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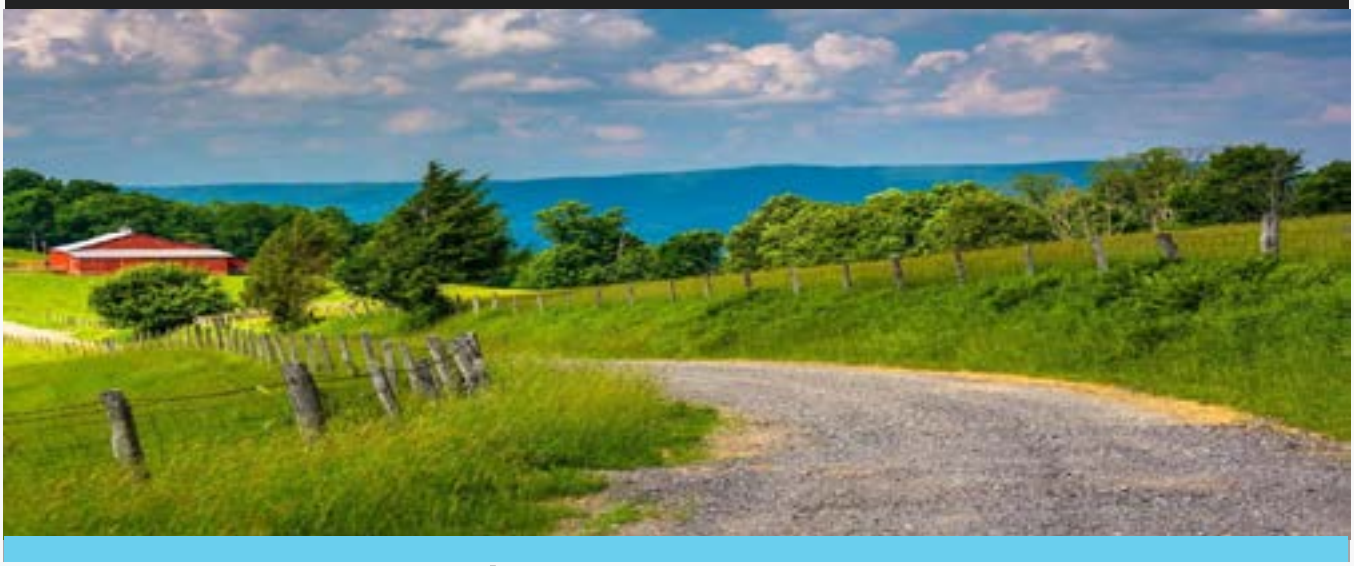

SERVING VIRGINIA'S RURAL CHILDREN AND FAMILIES

With an estimated population of 8.4 million people in the state of Virginia, roughly 12% live in rural communities (Economic Research Service [ERS], 2017). These communities exist throughout the state, but are largely in the southwestern region and in some regions that border West Virginia and North Carolina. With regard to income, the average income in rural communities in Virginia is lower and the poverty rate is higher than urban counterparts. Additionally, despite the significant changes that have been documented over the past 20 years, a gap still exists in education. More specifically, higher rates of ending education at or prior to obtaining a high school diploma and lower rates of completing college are found in rural communities in the state. While not an exhaustive list of the disparities between the rural and urban communities of Virginia, these issues intersect with the mental health needs of families in these communities.

RURAL MENTAL HEALTH ISSUES

Residents of rural communities have different life experiences that impact their wellness. Across the nation, poverty and the decline in populations in these rural communities have been dominant concerns (Smalley & Warren, 2012). Suicide also tends to hit harder in rural communities. The rate of death by suicide in rural communities is 17.32 per 100,000 people, while small and large metropolitan areas respectively have rates of 14.86 and 11.92 (Center for Disease Control [CDC], 2017). Greater possibilities for experiencing geographical isolation within a community are often associated with depression and other forms of mental illness. Fatalities from prescription opioid overdose have also had a greater impact on some rural communities in the southwestern region of the state, specifically, Wise, Dickenson, Buchanan, and Russell Counties (Virginia Department of Health, 2016). While Virginia appears to be impacted less by the recent increase in fatalities from opioid overdose than some neighboring states, the impact in the neighboring regions of the southern region of West Virginia calls for closer attention to the needs of adjacent and nearby communities in Virginia (West Virginia Department for Health & Human Resources, 2017).

