Abstract

Aims: To gain a deeper understanding of rural health social workers’ professional judgement and decision-making in the complex rural and regional environments within which they work. Methods: In-depth semi-structured interviews were undertaken with South Australian rural health social work leadership team members (n=10), with focus groups (n=14) before and after the interviews. Findings: Rural health social workers drew on both spatial and temporal understandings of their professional judgements and decision-making when explaining their rural health social work practice. Concepts of rural time, rural social space and acts of resistance were identified within the rich descriptions of professional judgement and decision-making in practice provided by the rural health social workers. ‘Rural time’ refers to the additional work that is done by rural health social workers across both their rural personal and professional social spaces. Conclusions: Institutional, systemic and spatial factors, constituted as they are of power dynamics, have implications for the skills needed to maintain a social justice practice. Clear-sighted analysis of these complexities, in the context of social power, can support this ongoing and longer-term project.

Keywords: Time, Social Space, Rural, Health, Hospital, Social Work

Time, Space and Power in South Australian Rural Health Social Work Practice

1. Introduction

Rural health social workers (RHSW) occupy a professional space framed by the dynamic situations for the people with whom they work, limited resources, multiple and often competing institutional demands on their time, and, values dissonance (Cleak & Turczynski, 2014; Harvey & Jones, 2021; Saltman et al., 2004; Waltman, 2011). Belonging-in-place (Malatzky et al., 2020) and embeddedness in rural places and cultures can be productive but also generate practice tensions and dilemmas. Saltman et al (2004, p.526-528) in their US/Australian comparative study of rural social work, report that Australian respondents' comment on the stresses of '…being constantly visible' within the rural community. Waltman (2009) in a review of papers published about rural social work, highlights boundaries and confidentiality as a common theme. She writes: '[M]aintaining confidentiality, observing appropriate professional boundaries, and dealing with multiple overlapping relationships are issues that are intensified in rural areas' (2009, p.237).

Whilst the health social work role is primarily generalist casework (Cleak, 2002), the nature of practice in rural settings has elevated the need for integrative thinking, adaptability, flexibility, and the creative use of resources (Dellemain et al., 2017; Green et al., 2009; Mason, 2011; Saltman et al., 2004). Each rural hospital setting has its own organisational culture (Farmer, Bourke, et al., 2012). Australian rural social work academic Dellemain et al. (2017, p.55) found that rural case managers' ability to make decisions, and to think outside of the box in terms of solutions for clients, was '…highly dependent on collective and cooperative relationships with other rural professionals, particularly those prepared to work flexibly with

eligibility criteria'. Australian rural researchers note the issues with attracting health workers to take up posts in rural areas (Brown & Green, 2009; Malatzky et al., 2020; Roberts et al., 2020).(Roberts et al., 2020)

Moreover, by virtue of geography and distance, the dynamics of time and space considerations are paramount. For the RHSW, distances to capital cities are considerable and distances between communities, that are geographically dispersed, has implications for the everyday ordering and use of time, and social connections (Phillips, 2009). Australian rural social work researcher Dellemein et al (2017) highlighted the travel time that rural case managers were undertaking and explored the construct of travel time as lost time or a 'waste of time' and how they worked to remain productive. Understandings and experiences of time are culturally located and have multiple meanings. In his study of busyness, US Psychologist Robert Levine explored the cultural manifestations of time and the links between time, money and power, and found that time is connected to social status, however this was not consistent cross-culturally (Levine, 2005). We explore concepts of time within the context of the rural health social worker in South Australia.

Mason (2011) contends that much of the ingenuity and creativity unique to rural practice is made possible through social workers being embedded in the life and identity of the communities they live and work in, simultaneously inhabiting professional spaces, organisational spaces and social spaces. This is also the source of tensions, as noted earlier. In this paper we draw on the understanding of social space as defined by the French sociologist Pierre Bourdieu. For Bourdieu social space refers to how people are related to each other with respect to their occupation and their social positioning. Social space is examined in the context of the rural health social worker and their professional judgement and decision-making. Bourdieu connects

social practices, modes of sociality and physical space and states: ‘Space as we inhabit is and as we know it is socially constructed and marked' (Bourdieu, 2018, p. 108). The concepts of both time and social space intersect in the rural and are imbued with power.

This research was initiated by the rural social work leadership group to seek greater understanding of their experiences in enacting the social work role in a rural health setting. This study provides an exploration of the dimensions of time, social space and power within the social workers particular rural context. This is a small-scale qualitative study which allows for in-depth exploration. The findings may be generalisable to other rural health practitioner contexts.

