners (Blalock & Drew, 2012; Getz, 2011). In addition, clergy and church staff rarely make referrals to access substance abuse or

mental health professionals or service programs. Often they are unable to assist families to navigate the complex web of local, state, and federal social services or have knowledge or access to informal services available within their respective community or county (Polson & Rogers, 2007; VanderWall, Sandman, Linton, Hernandez & Ippel, 2011). Unfortunately research has found that some clergy may deny that social problems, such as domestic violence, homelessness, child or elder abuse, or mental illness may be present in their congregation, or feel unprepared to address it. Studies report clergy may deny or dismiss a mental health disorder as a "*moral weakness"* or even direct an individual to discontinue medication (Getz, 2011; Homiak & Singletary, 2007; Payne, 2009; Roger, Stanford & Garland, 2012).

Social workers have also been slow to embrace the importance of spirituality to many clients, while clergy do not always recognize the need for referral. In rural areas, spirituality is an important part of community life as evidenced by rates of church attendance and the centrality of churches in meeting social service needs. Although there are exceptions (Taylor et al., 2000), opportunities for collaboration are being missed which result in low levels of service provision to people in need. There are opportunities for social workers to more effectively meet the health and mental health needs of elders by reconnecting professionally with faith organizations (Sherr & Wolfer, 2003).

To address these issues, the Joint Master of Social Work Program, administered by North Carolina A&T State University and the University of North Carolina at Greensboro, developed the Congregational Social Work Education Initiative (CSWEI) funded by a regional health foundation. The project provides mental health, health and gerontology classroom content and field instruction placements in communities and religiously affiliated organizations (RAOs) for MSW and BSW students who are preparing for professional social work practice. In concert with the Moses Cone Health System Congregational Nurse Program, which teams a community health nurse with the social work students, the project provides interprofessional health and psychosocial assessment, case management, crisis intervention, personal and health counseling, screening clinics, educational programs, advocacy, and care giving assistance to members of rural congregations in central North Carolina. This initiative demonstrates the opportunities for collaboration between professional social work and RAOs and prepares future practitioners to reduce health and mental health disparities in rural areas. The purpose of this paper is to discuss this initiative implemented in one rural county, Rockingham County, in North Carolina.

Rockingham County's Economic and Health Profile

In many ways, Rockingham County North Carolina reflects the economic and social service challenges being faced by many residents in rural America. The North Carolina General Assembly created Rockingham County North Carolina from the northern portion of Guilford County (564.94 square miles) on December 29, 1785. Located in the north central part of the Piedmont region of the state, with Guilford County to the south and the state line of Virginia to the north, it has been a very rural and remote area (Corbett, 1969). Settled by farmers moving north from Guilford County looking for cheap land to farm or establish small dairy operations, small settlements arose for farmers and dairymen to trade or sell their goods. After the American Civil War early manufacturing would develop primarily based on tobacco and textiles.

In 1874 a tobacco operation was established in Reidsville in the eastern central part of the County. The Penn Tobacco Company took advantage of a rail road line to ship their chewing, loose smoking tobacco, and later finished cigarettes to new markets. It was later acquired by the American Tobacco Company (ACT) in 1911. It continued to be the mainstay of the local economy until its sale and closure to a British conglomerate in 1994. Reidsville did have several small textile mills but did not have reliable power for larger operations. In the late 1880s, the upper northwest quadrant of the county experienced growth in textile manufacturing where small rivers or large creeks were damned to provide water power or through small electrical generators to drive spinning, weaving, and finishing operations (Corbett, 1969; Powell, 1989). The area around Eden would produce a vast array of cotton products sold to American consumers through department stores such as Macy's, Marshall Field & Company, Sears or through brand names such as Cannon, Fieldcrest, and Pillowtex. The 1980s brought considerable change as historian Brent Glass (1992) chronicled the collapse of the state's textile industry. Through mill acquisitions by financiers, hedge-fund managers, mergers and sell-offs, the demise of the textile industry in America would begin in the late 1980s and accelerate when production moved to China and Vietnam by the late 1990s. The American textile industry collapsed in the early 2000s due to mergers, high rates of automation, and provisions of the 1999 North American Free Trade Agreement for moving manufacturing to South America and Asia (Ensinger, 2011).