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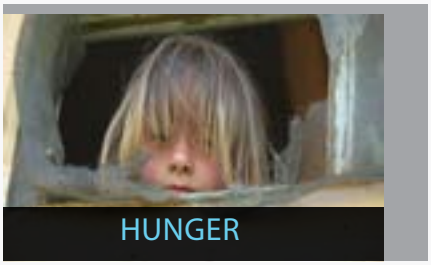
HUNGER


REFUGEE FAMILIES


SUBSTANCE ABUSE

Unfortunately, marginalized populations also endure more significant adversities in rural communities. For example, while poverty may be an issue broadly faced by a community, black and Hispanic people tend to experience greater levels of poverty (Smalley & Warren, 2012). Regarding those that identify as LGBTQ+, the geographical isolation in these communities can perpetuate social isolation from other members of the LGBTQ+ population. Additionally, these individuals may face heightened discrimination over their sexual orientation. Regarding exposure to forms of discrimination and prejudice, other historically marginalized groups may face these experiences in their communities as well. Lastly, women in rural communities disproportionately experience isolation, abuse, and the sole burden of childcare (Hench, 2015).

CHILD WELFARE

The impact of trauma in families has been documented in research on adverse childhood experiences (Substance Abuse and Mental Health Administration, 2017). Whether abuse, neglect, substance abuse, or the loss of a parent in the family system, children face greater risks to well-being and development. Additionally, these early experiences of adversity place these children at higher risks of perpetuating the cycle of risky behaviors later in life. Despite the threat of these mental health crises in rural communities, access to affordable mental and medical health care services continues to be elusive (Smalley & Warren, 2012). Additionally, shortages of mental health professionals in rural communities complicates this issue of access to services. According to the Virginia Rural Health Association (VRHA) expansions in coverage under Medicaid is one way that legislation can impact the well-being through increasing access to services for children and families of rural Virginia (2017). This expanse would be one way to lighten the financial burden of seeking mental health services for families that already live in poverty. Even with improving access to services, the stigma surrounding the use of mental health services serves as another barrier for rural communities.

FUTURE DIRECTIONS

The future of Medicaid has been a hot topic on both the federal and state level. With pregnant women and children being the primary beneficiaries of Medicaid, legislative action supporting the expansion of Medicaid coverage for those that fall short of eligibility would benefit the ability to access medical and mental health services. Currently, money that the state of Virginia spends on Medicaid is matched in federal funding (VRHA, 2017). Considering the potential harm from cuts in Medicaid funding, supporting the well-being of rural communities in Virginia would entail advocacy at the state and federal level. Likewise, advocacy and support for Medicaid expansion at the state level would be one way to support families without coverage that are currently unable to afford necessary care. Advocacy for rural Virginia could also take the form of supporting legislation and community efforts that aim to improve conditions related to poverty, unemployment, and less access and support in educational pursuits. Progress in integrating mental & physical health is another area of continued growth for supporting rural communities. In addition to improving the availability of trained mental health professionals, this integration could support efforts in changes in stigma towards the use of mental health services in times of need (Smalley & Warren, 2012). Lastly, rural communities have demonstrated the potential for resilience despite the adversities they face. Thus, professionals across disciplines might find supporting efforts of churches and other community and state organizations dedicated to addressing the needs of rural communities in Virginia to be beneficial. The Virginia Rural Health Association and the National Association for Rural Mental Health are just two of such organizations to reference regarding resources and updates on state and national needs of rural communities.

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REFLECTIONS OF A SOCIAL WORKER IN RURAL VIRGINIA:

Meet Ms. Mary Norris

Embracing a career as a social worker requires one to have the passion to make a difference, the endurance to work large, difficult caseloads, and the ability to balance long work hours. Ms. Mary Norris has dedicated 43 years of her life to helping children and families in the social work profession. As a 9th grader in high school, Ms. Norris knew that she wanted a career that would allow her to show her love for people by helping them through life experiences. She became a case worker in 1975 in Wise County, a rural area located in the southwestern area of Virginia. Over the years, Ms. Norris has seen many positive changes and much growth in the field. Effective December 31st, 2017, Ms. Norris has retired. She was kind enough to share some of her reflections over the course of her career and tips for the next generation of social workers.

CHALLENGES IN THE PROFESSION

When Ms. Norris first started working in the field, there were no policies or procedures to provide direction. Ms. Norris adopted the philosophy of "being flexible" and "working with what you have." For years, Ms. Norris worked long hours in an area which is "very spread out" geographically. There were few services available for families in remote, rural areas which presented a challenge when removing a child from a home. There were "no cellphones" or "access to the internet" like today, and case notes were done by hand. Even though these challenges created difficulty, the passion Ms. Norris felt for the population she was serving always motivated her to work harder.