2. Methodology and Method

There were three stages in the study as part of a Living Lab research design (Dutilleul et al., 2010). A Living Lab approach involves participants in the design of the research and was selected as part of a participatory approach (Donetto et al., 2015; Gibbs et al., 2008). The Social Work Leadership group participated in the design of the research. Their expertise was valued and provided them with capacity building in research processes. This approach fits within a critical interpretive epistemology (Neuman, 2011), where the research seeks understanding and has an eye to power disparities resulting from the rural/metropolitan divide routinely experienced by the social workers being interviewed. The three-stages included: first a focus group; second, qualitative interpersonal interviews and third a follow-up focus group.

2.1 Study setting

The setting for the study was Country Health located in South Australia (SA), Australia. South Australia’s land mass is 983,482 km^2 with a population of half a million people. Country Health SA Local Health Network (CHSALHN) is the government department that services 61 hospitals across the rural and regional area of SA (Country Health SA LHN, 2019). The

CHSALHN are responsible for the provision of the following health services including emergency medical care, inpatient care, primary and community care, intermediate and acute care, residential aged care and home care. There are no hospitals located in a 'remote' ARIA (Australian Bureau of Statisics, 2020).

2.2 Sample

Members of the Social Work Leadership group in CHSALHN were invited to participate in the study. Members of this group were all AASW accredited social workers and held a clinical supervisory or advanced clinical lead role within Country Health. These roles were primarily located in hospitals however some were in Regional Health Services. This research began in 2018 and was conducted during the amalgamation of the eight regions down to six regions in 2019.

2.3 Data collection

The Country Health Leadership group met on a quarterly basis and researchers were invited to attend this meeting to conduct the focus groups. The focus group held as the first of the three-stage research design involved the Social Work Leadership group in the design of the research and the development of the interview schedule. The following questions guided this focus group discussion: How do you think about professional judgement and decision-making in social work generally?; What is important to professional judgement and decision-making in social work?; How do social workers in leadership, practice or policy-making roles in South Australia navigate complex situations? The first focus group utilised these questions to scope the issues and develop the interview schedule for stage two.

For stage two, members of the Social Work Leadership group were invited to a one-to-one interview. Given the various rural locations of the SW practitioners, all interviews were

110 conducted by telephone and voice recorded. Having met the practitioners face-to-face at the
111 focus group in stage 1, author 1 invited the Social Work Leadership group members involvement
112 in the interviews at the focus group and followed up via email correspondence. Consent was
113 provided by reply email (and attached signed consent form) or verbal consent was recored via
114 phone interview.

115 The final focus group with the Social Work Leadership group conducted by authors 1 and
116 3 was where the key findings were shared face-to-face and 'sense-checked' with the group. The
117 aim was to identify implications for policy and practice.

118 **2.4 Analysis**

119 All interviews and focus groups were voice recorded, transcribed and ten percent of the
120 transcriptions were checked for accuracy by the interviewer. There were two sections in the
121 focus groups where participants spoke over each other which impeded the accuracy of the
122 transcription – these sections were manually reviewed and corrected where possible or deemed
123 unusable. The focus groups and interview transcripts were entered into Nvivo12 qualitative data
124 analysis software. The interview and focus groups were coded manually within Nvivo. Inductive
125 thematic analysis was undertaken following Braun and Clarke (Braun & Clarke, 2006, 2019). To
126 ensure rigour authors 1 and 2 undertook analysis, where author 1 cross-checked with author 2's
127 analysis.

128 **2.5 Ethics**

129 Ethics approvals were received from both Government and university human research
130 ethics committees (HREC 18/SAH/77; 8070). Separate consent was sought at each stage such
131 that involvement in one stage did not imply consent and involvement in the next stage.

132 **2.6 Research team**

133 Australian rural health researchers argue that a rural positionality adds to the researchers'
134 ability to gain access, interpret and theorise rural health experiences (Farmer, Bourke, et al.,
135 2012; Farmer, Munoz, et al., 2012). To locate the research team, the first author is a social work
136 academic who was born and raised until late teenage years in rural SA, and as an adult lived in
137 rural SA before moving to the city; she has worked for fifteen years in metropolitan site of SA
138 Health. Author 2 is an academic with a community development background, who has primarily
139 been an urban dweller. Author 3 completed her social work Honours degree and was born and
140 raised in metropolitan Adelaide.

141 **3. Results**

142 The results section has two parts. Initially the demographics of the sample will be
143 reported. This will be followed by an exploration of three themes identified from analysis of the
144 interviews and focus groups.

145 **3.1 Demographics**

146 The two focus groups were attended by 14 social workers at each meeting; and 10 of the
147 14 RHSWs agreed to be interviewed in-between the conduct of the two focus groups. Most of
148 the Social Worker Leadership group were involved in all three research stages. All eight South
149 Australian Country Health regional areas were represented within the interviews and focus
150 groups. The participants were all employed by SA Health in social work positions. There was a
151 range in years of leadership experience in rural and remote social work practice from two months
152 through to eight years. Of the fourteen in the leadership group, two were male, twelve were
153 women and none identified as non-binary. There were no gender specific themes identified. Due
154 to the small sample size and potential for re-identification, the gender and region of the

155 participants are not reported with quotes. The term ‘client’ has been used to reflect the language
156 used by the social workers interviewed. This is a contested term in the health social work context
157 and in this paper is used interchangeably with terms such as service user, patient or health
158 consumer.