County leaders in the mid-1970s recognized textile and tobacco manufacturing was changing in the state and nation and sought to attract other businesses to the area. Capitalizing on the areas reliable water sources, Miller Brewing Company was recruited in 1978 to build a plant to produce and distribute canned and bottled beers (Covington, 2010; Rorrer, 2011). Other support industries, producers of metal and glass containers for beer distribution, container manufacturing, and shipping companies moved in to support the brewing industry. Miller merged with Coors Brewing in 2008 and later MillerCoors merged with SAB Industries, with production sites in Virginia and Georgia, announced the plant would be closed by September 2016. The expected loss of 550 jobs with a median salary of $60,154 would again usher in the domino effect whereby support businesses would experience decline in sales, workforce reductions, and further business closures (Trotter, 2015). Without an influx of new business, the expected revenue loss through property, business, and personal income taxes would be devastating to county and cities operations and reduced funding for schools, health services, city, and county services (Ensinger, 2011; Glass, 1992; Only & Gemberling, 2014).

Rockingham County has been a designated a rural community by the state's Department of Commerce since it began ranking counties in 2007 (NC Department of Commerce, 2015). It has not experienced significant growth, either population or economic, in the last several decades and is among the most economically distressed counties in the state. According to the Office of Economic Development (personal communication, L. Critiz, December 10, 2015) the impact of MillerCoors closing, expected closure of Ball Corporation and container manufacturing, trucking operations, loss of water and business tax revenues, diminished sales in home construction, reduction in restaurants and retail sales, collectively will make it difficult to recruit new business investment to the area and negatively impact the standard of living of county and city residents.

Most of Rockingham County's 93,000 residents are White (75%) with a significant minority of Black residents (19%). There is a small but rapidly growing (6%) minority of Hispanic residents. The county's population has increased by only 2% since the 2000 census, a net gain of fewer than

2,000 people. Hispanics accounted for more than a quarter of the total growth of the state's rural population. Ten rural counties including Rockingham County avoided population loss only by virtue of their increasing Hispanic population who work as farm laborers or in other low-wage jobs (Rockingham County Profile, 2012).

Minorities suffer disproportionately high rates of heart disease, cancer, and diabetes. It is estimate that 80% of the Hispanic population and 100% of the homeless population in Rockingham County are financially needy. Statewide data shows that Hispanic families earn significantly less income than any other ethnic or racial group. Twenty-five percent of all Hispanic people living in NC are living below the federal poverty level. Sixty-five percent do not have health insurance. In addition the health of homeless people is reported to be worse than that of the general population. The most common medical problems in the County's homeless population include bronchitis and pneumonia, mental health issues, wound and skin infections, foot problems, dental issues, and sexually transmitted infections (Huber, 2014).

The *Rockingham County State-of-the-County Health Report* (2011) provides a picture of the health status and needs within the county. The primary killers in this region are chronic diseases – diabetes, cardiac disease, pulmonary disease, and obesity – that top the charts for men, women, whites and minorities. In addition to chronic disease, access to healthcare insurance continues to be a problem for many County residents. Focus groups reported that Hispanic and homeless residents highlight the burden of chronic diseases, the high cost of care and medication, and social barriers including documentation status (Hispanic), language difficulties (Hispanic), transportation issues (homeless) and experiences of discrimination (both). Many participants described widespread use of over-the-counter medications to self-treat and reported going without care for years at a time. The prevalence of chronic disease has both health and financial implications for the poor and uninsured.

In the rankings of all counties in the 50 states, the Population Health Institute (2013) at the University of Wisconsin found Rockingham County had higher pre-mature deaths than state and national averages. Rockingham County had 9,229 premature deaths – ones that occur before the age of 75 – compared to the state average of 7,404 deaths. It also found the County's uninsured rate at 19 percent. This report noted that Rockingham County was one of the unhealthiest places to live in North Carolina. The efforts of parish nursing and CSWEI efforts to improve access to care, make appropriate referrals to primary and preventative care, and educate people on the management of their chronic condition will both improve the county's overall health and reduce the cost of providing care.