While there have been many changes in the field over the years, including the implementation of federal regulations to keep families together, an increase in the number and type of programs to assist both children and family members, and a decrease in the time children spend in foster care, there are still challenges that social workers in rural areas face today. Although there have been technological advances, there are still families without cellphones and internet service which can create communication problems. There are still many family members who are unable to travel to access the services they need. Lastly, Ms. Norris explained, it can be difficult for social workers who do not understand local culture to gain the trust of families in rural areas. Family is a very important concept, and parents may feel threatened by outsiders offering help. It is important for social workers to be knowledgeable, understanding, and respectful.

REWARDS OF A SOCIAL WORK CAREER

Many people hear of the emotional, mental, and physical difficulties associated with being a social worker but miss the rewards. Ms. Norris highlighted a few rewards that have stood out to her during her career.

• There has been immense growth in the social work profession. As previously mentioned, when Ms. Norris entered the field, there were no policies and procedures to guide the profession. Since then, there have been many mandated rules and regulations to help guide social workers, and Ms. Norris has witnessed the creation and implementation of ethical models. Seeing the field develop clear goals, direction, and objectives has been exciting and rewarding for her.

• Ms. Norris has also been able to have "a seat at the table" by helping develop models that benefit families and children. She has been able to assume different roles such as case worker, advocate, consultant, etc., that have allowed her to contribute to the field but also continue to learn new ways to be an agent of change in the profession.

•Lastly, Ms. Norris loves people! Through her work, she has been able to change the lives of many families and children and has been deeply touched by the experiences and stories of her clients. In addition, Ms. Norris has also enjoyed providing consultation and assistance to 22 local offices on a daily basis.

TIPS FOR A LONG AND SUSTAINING CAREER

Ms. Norris advised that a career as a social worker can take its toll if you do not practice self-care. As with any career, you must be passionate about what you do! This is particularly important in the social work profession. Ms. Norris explained that her passion fueled her 43-year career. She says it's natural to face difficult moments and even burnout at times, but remembering why you are so passionate about this profession and the families and children you are helping is a wonderful motivator to keep pushing forward.

Self-care is of upmost important in helping professions. Ms. Norris stressed the importance of having "a life outside of work" and "having hobbies and things that refresh you and keep you going." Stress is inevitable, she says, but workers should try to see the positive instead of dwelling on the negatives. She encouraged those in the profession to look at clients through a different lens and help them identify their strengths and resiliency.

TIPS FOR THE NEXT GENERATION OF SOCIAL WORKERS

1. Learn the policies and procedures of the Social Work Profession.
2. Learn the code of Virginia.
3. Have a good sense of humor! This field can be tough and self-care is so important.
4. Recognize the important role of trauma and how it can affect you in working with certain cases.

VDSS gives a huge and heartfelt thank you to Ms. Norris for all her hard work, time, and dedication in working with children and families in rural communities. Although Ms. Norris is retiring, she will continue to be an inspiration to all those in helping professions, reminding us to continue working hard, give back to the community through service, and never stop helping those in need.

REFUGEE CHILDREN AND FAMILIES IN RURAL VIRGINIA: A GROWING POPULATION

The refugee population in Virginia is growing, especially in rural areas. In 2017, 1,665 refugees under the age of 18 resettled in Virginia compared to 408 in 2013 (Virginia Department of Social Services, 2017), an increase of almost 308%.

A refugee is a person who has been forced to leave their country in order to escape war, persecution, or natural disaster. All refugees are documented residents and are allowed into the country through a legal process. This process can take anywhere from 18 months to 3 years and is filled with background checks, medical screenings, interviews, and security investigations. Refugees typically wait in a host country, often in refugee camps, until they receive their clearance to enter the United States.

Refugees are extremely vulnerable and are susceptible to mental and physical health problems during their arduous journey to their new home. These problems are often associated with the physical conditions of the refugee camps or waiting areas as well as trauma experienced pre and post flight.