159 **3.2 Rural Time**

160 The first theme identified was rural time. In an interview, one of the RHSWs talked about
161 the need to be able to provide services outside of business hours for farmers who work in
162 daylight hours:

163 [A rural social worker needs to be] able to work outside of the 9 to 5 timeframe, …
164 family [businesses], you know they're very, very work orientated, so if we had a, you
165 know a gentleman with a health issue, asking him to come into town to see me, you know
166 between 9 to 5 is probably not going to be appropriate. [CH_I_ 3]

167 This RHSW acknowledges how their 9-5pm workday did not correspond with the work
168 time of the families who seek services in the rural community. The RHSW talked about the
169 farming families and their time orientation was based on daylight hours, not how the social
170 workers workday is organised.

171 All RHSWs talked about time in relation to space or the distance travelled between
172 physical places, so time as duration or a limited unit connected to distance. Vast distances
173 between dispersed communities and services means time is required for clients to travel to access
174 services, for social workers to travel between health services and to visit clients at their homes.
175 Some RHSWs worked across multiple hospitals in differing towns within the same regional area
176 and so were required to travel as part of their employment. The following conversations were not
177 uncommon amongst the social work team working out how much time to allow for travel:

178 well the next [health] facility closest to [regional city] is [country town] which is half
179 hour drive, [country town]'s an hour, [country town]'s about an hour and three quarters
180 and I think [country town] from here is about two and a quarter hours and it's a good,
181 how far is it to [country town] from here, probably … good hour and a half, hour and
182 forty-five minutes to [country town]. [CH_I_6]

183 Later in the same interview the RHSW commented: 'the time that elapses with travel'
184 [CH_I_6] as time that is essential work time but it is time that is lost. The RHSWs needed to
185 routinely factor travel time (both their time and a colleague's time or their client's time) into
186 their decision making and their social work practice.

187 The social worker went on to describe the SA Country Health travel policy that requires
188 two workers attend home visits. This policy had resulted from the murder of a rural nurse
189 traveling remotely alone:

190 Looking at … the safety factors, because if you don't know the client and there's
191 potential social issues, there's drug misuse, … domestic violence, you could be walking
192 into an unknown quantity so there's huge safety factors with that. So … they actually go
193 out in pairs,… they'll go out with a mental health worker … I know that's …routine
194 practice which is time intensive and resource intensive. [CH_I_6]

195 The home visits are described here as being resource intensive in terms of staff time.
196 There are multiple costs associated with the visits. Another social worker talked about being the
197 second person and attending a home visit with a colleague to build a connection with the client:

198 We… go out with two people. … we're mindful about [the policy], and again different to
199 our normal practice, is if we receive that referral from a community member or from
200 someone within health, I'll actually go with the, the two contacts that I work with, the

201 nursing, community nurses, there's one in [country town] and one in [country town], and
202 I'll say to them, "Do you know this client?" …"Hey let's do a joint visit, you know the
203 person, introduce me to them and then I can talk to them about my [Social Work]
204 service", rather than going out there randomly … So we always try and make sure we've
205 got a connection before we just go randomly out to someone's home or property, and we
206 talk about risks as well. [CH_I_3]

207 The social workers are mindful of the risks involved in home visits and the importance of
208 building on an established connection to a rural client, rather than cold calling. Building on the
209 social space that has previously been established by other colleagues.

210 In the second focus group one of the social workers stated:

211 …it [time-distance] changes our focus from what potentially they've come in for
212 [depression] to what now we need to support them with [service access]. … how much
213 time that takes … , but then that's not actually the real issue, the real issue is their
214 depression. [CH_FG_2]

215 The RHSW identified how the focus on time-space-distance can shift the focus of the
216 social work intervention away from the client's presenting issue, in this case, depression, to a
217 focus on their access to services. Specifically, the RHSW was responsible for facilitating the
218 client's access to metropolitan specialist health services. The RHSW contrasted their work with
219 that of a metropolitan social worker. When asked about the additional work that a RHSW does
220 over their day, a social worker in the focus group stated: 'so it could actually take a minimum of
221 three hours to organise a piece of work that a metro[politan] social worker would never even
222 have that referral across their desk' [CH_FG_2]. The term 'organise a piece of work' in the
223 preceding quote might refer to the time taken to organize the appointment with a medical

specialist, including booking the return airline or bus tickets to travel to the appointment and back within the same day. Then perhaps including accommodation bookings if no return trips are available in the evening and sourcing funding for the travel and accommodation. In this case the patient's access to services becomes the issue and the social work time is then dedicated to organising these services and the associated travel and accommodation. This comment highlights the additional workload of the RHSW based on their rurality, or what we have named: 'rural time'. Therefore, what may have originally been 'patient time' intervening in response to their depression, is now 'rural time' as the RHSW negotiates the tasks required 'access to services' problematic due to the patient's rurality.