The Congregational Social Work Education Initiative: Case Study

The title of this project is the Congregational Social Work Education Initiative (CSWEI). The project has three educational components: (a) pre-service training in gerontology, health and mental health; (b) field instruction in religiously affiliated organizations serving older persons; and (c) the use of a collaborative team approach involving social work students, community health nurses, clergy, and other professional disciplines that are affiliated with congregations and/or RAOs served by the CSWEI. Under the supervision of the program director, the initiative offers vulnerable individuals and families access to a number of health and social services.

Administrative Structure & Student Supervision

The CSWEI program director, who is both a MSW licensed clinical social worker and a licensed registered nurse, oversees the learning activities of the students and serves in the dual role of both clinical supervisor and field instructor. One of the principal investigators, a licensed clinical social worker holding an MSW degree, supervises the program director. This flat administrative structure minimizes human resource program cost, maximizes program coordination, and minimizes role confusion for the student participants. The program director provides clinical supervision to all interns, directs all CSWEI activities, curriculum development, and fiscal management of the program. Combining both clinical supervision and field instruction roles allows the program director to accurately assess students' growth in knowledge and skills and provides an opportunity for interns to have a trusted teacher, supervisor, and mentor. In its current program configuration, the initiative accepts a maximum of 15 students. In addition, the program is entirely community based without any office setting. Students are not in an office within the congregations where they work; rather, they are mobile and provide services in the person's environment. Students receive weekly supervision; however, texting is a major method of contact between interns and program director if there is an immediate need for a clinical consultation or crisis intervention.

Following successful completion of the required pre-service training, students receive their respective assignment to a local religiously-affiliated organization or community outreach center. A distinctive component of the initiative is the collaboration between the social work student and the registered nurse. Together the interns and registered nurses provide a continuum of care through direct services and referrals to other community-based services, helping to bridge the gaps that often occur as people attempt to navigate complex and complicated social service and health systems. Nurses initiate referrals to the CSWEI, since each RAO has an assigned nurse who is familiar with the community and its needs.

Pre-service Curriculum

Prior to entering fieldwork each fall semester, students complete a 48 hour pre-service program which is delivered in seminar and workshop format face to face. Content is focused on the biology and psychology of aging, individual, interpersonal, and social problems related to aging, and health and mental health issues including specific topics such as co-morbid or co-occurring mental and physical disorders. Content on the major developments in treatment and psychological dynamics of major physical illnesses, with specific focus on cardiac disease, dementia, diabetes, stroke, pain, and oncology, is also covered. Additionally, students discuss cultural competence and sensitivity, safety, holistic care, ethical considerations, service documentation, the role of medications and medication management, and risk assessment including assessment for suicidal and homicidal concerns. Specific attention is given to conducting psychosocial and functional assessments, and service planning in an interprofessional environment, including in rural communities. The pre-service program is jointly taught by the CSWEI project director and the director of congregational nursing who holds BSN and MSN degrees (CSWEI, Training Manuals, 2007-2015).

The 48 hour pre-service training is integral to the success of the initiative. The intensive coursework, coupled with the small class size, enables the program director to assess the skill level

and learning needs of each student intern prior to receiving his or her field assignments. Pre-service training also increases students' knowledge base and preparedness, thus increasing the quality of service and competence in delivering health and mental health services.

In addition to those topics already outlined, the pre-service program offers training in the following areas: intern safety, overview of mental illness and substance abuse, healthy aging, practice in rural communities, and resource development. Given the unique challenges of a nontraditional field placement, the pre-service program also provides extensive training in the areas of ethics, boundaries, confidentiality, and role differentiation, particularly with regard to interprofessional team work and practice in RAOs. Students are instructed in HIPAA standards to ensure confidentiality and record storage compliance; each is assigned a lock box to store client records since they may serve multiple locations. Each intern is evaluated throughout the pre-service training through CSWEI director observation during exercises, intern presentations and writing exercises, group activities, and short quizzes (CSWEI, Training Manuals, 2007-2015). Additional information concerning the pre-service curriculum may be obtained by contacting the senior author.