The United States Department of Health and Human Services provides services to refugees through the Administration for Children and Families (ACF). Under ACF, the Office of Refugee Resettlement provides critical resources for integrating refugee children and families into American Society (U.S. Department of Health & Human Services, 2017). Their services include:

- Refugee Assistance
- Refugee Health
- Resettlement Services
- Children Services

The above services are managed by each state. In Virginia, the Department of Social Services' Office of Newcomer Services (ONS) is responsible for administering the Refugee Resettlement Program. Under the guidance of this office, there are 12 service providers throughout the Commonwealth. Services are provided by organizations such as Church World Service Immigration and Refugee Program, Catholic Charities of the Diocese of Arlington Migration and Refugee Services, International Rescue Committee, Commonwealth Catholic Charities Refugee Resettlement Program, Lutheran Social Services of the National Capital Area Refugee Immigration Services, and Ethiopian Community Development Council Refugee Resettlement Program (Virginia Department of Social Services, 2017).

To learn more about the services provided to refugees in Virginia, please visit the websites below:

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U.S. Department of Health & Human Services (2017). Office of Refugee Resettlement. Retrieved from https://www.acf.hhs.gov/orr/resource/unaccompanied-alien-children-released-to-sponsors-by-state

Virginia Department of Social Services (2017). Office of Newcomer Services Virginia Refugee Resettlement Service Providers. Retrieved from http://www.dss.virginia.gov/files/division/cvs/rr/announcements_news_events/providers/Refugee_Resettlement_Providers_121217.pdf

The Impact of Hunger and Food Insecurity on Healthy Child Development

The US department of Agriculture has estimated that nearly 2.94 million households, containing approximately 12.79 million people, are food insecure (Jacobs et al., 2006). Additionally, the Community Childhood Hunger Identification Project (CCHIP) estimates that of those 12.79 million people, 4 million are American children who experience both food insecurity and hunger.

Food insecurity in children 3 to 8 years old has been associated with low psychosocial functioning, poor academic performance, low physical functioning, and wait gain among females (Kleinman, 1998). Jacobs et al. (2006) found that children from 4- to 36- months old were at a greater risk for developmental difficulties if they came from a household where they were food insecure. This is important to note because during these early years in a child's development, adequate nutrition is paramount in order for the children to keep up developmentally with their peers. Adequate nutrition is necessary for a child's physical, mental, emotional and social development.

Hunger in children can affect both behavioral and emotional functioning. In a study by Klienman (1998), 21% of hungry children had a current or past history of mental health counseling. This is significantly more than non-hungry children (Klienman, 1998). Further, six factors were chosen from the Pediatric Symptoms Checklist (PSC) to be examined for correlations between hunger and clinical dysfunction. From this checklist, certain questions were asked about the children's behavior. Hungry children were found to be 12 times more likely to steal than non-hungry children, and were 7 times more likely to engage in fights. Hungry children were also significantly more likely to display symptoms of oppositional behavior disorder and aggression than non-hungry children. Further, hungry children ranked higher on the irritability/anxiety factor on the PSC (Kleinman, 1998). Overall, hungry children were 7 times more likely than non-hungry children to receive a score on the PSC that was indicative of clinical dysfunction.

Cognitive and social development and academic performance are also affected by hunger. According to a study by Kleinman (1998), 29% of hungry children are likely to receive special education. This is significantly more than non-hungry children. In addition, a study by Alaimo, Olson, and Frongillo (2001) found hungry children were significantly more likely to repeat a grade and score significantly lower than their peers on arithmetic tests. Hungry children also had difficulty getting along with their peers (Alaimo, Olson, & Frongillo, 2001).

In a study by Jyoti (2005), food insecurity extending from kindergarten through third grade increased the delay in reading compared to food insecurity through kindergarten alone. When it came to math, the biggest negative impact occurred through kindergarten.

Overall, hunger negatively impacts children in a variety of ways. Socially, these children can have difficulty mingling with peers and are more likely to engage in physical altercations. Academically, hungry children preform worse than their non-hungry peers on both literature and math assessments and have a higher rate of grade repetition than other students. Hungry children also show symptoms of anxiety as well as oppositional and conduct disorder. They also have a greater need for counseling and lower attention spans. Children who experience chronic hunger or food insecurity are at a disadvantage early in life when compared to their non-hungry peers. As we work with vulnerable children and families, it is important to remember what a powerful impact nutrition, or lack thereof, has on health, mental health, and development.