Another RHSW talked about time as a discrete point or deadline, in respect to their professional judgement and decision-making; the stress of making timely decisions in the rural context. This social worker stated in their interview:

> I find it, really quite stressful and anxiety provoking to have to make decisions really quickly, … unless I've had the space to do those things …[a] proper assessment, to gather the information that I need to consult with any experts that may be able to help with that particular decision, and then sit and reflect on all of that, and think about that, and analyse it, usually [confer] with somebody as well. [CH_I_1]

This quote highlights the stress and anxiety resulting from the pressures to make 'good' decisions in the 'here and now' without immediate access to colleagues to confer. This is often the case when working rurally from having smaller teams or fewer colleagues in rural/regional areas. There is also a glimpse here of the pressure felt by the RHSW resulting from the risk averse nature of social work, created by holding individual social workers accountable, where findings from Royal Commissions and Coroners inquiries have added pressures to the social

work role. It is evident that the RHSW must overlay and consider ‘rural time’ within their daily activities. That is, time that is used for tasks specific to being in a rural context.

3.2 Rural Social Space

In the second focus group, one of the RHSWs identified their self-awareness of managing professional boundaries in the rural social space: ‘and if you’re in that rural setting and the decisions been made from an organisational perspective you’re the one that has to walk down the street and see the client’ [CH_FG_2]. This is an example of the RHSWs’ professional/ occupational social space intersecting with their personal social space. This intersection is more likely to happen to the RHSW. In comparison with the metropolitan health social worker ‘running into a client’ at the local supermarket is a rare event, rather than a likely event for the RHSW. As a RHSW stated:

> I think it makes you very conscious about the boundaries that you set, and I know when I was living and working in [rural SA town] I would have very clear conversations with clients and even with other staff around boundaries and because they needed to know that it was me and that I live in the community. And that they might see me at the pub and they are probably highly likely to see me in the supermarket or the chemist, so we need to work out what that means. [CH_FG_1]

The likelihood of this happening resulted in the RHSW building into their intervention with their client a conversation about how they will act if they were to see the client in a shared social space in the rural town.

In an interaction with a client who had no immediate family in the rural town, a RHSW talked about needing to negotiate with their client who their substitute support system might be and the conflicts of interest that arose. The RHSW stated:

270 I'm thinking of a client we've got at the moment who has little to no family in our town,
271 happens to know me through my partner. And we had a conversation and I said, "Who is
272 your [support] system?" And he just looked at me, "Well there's him and him and him
273 and him." And I said, "So are you saying you would like me to and the nurse that was
274 there, that you're actually wanting the informal support systems to be put into place and
275 that you're actually wanting me to ask my partner to visit you to make a list of how we're
276 going to [sell] your house?" And he said, "Yes." So that was put down simply as his
277 informal supports and the conflict of interest was declared in the notes [CH_FG_2].

278 This is an example of the personal and the professional social spaces converging; where
279 the conflicts of interest arising were unavoidable in rural communities where there were
280 insufficient social work staff to transfer the client to.

281 RHSWs talked about the emotional labour in navigating the intersections of the social
282 and professional spaces within their rural community. In the focus group a RHSW stated: 'being
283 a community member and a staff member at the same time in a small community adds a whole
284 range of complexity that is not necessarily applicable [compared with their metropolitan
285 colleagues]' (FG). This social worker recognised the complex interplay between her role as a
286 rural community member and her social work role.

287 Several examples were shared where there was a convergence of the personal and
288 professional spaces. One RHSW mentioned how in the social space of the supermarket their
289 clients worry that 'the social worker might approach them' fearing that their own social space be
290 invaded or that their help-seeking from the social worker is revealed through a conversation or
291 acknowledgement from the social worker: 'a private thing… because people know that, you
292 know, [if they] talk to us in Woollies [Woolworths – an SA supermarket chain] and stuff and you

293 never have to worry about that [confidentiality]' [CH_FG_2]. Alternatively, the situation of the
294 over-friendly client, a RHSW in the focus group commented: 'they want to be friends, they want
295 to come around for tea' [CH_FG_2], another RHSW in the focus group understandingly
296 commented: 'Not tonight' [CH_FG_2]. The interruption of the client and/or the social workers
297 'social space' needs to be navigated within a rural community as it is much more likely to occur
298 given the low population of small country towns. Another RHSW with school-aged children
299 discussed a situation in which their personal-professional spaces converged. They described how
300 their child had befriended another child at school and was invited to go to their house for 'a
301 play'. They knew of the family from their social work practice and was aware of their history of
302 violence and abuse, heightening their anxiety as a parent. This provided additional tensions in
303 navigating the rural social space ensuring the safety of their child whilst also balancing the
304 confidentiality requirements of the professional space maintaining the privacy of the family
305 (professional client).