Upon completion of this pre-service education, students are placed in area churches and other RAOs where they complete their field instruction as a member of a nurse-social worker team. MSW students complete one to three semesters of field instruction in this environment, twenty-four hours per week. BSW students complete two semesters of field instruction, sixteen hours per week. Using a strengths-based model of intervention, services provided by the social work student-nursing teams include psychosocial and functional assessment, treatment planning, case management, referral, advocacy, education, and evaluation. In addition, students present community education workshops with faculty, other interns, and nursing personnel on topics such as physical and mental health issues, community services, care giving, substance abuse, and healthy living. Based upon data from the *Rockingham County State-of-the-County Health Report (*2009), CSWEI targeted childhood and adult obesity, diabetic care, smoking cessation, aerobic exercise, well-baby care, and recognition and management of adult depression (CSWEI, Annual Reports, 2007-2015).

As a rural county in economic collapse, it has far fewer resources than the adjoining urban county where CSWEI is based. The dual placement of rural versus urban provides the interns a unique comparison in regards to service challenges, resources, culture, and demographics. One of the most striking anecdotal comparisons from students placed there is the startling difference in the education level of persons served. One intern noted that after 14 weeks of service, she has yet to provide services to a client who has completed high school. Despite the myriad challenges of providing social work services in an economically decaying, rural community, CSWEI interns have been quite adroit at developing and implementing creative solutions to the diverse concerns voiced by clients.

As with all CSWEI internships, every student has a minimum of two separate placements per field week. CSWEI places an MSW and a BSW student in Rockingham County on different week days, each intern serving one day a week, totaling two service days per week. Although their services are highly coordinated, they are programmatically distinct, with the BSW focusing on case management/resource activities, and the MSW focusing on mental health diagnosis, intervention, and treatment. CSWEI provides some services through its partnership with some

longstanding community entities, such as Salvation Army and the Free Clinic of Rockingham County. CSWEI's service target populations include persons experiencing homelessness, immigrants/refugees, older persons living in poverty, and the working poor, all of whom lack affordable access to ongoing medical care. Mirroring its service focus in neighboring Guilford County, CSWEI's primary service area, CSWEI endeavors to connect health disparate groups to primary medical care.

Since CSWEI commenced services in Rockingham County in the fall of 2012, it has provided an array of social work services to 112 unique individuals. Of those, 60% identify as White, 20% Black, and approximately 20% Hispanic. CSWEI's success in providing services to the Hispanic population may be skewed by program year since a service percentage jump occurred when CSWEI had Spanish speaking students on the team, thus enabling the Initiative to have greater service penetration for those years. Regarding gender, 47% identified as male and 53% identified as female, with zero identifying as transgendered. In Rockingham County, CSWEI provides services primarily to adults most frequently between the ages of 21-60 with 17% in their twenties, 28% in their thirties, 17% in their forties, 22% in their fifties, and 9% older. The Initiative has demonstrated success in reaching its target populations as 74% of individuals served report zero income and 87% are medically uninsured (CSWEI, Annual Reports 2012-2015).

CSWEI also captures service data and client outcomes to both monitor outcomes and better inform the Initiative in its programming, so it can remain programmatically nimble in order to quickly and effectively respond to community conditions that impact practice. To date, CSWEI has made 293 client referrals with mental health care and medical services, the most commonly requested services. Other resource requests include housing, Social Security Administration (disability income assistance), and legal assistance. A simple, two-question pre- and post-test is administered at the beginning and end of each client session. These questions are designed to measure mood and functioning. Mood increased on average by 17% and functioning increased by 15%. With CSWEI's transient population base, many contacts are one time only making these outcomes more impressive (CSWEI Annual Reports, 2012-2015).

In order to demonstrate its program success, CSWEI also documents its outcomes through *Stories of Impact*, which highlights the individual stories of success, several of which are presented below.

Stories of Impact

- A 27 year-old Caucasian female presented to the Salvation Army in Rockingham County seeking dental assistance. The congregational nurse did initial assessment and referred client to the BSW social work intern. Client disclosed she was in a domestic violence situation with her fiancé. He has isolated the client, taken possession of her cell phone, and only allows her to visit the doctor. Client expressed the desire to leave; the social work intern linked her with a local domestic violence shelter and she is now safe. In follow-up with client, client is still in the shelter, "feels safe" and is working on a plan for independent living.