NAVIGATING THE DESTRUCTIVE EFFECTS OF PARENTAL SUBSTANCE ABUSE

Substance abuse is a growing and dangerous concern in the United States. With the opioid epidemic recently declared a national emergency, there should be increased and focused attention paid to families and children touched by substance abuse and addiction. In 2007, The National Survey on Drug Use and Health reported that an estimated 8.3 million children live with at least one parent who is struggling with alcoholism or abusing an illicit drug, (US Department of Health and Human Services, 2009a). This struggle can profoundly affect a child even before birth. An average of 5.4 percent of pregnant women reported using an illicit drug while pregnant, and 9.4 percent reported consuming alcohol sometime during the course of pregnancy (Substance Abuse and Mental Health Services Administration, 2014). These statistics are representative of the profound effect substance abuse has on children and families.

Three out of four child welfare caseworkers surveyed reported that they believed parental substance abuse was the primary reason for the rising rate of child maltreatment. This rate has been on an upward trend since the late 1980s. Children coping with a parent's substance abuse are removed more frequently from their homes and less likely to be ultimately reunified with their parent, (US Department of Health and Human Services, 2009b). This reality results in a great deal of emotional upheaval and often housing instability for children as they are shuffled within the foster care system. Thus, it is paramount to examine methods of intervention and treatment for families struggling with substance abuse concerns.

PARENTAL SUBSTANCE ABUSE EFFECTS ON CHILDREN

Substance use disorders often have a significant effect on an individual's ability to parent their children, although their presence alone does not constitute child maltreatment. Substance abuse can, however, impair a parent's ability to effectively supervise their children and ensure their safety. The time needed to obtain, use, and recover from substances often diminishes the time parents have available to spend with their children, as well as the quality of that time. Lack of food, stable housing, and/or prompt medical treatment can result as parents often use vital funds to fuel their addiction instead of meeting their child's physical needs.

Using illicit substances or abusing alcohol can compromise the parent-child bond and reduce the chance of parents forming a consistently responsive relationship with their children. For older children, there is also an increased risk of parentification, a damaging role-reversal in which children care for parents and/or younger siblings and provide for their physical and emotional needs, often at the expense of their own (US Department of Health and Human Services, 2009b). This creates an enormous burden of responsibility on the shoulders of young children who, by the necessity of their environment, must function as adults.

SUPPORT FOR CHILDREN

One of the foundational ways to support a child who has a parent with a substance abuse disorder is to gain the perspective of the child. Providing space and time for the child to safely and freely tell the story of their feelings can be therapeutic in itself. Due to the risk factors of conduct, emotional and social problems, children would benefit from being able to express their feelings (Solis, J. M., Shadur, J. M., Burns, A. R., & Hussong, A. M., 2012)

It also provides a first hand account and window into their life and their needs. Itäpuisto (2014) found that many outpatient substance abuse treatment providers exclude the perspective of the child (ren) due to their belief that substance abuse treatment pertains only to the substance abuser, the parent. Their research also indicated that some healthcare organizations didn't ask the person in treatment whether they had children.

PARENTAL SUBSTANCE ABUSE...

Some providers ask women whether they have children but exclude the same questions for males who present for substance abuse treatment. Failure to consistently ask questions pertaining to the presence and perspectives of children excludes a major aspect of affected individuals within the family system. Gaining the perspectives of children provides a roadmap of effective treatment options tailored to the specific needs of the family.

Psychoeducation is also an effective treatment strategy for children. They often require psychoeducation about addiction to help demystify it and put it in terms that they can understand, (US Department of Health and Human Services, 2009b). Psychoeducation that is age-appropriate helps a child process their feelings and experiences. A crucial way to mitigate the consequences of living within a family context of substance abuse is to separate a parent's substance abuse from the child. A common mnemonic, originally drawn from the teachings of the popular organization Al-Anon, is the "Three C's" as in you did not cause a parent's substance abuse, you cannot control it, and you cannot cure it. These simple statements aim to help a child see a parent's substance abuse for what it is: an adult illness that exists wholly apart from their actions (US Department of Health and Human Services, 2009b).

SUPPORT FOR PARENTS

It is helpful to provide a listening ear to parents with substance abuse needs. Maintaining a non-judgmental stance helps build trust and increase self-disclosure. There are many reasons that people abuse substances and it may be helpful for parents to have a space to express themselves. Beyond offering the initial listening ear, linking parents to licensed professionals for individual and/or family counseling can provide the space and long-term support needed to bring wholeness, peace and sobriety. Motivational interviewing is also suggested as a way that parents may gain drive to help their children (Itäpuisto, 2014).