306 In the second focus group, with 13 colleagues listening, a RHSW stated: 'you can tarnish
307 your reputation really easy in a small community', the room full of RHSW nodded, and another
308 RHSW commented: 'so you're not anonymous in the community, you've got to be aware of how
309 you represent yourself'. Other RHSW again nodded in agreement; with one RHSW reinforcing
310 the comment by stating: 'at all times', a continual alertness is required as to the personal and
311 professional self within the shared social space of the small rural community.

312 **3.3 Intersections of time, social space and power**

313 Some RHSWs talked diplomatically about the trickiness of their role in balancing the
314 best interests of the client with the interests of their organisation, the hospital. Power is exercised
315 through knowledge and resource allocations. A RHSW, in their interpersonal interview stated:

316 …trying to support the client as much as possible, but also being pressured by the
317 hospital in terms of discharge and so you might think that client really should not be
318 discharged yet, they're not ready for discharge and the hospitals saying well we need the
319 bed, find a place for them to go. [CH_I_2]

320 This social worker provides an example of how frontline hospital social workers are
321 pressured to move clients who are medically stable but not socially stable before a safe place for
322 them to go becomes available. Due to cuts across other sectors such as housing and disability,
323 RHSWs often have fewer options for referral to housing or supported accommodation in rural
324 communities that support safe discharge, which then in turn takes more time to establish a
325 suitable discharge plan. Another RHSW shared the challenges of professional judgement and
326 decision-making with their long-stay patient, who was described as disadvantaged. Unbeknownst
327 to the client they were being charged a daily bed fee. The RHSW was required to tell the patient
328 that they were being charged the fee and help negotiate with the patient to pay their fee via direct
329 debit. In an act of resistance, the social worker advocated to the hospital finance manager stating:

330 Actually, no, that's not the social workers role. Our role is support, advocate for that
331 client and we will not be going – marching in there and doing finances job. Also, we want
332 to see how that was documented – that discussion with the client, if that was documented
333 in the case notes. That would prove that discussion happened with the client. However, if
334 we can't prove that that discussion was had with the client about the daily bed stay fee,
335 which is absolutely substantial at the moment, then that should be waived. [CH_I_1]

336 Similarly, another RHSW, described how for one patient they spent five months
337 negotiating: 'all the systems to work for a result that's going to meet everyone's needs including
338 the client' [CH_I_4]. She counted the involvement of 20 staff across no less than five

339 government departments including Health, Department for Correctional Services, Disability
340 Services, Department for Community Services and Social Inclusion and the Office of the Public
341 Advocate. At the end of the five-month stay in hospital, the social worker had successfully
342 negotiated the client's discharge from hospital to more appropriate and safe care. The 'patient'
343 entered hospital following an adverse event soon after their release from prison. The patient's
344 criminal history impacted how they were treated by hospital staff and service providers outside
345 of the hospital. For example, services actively avoided contact with the patient. The social
346 worker stated that most services were prepared for the patient to 'live forever in a hospital',
347 rather than provide the patient services. The patient's medical condition rendered them
348 unresponsive and not requiring ongoing 'medical' care. A clinician from the city had diagnosed
349 the rural patient from a distance with a medical condition that belied the symptoms observed by
350 rural hospital staff who saw the patient daily at the treating rural hospital. The patient's rare
351 diagnosis (from the city clinician) excluded the patient from eligibility for services from first, the
352 disability sector as well the patient's young age meant they were unable to access an aged care
353 assessment. This resulted in the patient, who was medically stable but socially unstable,
354 becoming a long-stay 'patient' in hospital. In a show of patient-centred care, the RHSW
355 advocated for re-diagnosis of the patient. The RHSW described how they had invited the
356 metropolitan Clinician to attend the rural hospital 'in-person' to make sense of the combined
357 social, physical and biological symptoms of the medical condition, rather than rely on diagnosis
358 by distance from the X-ray alone. The RHSW described how they had challenged the Clinician:

> 359 If you think [the patient] is not that bad, why don't you pop yourself on a plane and come
> 360 here and actually visually look at this [patient] or I can video [the patient] for you…I'm

361 happy to put [the patient] on a plane and send [them] down to the [metropolitan hospital]
362 and we'll see how that goes [CH_I_4].

363 The social worker was dissatisfied with the outcome of the 'diagnosis from a distance'
364 and argued for the need for the metropolitan Clinician to attend the patient (or patient to attend
365 the Clinician) to conduct a 'visual' examination of the patient. The RHSW was sure that a real-
366 time consult where the visible symptoms together with the face-to-face interpersonal engagement
367 would result in the clinician re-diagnosing the patient. A re-diagnosis would then allow the
368 patient to be eligible for services and exited from the hospital with minimal medical and safety
369 risk. The RHSW practice is time-bound, restricted by the social space of their profession and the
370 economic and political context of their work.