- A Caucasian male presents to a BSW intern. Client states he was kicked out of the place he was living that morning and has no place to stay. He is "scared that he will get in trouble if he stays on the streets." With no shelters available in Rockingham County, social work intern

contacts shelters in Greensboro, NC (Guilford County) to secure a bed. Since transportation must be arranged a volunteer agrees to drive the client to the shelter where the social work intern at the shelter has been notified and referral for further assessment and casework services to be continued.

- A 49 year-old Caucasian female client seeking temporary shelter was assessed by MSW intern wherein she requested substance abuse treatment for alcohol dependency. Temporary shelter was obtained, intern through motivational interviewing assessed her willingness and commitment to change, and an appointment with Daymark Recovery Services made 3 days later. Intern is providing out-patient follow-up in collaboration with Daymark Recovery's out-patient program.

- A 40 year-old Caucasian male presented to MSW intern "just to talk." He recently was released from state prison following a decade long incarceration. He was assessed for PTSD following his disclosure of observing multiple rapes, assaults, and murders. He commenced weekly therapy with intern. Over the course of their therapeutic sessions, supervised by CSWEI program director, the client has secured employment, rented a home, and regained custody of one of his children.

- A 48 year-old Latina was referred to MSW intern because she was "experiencing depression and very hard times." The client stated that she was struggling at home with her ex-boyfriend and with her kids. One child was battling depression and experiencing acute anxiety and had just started using drugs to self-medicate. The client had had suicidal thoughts as a result of her getting 'kicked onto the street' by her ex-boyfriend. She was assessed for safety and referred to a local mental health center for medication evaluation.

- A MSW intern was able to conduct therapy with a 79-year-old African American client diagnosed with kidney failure (not a candidate for kidney transplant due to other underlying medical complications). The focus of therapy was on the psychological needs identified by client, her diagnosis, terminal care needs, and communicating her desire for a natural death with her children and family.

Challenges

Overarching service themes and challenges have emerged following CSWEI's expansion into a rural setting. Ongoing access to medical care continues to be a challenge for the population groups targeted by the Initiative, especially for the exponentially expanding working poor. Also, if individuals are able to access medical or behavioral health services, the inability to purchase the prescribed medications creates an additional barrier to treatment. The *Rockingham County State-of-the-County-Health Report (2011*) underscored that lack of insurance and inability to pay for services was one of the most common barriers to care. However, housing, and more specifically, housing for those persons experiencing homelessness coupled with a mental health issue was identified as a gap in care.

Substance abuse services were equally difficult to access. Until recently, the area's free medical clinic discharged and declined to treat active substance abusers who tested positive for substances. A congregational nurse was the catalyst for the change to this practice policy. Health

and mental health literacy proved an important component of CSWEI's service array so that clients - and potential clients - comprehended the importance of accessing health and behavioral health services.

In short, many of the challenges outlined are also common barriers to CSWEI's urban service area; however, these challenges exist to a greater degree in the rural setting. The dearth of resources forces student learners to expand their creative problem solving and critical thinking skills, resulting in greater resourcefulness by the rural county student team. In end-of-the-year surveys for 2013 through 2015, students working in Rockingham County consistently rate the program, pre-service training, and supervision very high. On a 5 point Likert scale from 1 to 5, with 5 highest level of satisfaction, interns on average rate their overall satisfaction as 4.9. Moreover students note the pre-service model was successful in boosting their confidence and skills in working in this non-traditional rural field education setting (CSWEI Annual Reports, 2012-2015).

A key success for the Initiative is the establishment of relationships among program participants and other faith membership partners. To date, the CSWEI and Congregational Nursing programs have successfully collaborated with religious organizations to provide holistic, no-cost services to congregants. The CSWEI and CNP work as a joint collaborative to meet the bio-psychosocial needs of this area's underserved residents through collaboration with faith-based entities who further serve the spiritual well-being of those receiving services.

Discussion

Increased attention needs to be given to the health and social service needs of rural residents. In the wake of the great recession of 2007, many rural areas continue to suffer high unemployment and poverty while residents lack access to adequate health and social services (Huskins, 2014). Social work research has shown that rural areas require innovative solutions to service delivery (Butler & Kaye, 2003; Davenport & Davenport, 2008). This case study of the Congregational Social Work Education Initiative presents a unique collaboration between congregations, local religiously affiliated organizations, congregational nursing, and public university social work education. While social work is not a stranger to RAOs or practice in rural areas, the initiative presents an interprofessional model for service delivery in rural areas. Access, service gaps, low public resources, persistent and rising unemployment, and a dwindling young population all contribute challenges to rural communities. Rockingham County is no exception to this trend and this has required innovative service delivery approaches such as the CSWEI.