Many parents who are substance abusers lack appropriate parenting skills. Research shows that many providers fail to link parents with helpful parenting resources (Itäpuisto, 2014). Providing referrals to parenting classes gives parents the practical tools to teach them how to connect with their children. These classes also provide them with social and peer support. Parenting programs such as the Strengthening Families Program use cognitive restructuring and establishment of boundaries and expectations to help reorient the parenting dynamic. The goal is to create a more consistent and safe environment for children. Researchers found a variety of positive outcomes including increased parental involvement and efficacy, decreased parental substance use and decreased behavioral problems among the cohort of children, (Kumpfer, Whiteside, Greene, and Allen, 2010).

Providing services to children and families with substance abuse concerns can be an incredibly rewarding experience. Through patience, continuing education and genuine care, families can receive the help they need to create and maintain healthy lives. Providers should seek out the support that they need to link to appropriate services while maintaining a healthy sense of well-being.

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FIVE TIPS FOR PROVIDERS WORKING WITH PARENTAL SUBSTANCE ABUSE IN RURAL AREAS

Know what you know and what you don't know.
Working with families and children with substance abuse concerns can be overwhelming. Difficult issues can include multi-generational substance abuse, co-occurring disorders, and poverty and isolation. Be honest with yourself about your professional competency. Don't make up information or make judgments based on guesses.

Be aware of the local resources available to help the client and their family.
This includes being aware of social workers, licensed professionals and/or doctors who have experience and specialize in addressing substance abuse concerns. It is also advantageous to find providers who can address the needs of children in addition to adults. Link with those providers through phone, email or in person meetings to ask questions and/or consult. Attend conferences and/or join a local providers organization. You cannot refer clients to services that you are not aware of.

Be aware of personal biases and prejudices.
Personal biases and prejudices can prevent fairness, attunement and appropriate treatment. Seek feedback through supervision. Follow your state and professional organizations' Code of Ethics.

Manage transference and personal emotions through supervision and self-care.
Helping parents through the cycle of addiction and recovery can be incredibly taxing. The physical energy required to coordinate care while listening to a parent's pain can cause a lot of stress. Use supervision to express feelings and frustrations in a healthy manner. Take time in your week or weekend to recharge and nurture your soul.

Isolation can be dangerous!
Providing services in rural areas can be a lonely experience as you may be driving off-the beaten path. Maintain communication with your supervisor(s) so they are aware of your schedule. Create a travel bag with the necessities for travel. Pack items such as snacks, your work and personal cell phone, a blanket, car jump cables and keep a full tank of gas. Maintaining communication is key to safe travel!

A SHIFT IN PERCEPTION: How professionals can help rural families engage in mental health care

Social workers who intervene with impoverished rural families can face significant barriers to success, including perceived stigma, discomfort with professionals, and complex trauma. Although factors such as parental neglect or abuse can bring these families into services, persistent poverty is often a major contributing factor to the family's problems. Several large studies have linked poverty, mental health and child development across racial and cultural lines, underscoring the need for professionals to understand the interplay of these phenomena (e.g. Costello, Copeland, & Angold, 2016; Evans, & Fuller-Rowell, 2013).

Psychotherapy is often indicated for impoverished rural families, but they have among the lowest mental health utilization rates of any population (Hauenstein, Petterson, Rovnyak, Merwin, Heise, & Wagner, 2006). This article explores negative cultural stereotypes about poverty as a barrier to some rural families engaging in mental health treatment, and what social workers and other professionals can do to overcome this barrier. Specifically, social workers can foster engagement in therapy by understanding the impact of poverty on mental health, historical factors underlying persistent poverty in some rural communities, and unconscious biases they may carry into professional interactions.

Throughout the past century, negative stereotypes about impoverished rural Southern families have remained prevalent in American media and popular culture. Some examples of this phenomenon include the pejorative use of terms like "hillbilly," as well as repetition of stereotypes regarding low levels of education and intellectual development. These negative stereotypes result in real-world discrimination and in many cases disillusionment with mainstream cultural institutions on the part of impoverished rural families (Fraley, 2013; Downey & Anyaegbunam, 2010). Social workers and other professionals who encounter these families can develop sensitivity to their cultural context, and understand that impoverished rural families have likely experienced discrimination on the basis of their social class, culture and family history. For example, in one community mental health study, participants reported experiencing discomfort with "outsiders," and "concern with being treated unkindly or unfairly" as salient barriers to utilizing mental health treatment (Fox, Blank, Rovnyak, & Barnett, 2001). These data and others (e.g. DeCou & Vidair, 2017) highlight the need for professionals to attend to subconscious biases in order to create effective working relationships.