371 4. Discussion

372 The concepts of 'rural time' and 'rural social space' have been identified in this study to
373 describe the work of the RHSW that occurs solely because of rurality. For example focusing on
374 the patients access to services, rather than on their presenting social issue.

375 Across epistemic fields time is conceptualised with various meanings (Evans, 2005) and
376 structure; e.g. chronological time, historical time, synchronous time, time as a passage, time as a
377 commodity, social time. In this study time is omnipresent. The RHSWs have drawn on multiple
378 meanings of time. For example English historian E. P. Thompson (1967) examined the time,
379 work-discipline at the rise of industrial capitalism identifying two notions of work time either
380 task-oriented (working until the job gets done) or timed labour (working a set number of hours
381 per day on the job) (Thompson, 1967). Thompson (1967) claimed that a community where work
382 is task-oriented shows least boundaries between 'work' and 'life' and so a convergence of the
383 professional and the personal social spaces. The farming communities described by the RHSWs

384 provided example of task-oriented understandings of time, where the only way to provide social
385 work services was to provide them outside of daylight hours. Not uncommon in descriptions of
386 rural health professionals practice are comments on the time taken to travel vast distances
387 (Cheers, 2007; Dellemain et al., 2017), the passage of time. While a social worker in this study
388 talked about this travel time as 'lost time', in an Australian study, Dellemein et al (2017) found
389 that RHSWs worked to make this time productive, through attending phone meetings (if in
390 phone range) or undertaking professional development (eg listening to podcasts). Social
391 Worker's time, like nurses is also consumed with navigating service delivery rules and
392 procedures or 'hospital time' as coined by Ihlebæk (Ihlebæk, 2021) in their ethnographic study
393 of metropolitan nursing staff time allocations in Norway.

394 UK sociologist Anthony Giddens is an influential thinker about time and space. In his
395 theory of structuration, of the interplay of human agency and institutional structures, he sets out
396 intersecting forms of time; 'the temporality of immediate experience', 'the lifecycle of the
397 organism' and 'institutional time' (Giddens, 1981, p. 93). Everyday action is set within and
398 reflects, in varying ways, the dynamics of institutional processes shaped over time. His concept
399 of time-space distanciation' is defined as: '…the conditions under which time and space are
400 organised so as to connect presence and absence' (Giddens, 1990, p. 14). Our paper was written
401 at the time of the COVID-19 pandemic providing fertile examples of social connections in and
402 across spaces (i.e., through Zoom) where same time zone and place-based contact is absent.
403 Gabbert notes the tensions and possibilities in these dynamics for social relations beyond places,
404 and the 're-embedding' of local relations (Gabbert, 2007, pp. 182-183). The metrocentric nature
405 of health services was identified on several occasions, in particular the limitations of diagnoses
406 by distance and the need, in some instances, of real-time clinical engagement. Time is a

407 component of social work practice; it is needed to manage all facets of a service system and
408 ensure client's needs are met. As identified in this study rural health social work practice time is
409 spent negotiating and advocating with metropolitan service systems, organising and funding
410 travel and accommodation arrangements on behalf of rural patients.

411 The concept of social time is unpacked by Lewis and Weigert (1981) as 'embeddedness,
412 synchronicity, and stratification' (Lewis & Weigert, 1981, p. 435) and how these relationships
413 affect organisations and individuals. Other studies into rurality and professional practice have
414 identified the need to traverse both professional and personal spaces when working and living in
415 the rural space (Pugh, 2007) as a result of the embeddedness within their local rural community.
416 French sociologist Pierre Bourdieu describes social space as '…the mutual exclusion of positions
417 which it, that is, as a structure of juxtaposition of social positions' (Bourdieu, 1991, p. 106).
418 Jenkins (Jenkins, 2002, p. 69) commenting on Bourdieu's notions of 'practice, habitus and field'
419 asserts that: '…practice is located in space and, more significantly in time' and that any
420 'interaction takes time - and it occurs in space'. Bourdieu (1991) contends that there is no space
421 within an hierachized society that is not hierarchized or imbued with power and social
422 hierarchies. Bourdieu (1991, p.108) states: 'Space as we inhabit it and as we know it is socially
423 constructed and marked' and it is inscribed with both objective - physical and subjective - mental
424 structures. This quote from Bourdieu highlights the power relations at play, and this study has
425 identified the intersections of the professional and personal social spaces within a small rural
426 community.