The social work profession has long emphasized the ability to assess systems and people in their environments as a way to develop relevant and useful methods of helping people meet their needs and enhance the quality of life for the community at large. The CSWEI case study is presented as an example of how innovative collaborative efforts may enable links between RAOs, social work, nursing, and educational institutions to form, flourish, and produce educational benefits for students and service delivery effectiveness for vulnerable individuals and families living in rural communities.

References

Abbott, S., Garland, D., Huffman, N., & Stewart, J. (1990). Social workers' views of local churches as service providers: Impressions from an exploratory study. *Social Work & Christianity, 17*, 7-16.

Berner, M., Vazquez, A., & McDougall, M. (2016, March). *Documenting poverty in North Carolina.* Chapel Hill, NC: University of North Carolina at Chapel Hill.

Blalock, L., & Drew, R. (2012). A pilot study survey of clergy regarding mental health of children. *Depression Research and Treatment*. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3388475/pdf/DRT2012-742410.pdf

Boddie, S. (2002). Fruitful partnerships in a rural African-American community: Important lessons for faith based initiatives. *Journal of Applied Behavioral Sciences, 38*, 317-333.

Butler, S. S., & Kaye, L. W. (2003). *Gerontological social work in small towns and rural communities*. Binghamton, NY: Haworth Social Work Practice Press.

Cnaan, R., Sinha, J., & McGrew, C. (2004). Congregations as social service providers: Services, capacity, culture, and organizational behavior. *Administration in Social Work, 28*, 47-68.

Colvin, A., & Bullock, A. (2015). Building collaboratives with southern rural African American churches through the integration of the interorganizational collaborative framework, *Contemporary Rural Social Work, 7*(2), 1-17.

Congregational Social Work Education Initiative, Annual Reports 2007-2015. JMSW Program, North Carolina A&T State University and University of North Carolina at Greensboro.

Congregational Social Work Education Initiative, training manuals, 2007-2015. JMSW Program, North Carolina A&T State University and University of North Carolina at Greensboro.

Corbett, L. (1969). *Formation of NC counties: 1963-1943*. Raleigh, NC: North Carolina Department of Archives.

Covington, Jr., H. (2010). *Once upon a city*. Durham, NC: BW & A Books, Inc.

Davenport, J. A., & Davenport III, J. (2008). Rural practice. In T. Mizrahi & L. Davis (Eds.). *Encyclopedia of social work*. (20th ed). New York, NY: National Association of Social Workers and Oxford University Press.

Davis, J. (n.d.). Four pressing needs in rural communities, and how the church should respond, *Columbia Connections*. Retrieved from http://www.ctsnet.edu/four-pressing-needs-in-rural-communities-and-how-the-church-should-respond/

Elliott, M. (1984). The church related social worker. *Social Work & Christianity, 11*, 40-45.

Ensinger, D. (2011, May 27). The American textile industry is a victim of failed trade policy. *Economy in crisis: American economic report.* Retrieved from http://www.economyincrisis.org/content/textile-industry-victim-failed-trade-policy

Farley, O. (1982). *Rural social work practice*. New York, NY: Free Press.

Garland, D., & Bailey, P. (1990). Effective work with religious organizations by social workers in other settings. *Social Work & Christianity, 17*, 79-95.

Getz, L. (2011). Connecting with clergy: Stepping stone to treatment. *Social Work Today, 11*, 15-16.

Ginsberg, L. (2005). *Social work in rural communities* (4th ed.). Alexandria, VA: Council on Social Work Education.

Glass, B. (1992). *The textile history in North Carolina: A history*. Raleigh, NC: Historical Publications, NC Official Archives & History.

Harr, C., & Yancey, G. (2014). Social work collaboration with faith leaders and faith groups serving families in rural areas. *Journal of Religion & Spirituality in Social Work: Social Thought, 33,* 148-162.