Several factors have contributed to long-term economic distress in rural areas, including many in the southeastern US and Appalachia. There is a history of corporations and other parties without long-term investment in small communities bringing industry that capitalizes on local resources, develops a supportive economy, then disappears when the natural resource is exhausted or corrupted, leaving behind a population struggling to survive (Mannion, 2006; Cotter, 2002). This first occurred in the 1800's with logging and tobacco, followed later by mineral extraction and coal mining (Lee, 2014). The economies of southern states were also decimated following the civil war by both declines in agricultural production and infrastructure damage. In other areas, once thriving factories have ruined local ecosystems and then moved on to other locations that offered better profits or reflected changing global consumption trends (Fraley, 2013; Mencken, 1998). This same cycle may soon repeat itself due to the recent hydraulic fracturing (fracking) boom in natural gas production (Horowitz, 2014). As large amounts of money pour into small rural areas in a short period of time, economic development occurs, but these communities can be left struggling later when resources are depleted.

Unfortunately, families may not fully understand the impact of regional economic factors and their contribution to persistent poverty. They may, for example, know that they personally have had a hard time finding satisfying work, but have little context to understand that their group or family has been systematically disenfranchised for generations. Nevertheless, acknowledging this systemic level of economic oppression can help build trust and generate empathy by naming a factor that people feel impacts their lives, but have a hard time talking about. Understanding the context of human development does not alleviate personal responsibility or create a scapegoat for consumers' choices, but can normalize consumers' experiences and promote engagement in services. When consumers feel misunderstood, judged, or stereotyped by professionals, they are less open to receiving therapeutic services, make less progress, and may expend additional resources (DeCou & Vidair, 2017).

One likely reason that understanding the social and historical context of rural poverty may help consumers engage therapeutically is that it reduces the impact of a common type of bias known as the fundamental attribution error (Myers & DeWall, 2016). This term describes the cognitive tendency to overestimate the effect of personal characteristics on other people's behavior, while underestimating the effect of situational factors. When considering their own behavior, however, these perceptions are reversed, and people more accurately assess the impact of circumstances on their own behavior. This perceptual bias occurs despite the fact that all human behavior is driven by both personal characteristics and situations. Most people commit the fundamental attribution error without being aware of it, resulting in a variety of inaccurate judgements about individuals and groups they encounter. Regarding rural poverty, researchers have noted that rural individuals can be particularly sensitive to these biased judgements (Cotter, 2002; Duncan, 1996). Essentially, impoverished rural families may be concerned that professionals see their poverty as a result of their choices or personal failings, while they themselves may feel shame about poverty or strongly wish to not be impoverished. By becoming aware of this unconscious bias, professional helpers can remain open to understanding consumers' lives as they get to know them, and take the time to communicate awareness of the contextual factors that have contributed to their current circumstances.

Despite the challenges that social workers and other professionals face when working with impoverished rural families, there are several perspectives and practices that can foster positive engagement with the system. Doing some basic research about the economic history of an area one is working in, assuming that impoverished families have been discriminated against, and actively working to check one's natural tendency to commit the fundamental attribution error can all help create a valuable positive first impression, and hopefully sustainable and productive service relationships.

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A PROMISING TREND:

PRIMARY CARE MENTAL HEALTH INTEGRATION IN RURAL COMMUNITIES

Approximately 15% of children between 2 and 8 years of age in the United States have a parent-reported mental, behavioral, or developmental disorder (MBDD) diagnosis. Such diagnoses include, but are not limited to, Attention-Deficit/Hyperactivity Disorder, depression, anxiety, behavioral or conduct problems, autism spectrum disorder, learning disability, intellectual disability, and developmental delay. According to the Centers for Disease Control and Prevention (2017), 18.6% of children in rural areas and 15.2% of children in urban areas are diagnosed with MBDD's. Across rural areas, a myriad of factors including a shortage of child mental health providers, higher poverty rates, geographic isolation, and transportation limitations, can create limited access to care. With primary care as a central access point for many health-related services, primary care mental health integration can improve access to mental health services and create a team approach involving primary care and mental health clinicians working together with children and their families to address health care needs (CDC, 2017).