427 In the allocation of cases amongst the team, RHSW considers the rural social space of the
428 social worker in relation to the patient. This requires good communication skills, a high level of
429 knowledge about your staff and their social networks to avoid a situation which makes both the

430 client and the RHSW uncomfortable. The potential for this personal/professional intersection
431 constructs and inscribes the RHSWs behaviour and actions within professional social space:
432 'define[ing] the rules of the game' (Bourdieu, 1998) p.38). In the context of negotiating rural
433 social spaces, the RHSW provided the client with an opportunity to pre-prepare for the chance of
434 meeting socially, thereby 'providing a level of confidence in how things will happen' (Tilly,
435 2002). In turn, this reduces the potential unequal power in the social space. Viewing the
436 supermarket as a 'social space', to borrow Bourdieu's expression, the social worker and the
437 client and their associated positions and hierarchies are played out amongst the aisles of the fruit
438 and vegetables. The client hoping not to be publicly recognised by the RHSW in the shared rural
439 social space of the supermarket. As a result the RHSW acknowledged the power, allowing for
440 power relations to be managed. Again, borrowing Bourdieu's notions of 'cultural capital' the
441 social workers professional status may imbue cultural capital but the nature of the social work
442 intervention (e.g. for people experiencing poverty, disadvantage, or mental health issues) results
443 in the associated social capital of the social worker being renounced by the client. These
444 navigations take time, rural time.

445 An institutional time marker for RHSW is their patient's length of stay in hospital. The
446 phrase 'length of stay' refers to the number of days (time) a patient uses a bed in hospital (space)
447 and draws on dual meanings of time, both duration and commodity. This construct was used in
448 common parlance by the RHSW. 'Length of stay' in Australian health and hospital systems is
449 considered a measure of the 'success' of their intervention; the shorter the 'length of stay' the
450 better. Under this guise, the role of the RHSW becomes facilitating a safe discharge as quickly as
451 possible. Each diagnosable condition is allocated a particular length of stay. In Australia,
452 hospitals are paid by the treatment of the diagnosed condition by the allocated length of stay

453 (Duckett, 1995) known as Diagnostic Related Groups. These payments are made from the
454 Federal government to the State governments based on 'episodes of care' or the diagnosis of the
455 patient and the 'expected length of stay' allocated to that diagnosis (Duckett, 1995). When the
456 actual length of stay exceeds the budgeted length of stay, patients may be required to fund the
457 difference. In this respect, the health system has applied a market value (commodity) on the
458 duration of time in hospital. The RHSW 'acts of resistance' or advocacy enabled the social
459 worker to use their professional judgement and decision-making to get an outcome that was
460 desired by both the client, aligned with the social worker's professional value-base and the
461 organisational demands but which may have required substantial negotiation on behalf of the
462 social worker, against the dominant medical model. The RHSW demonstrated their agency
463 against the dominant payment practices within the hospital system, as defined by Bourdieu
464 (1998), acting to resist the neo-liberal pressures to engage in the fee negotiations for the hospital.
465 In the case requiring re-diagnosis, the RHSW resisted the metrocentric nature of health services.
466 In this case the RHSW, who was relegated to subordinate positions within the dominant medical
467 model in the hospital system employed multiple 'acts of resistance' in the 'battlefield of the
468 distribution of capital accrued to the medical profession' (Bourdieu, 1998). In the neo-liberal
469 economic environment, the RHSW was under pressure to reduce the length of stay and increase
470 patient flow through the hospital system. This however relies on the multiple metrocentric
471 private and public support and service systems outside of the rural hospital system to engage and
472 be prepared to negotiate eligibility, so the client receives care and support.

473 Bourdieu's collection of writings and spoken contributions to movements and moments
474 of resistance titled 'acts of resistance' provide, as he had hoped, useful weapons in an armory for
475 those striving to resist the 'scourge of neo-liberalism' (Bourdieu, 1998, p. 1). Bourdieu named

476 the social work as a profession (p. 103) which was facing an extreme case of contradiction, in
477 that governments were withdrawing from areas for which it was previously responsible and he
478 named: ‘social housing, public service broadcasting, schools, hospitals etc’ (1998, p.2). In the
479 Australian context, these forces have been acutely felt in the shrinking provision of services in
480 rural and regional areas, by social workers directly as their therapeutic intervention time shrinks
481 as have the services that they refer to. Moreover, market thinking has reframed the practices
482 within state services. Bourdieu (1998, p.3) stated:

483 All that [neoliberal agenda] is somewhat shocking, especially for those who are sent to
484 the front line to perform so-called ‘social’ work to compensate for the most flagrant
485 inadequacies of the logic of the market, without being given the means to really do their
486 job.

487 The temporal and spatial dimensions of RHSW’s professional judgement and decision-
488 making have been identified. Multiple faces of time/ space nexus are evident in their practice,
489 which offers a window into the complexity of social work practice in a rural setting. In the
490 provision of health care, time has been commodified such that time is money and power. If your
491 profession is proven to save hospital ‘time’ by reducing the patient’s ‘length of stay’ then their
492 contributions to the patient pathway are highly valued. Again, time is power. The demands on
493 the social workers to engage in thorough discharge planning, make timely and informed
494 decisions was compromised by the complexity of the cases and the time to develop informed
495 options with the available knowledge and services at hand.