Homiak, K., & Singletary, J. (2007). Family violence in congregations: An exploratory study of clergy's needs. *Social Work & Christianity, 34*, 18-46.

Huber, A. (2014, December 16*). Ingless con barerera: Challenges facing Rockingham County's poor.* Report presented at Rockingham County Forum on Immigrant Needs, Wentworth, NC.

Huskins, B. (2014). *NC regional and statewide strategies for community and economic development.* Raleigh, NC: NC Association of Regional Councils of Government.

Lewis, M., Scott, D., & Calfee, C. (2013). Rural social service disparities and creative social work solutions for rural families across the life span. *Journal of Family Social Work, 16,* 101-115.

Lohmann, N., & Lohmann, D. (Eds). (2005). *Rural social work practice*. New York, NY: Columbia University Press.

Manthey, B. (1989*). Social work, religion and the church: Policy implications* (Unpublished doctoral dissertation). University of Texas at Austin.

Moore, S., & Collins, W. (2002). A model for social work field practicums in African American churches. *Journal of Teaching in Social Work, 22*, 171-188.

North Carolina Department of Commerce (2015, December 15). *2016 county tier designations*. Raleigh, NC.

Only, J., & Gemberling, K. (2014). *Dwindling North Carolina textile industry*. Elon, NC: Elon University Press.

Paul, P., Hussey, T., & Arnsberger, P. (2002). Meeting the mental health needs of Christians in a rural Maine county: A survey of clergy and their congregations. *Social Work & Christianity, 29*, 224-239.

Payne, J. (2009). Variations in pastors' perception of the etiology for depression by race and religious affiliation. *Community Mental Health, 45*, 355-365. doi: 10.1007/s10597-009-9210-y

Polson, L., & Rogers, R. (2007). Counseling and mental health referral practices of church staff. *Social Work & Christianity, 34*, 72-87.

Population Health Institute (2013). *County rankings & roadmaps*. University of Wisconsin. Madison: WI.

Powell, W. (1989). *North Carolina through four centuries.* Chapel Hill, NC: Chapel Hill Press.

Rockingham County Profile (2012). *Rockingham County Community Assessment* (pp. 11-26). Wentworth, NC: County Department of Public Health, United Way of Rockingham County, Rockingham County Healthy Coalition Partnership.

Rockingham County State-of-the-County Health Report (2011). Wentworth, NC: Rockingham Co. Department of Public Health. Retrieved at http://rchealth.municipalcms.com/files/documents/2011_SOTCH_Report_01-25-2012_013500.pdf

Rockingham County State-of-the-County Health Report (2009). Wentworth, NC: Rockingham Co. Healthy Carolinians Partnership and Co. Department of Public Health. Retrieved at http://www.rockinghamcountypublichealth.org/files/documents/SOTCH_Report_10-14-2010_033148.pdf

Roger, E., Standford, M., & Garland, D. (2012). The effects of mental illness on families within faith communities. *Mental Health, Religion and Culture, 15*, 301-313.

Rorrer, J. (2011, November 17). Industrial companies love to do business here. *Our Town Rockingham County*, 28-33. Wentworth, NC: Rockingham County Department of Economic Development & Tourism.

Scales, T., Streeter, C., & Cooper, H. (2013). *Rural social work: Building and sustaining community capacity*. Hoboken, NJ: John Wiley & Sons.

Sherr, M., & Wolfer, T. (2003). Preparing social work students for practice with religious congregations within the context of charitable choice: The Grace House Ministry (A). *Social Work & Christianity, 30*, 128-148.

Taylor, R., Ellison, C., Chatters, L., Levin, J., & Lincoln, K. (2000). Mental health services in faith communities: The role of clergy in black churches. *Social Work, 45*, 73-87.

Trotter, G. (2015, September 15). Beer sales lag: MillerCoors to close N.C. plant. *The Chicago Tribune*, pp. 1B, 4B, 7B.

VanderWall, C., Sandman, A., Linton, S., Hernandez, E., & Ippel, I. (2011, spring). Clergy as gatekeepers to mental health and substance abuse services. *Connection for communities that care*. Lansing, MI: Michigan Association of Community Boards.

Yancey, G., & Garland, D. (2014). Christian congregations as context for social work. *Social Work & Christianity, 41*, 279-307.