Page County, Virginia is a strong, resilient community in the Shenandoah Valley. Like many rural communities, it could benefit from increased access to health-related resources. A Community Health Needs Assessment (CHNA) conducted in 2016 identified the following prioritized health needs: 1.) Physical Activity, Nutrition, and Obesity-related Chronic Diseases 2.) Access to Primary and Preventive Care 3.) Financial Hardship and Basic Needs Insecurity 4.) Mental and Behavioral Health 5.) Substance Abuse and Tobacco Smoking and 6.) Maternal and Child Health (Page Memorial Hospital, 2016). There is often a relationship between such health needs. Attention to mental health needs can improve physical wellness, reduce reliance on substance use as a coping strategy, positively impact relationships and functioning at school and in the workplace, and help families to provide a stable and nurturing home environment (Virginia Department of Health, 2013).

James Madison University, located approximately 45 minutes south of Page County in Harrisonburg, Virginia, has been in a unique position to collaborate with the Page County community. Through JMU's Counseling and Psychological Services clinic, students from programs in Clinical Mental Health Counseling and Combined Integrated Clinical and School Psychology, supervised by licensed faculty with expertise in areas such as child and family mental health, play therapy, school psychology and neuropsychology, are able to coordinate with Valley Health Page Memorial Hospital and provide services at a more affordable cost. The co-location and partnership of primary care with mental and behavioral health at the hospital creates an opportunity for both physical and mental health needs to be addressed in an integrated manner. Due to the reduced travel time and increased service coordination between providers, families gain increased access to care with this model. Students benefit as well and gain opportunities to learn with, from, and about primary care physicians, nurse practitioners, children, their families, and others as part of a team dedicated to improving health outcomes. This partnership serves as an excellent model of what is possible when we all come together.

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Special thanks to all the wonderful contributing writers for our February 2018 issue:

Darius Green, Rural Mental Health in Virginia
Tiffanie Sutherlin, Reflections of a Social Worker in Rural Virginia
Mina Attia, Refugee Children and Families in Rural Virginia: A Growing Population
Sydney Nolan, Impact of Hunger & Food Insecurity on Child Development
Cierra Davis & Caroline Hamby, Navigating the Destructive Effects of Parental Substance Abuse
Matt Bukowski, A shift in perception: How professionals can help rural families engage in mental health care
Kelly Atwood, PsyD, Primary Care Mental Health Integration in Rural Communities
Meagan Dye, Capitalizing on the Connections in Rural Communities

CAPITALIZING ON THE CONNECTIONS IN RURAL COMMUNITIES

In Virginia, many of our rural communities are rich with natural resources, surrounded by beautiful scenery, and steeped with history. Amidst this landscape, rural communities face many challenges when addressing child welfare needs including such issues as poverty and limited mental health resources. The inherent strengths in rural communities ultimately benefit children at risk, their families and the larger community. Strengths like trust, interconnectedness, and a willingness to assist other community members can often be found in these areas that are made up of tightly knit networks of people (Child Welfare Information Gateway, 2012). Gaining access to this close community can sometimes be an obstacle in that insiders may not trust outsiders. This same social connectedness allows Virginia's mental health workers and child advocates to broaden their reach in areas where resources are sometimes limited.

Establishing a relationship with community members may initially be an uphill battle for a child welfare worker. However, since many of the members of rural communities have lived in the area for a long time and are known to each other, relationships tend to have stability and longevity once established. (Bierman, 1997). An authentic partnership with community members helps child welfare workers create region specific programming that is inclusive and representative of the community's needs (Heflinger & Christens, 2006). Because of the close relationships formed within rural communities, getting citizens involved in programs that support child welfare can benefit the reach and efficacy of the work by capitalizing on the investment that community members have in each other (Bierman, 1997).

Strong connections result in rural areas having a network of natural helpers that may include church leaders, law enforcement, teachers, and administrators among others (Helfinger & Christens, 2006; Blank, 2002). Working together with those people in the community who have access to more children and families allows child welfare workers the ability to provide support to children who may have experienced maltreatment and build important relationships and connections (Hartman, Stotts, Ottley, & Miller, 2016). In Virginia, Children's Advocacy Centers call on these strong connections to support children who have experienced trauma or abuse. With 16 centers throughout the Commonwealth and three satellite locations, many of these offices service Virginia's rural communities and rely on relationships with local law enforcement, counselors, medical professionals and community members to support positive outcomes for victims of abuse ("Virginia CAC's", 2017). Partnering with these natural helping networks provides the framework for support and swifter reactions from engaged community members (Heflinger & Christens, 2006).

Developing genuine relationships with community members in rural Virginia is a mountain to overcome in the landscape of supporting the needs of children in rural areas. By partnering with the community, Virginia's Children's Advocacy Center's access the natural helping networks and inherent connectedness that are found in these areas, bolstering the care of rural youth and families in need.

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