5. Conclusion

Building on previous research examining rural social work practice, this paper presents the concept of ‘rural time’ and ‘rural social space’, a recognition of the time RHSWs spend because of being rural across both their professional and personal social spaces.

RHSWs have engaged in ‘creative’ social work practice (Dellemain et al., 2017) or as Bourdieu (1998) named ‘acts of resistance’ against the neoliberal pressures from within their organisation to reduce the length of stay and therefore the spend of the hospital. These pressures exacerbate other challenges that face RHSW in rural settings about navigating social relationships, personal identity and boundaries, and professional identity and accountability. These temporal, institutional, systemic and spatial factors, constituted as they are of power dynamics, have implications for the skills and vision needed by RHSW to maintain a focus on social justice practice. Clear-sighted analysis of these complexities in the context of social power can support this ongoing and longer-term project.

509 References

510 Australian Bureau of Statisics. (2020). *The Australian Statistical Geography Standard (ASGS)*
511 *Remoteness Structure*. Australian Government,. Retrieved 29/9/20 from
512 https://www.abs.gov.au/websitedbs/d3310114.nsf/home/remoteness+structure
513
514 Bourdieu, P. (1991). *Language and Symbolic Power*. Polity.
515
516 Bourdieu, P. (1998). *Acts of Resistance: Against the New Myths of our Time* (R. Nice, Trans.;
517 Vol. Reprinted 2000). Polity Press and The New Press.
518
519 Bourdieu, P. (2018). Social space and the genesis of appropriated physical space. *International*
520 *Journal of Urban and Regional Research*, 106-114. https://doi.org/DOI:10.1111/1468-
521 2427.12534
522
523 Braun, V., & Clarke, V. (2006, 2006/01/01). Using thematic analysis in psychology. *Qualitative*
524 *Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa
525
526 Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research*
527 *in Sport, Exercise and Health, 11*(4), 589-597.
528 https://doi.org/https://doi.org/10.1080/2159676X.2019.1628806
529
530 Brown, G., & Green, R. (2009). Ensuring the Future of Rural Social Work in Australia. *Rural*
531 *Society, 19*(4), 293-295. https://doi.org/doi:http://dx.doi.org/10.5172/rsj.351.19.4.293
532
533 Cheers, B. (2007). *Social care practice in rural communities*. Annandale, N.S.W. : Federation
534 Press.
535
536 Cleak, H. M. (2002). A model of social work classification in health care. *Australian Social*
537 *Work, 55*(1), 38-49. https://doi.org/DOI: 10.1080/03124070208411670
538
539 Cleak, H. M., & Turczynski, M. (2014). Hospital Social Work in Australia: Emerging Trends or
540 More of the Same? *Social Work in Health Care, 53*(3), 199-213.
541 https://doi.org/10.1080/00981389.2013.873516
542
543 Dellemain, J., Hodgkin, S., & Warburton, J. (2017). Time, terrain and trust: Impacts of rurality on case
544 management in rural Australia. *Journal of Rural Studies*, 50-57.
545 https://doi.org/doi:https://doi.org/10.1016/j.jrurstud.2016.11.006
546
547 Donetto, S., Pierri, P., Tsianakas, V., & Robert, G. (2015). Experience-based co-design and
548 healthcare improvement: Realizing participatory design in the public sector. *The Design*
549 *Journal, 18*(2), 227-248. https://doi.org/10.2752/175630615X14212498964312
550
551 Duckett, S. (1995). Hospital payment arrangements to encourage efficency: the case of Victoria,
552 Australia. *Health Policy, 34*(2), 113-134. https://doi.org/https://doi.org/10.1016/0168-
553 8510(95)94014-Y
554

555 Dutilleul, B., Birrer, F. A. J., & Mensink, W. (2010, June). Unpacking European Living Labs:
556 Analysing innovation's social dimensions. *Central European Journal of Public Policy,*
557 *4*(1), 60-85.
558
559 Evans, V. (2005). The meaning of time: Polysemy, the lexicon and conceptual structure. *Journal*
560 *of Linguistics, 41*(1), 33-75. http://www.jstor.org/stable/4176917
561
562 Farmer, J., Bourke, L., Taylor, J., Marley, J. V., Reid, J., Bracksley, S., & Johnson, N. (2012).
563 Culture and rural health. *Australian Journal of Rural Health, 20*(5), 243-247.
564 https://doi.org/https://doi.org/10.1111/j.1440-1584.2012.01304.x
565
566 Farmer, J., Munoz, S., & Threlkeld, G. (2012). Theory in rural health. *Australian Journal of*
567 *Rural Health, 20*(4), 185-189. https://doi.org/https://doi.org/10.1111/j.1440-
568 1584.2012.01286.x
569
570 Gabbert, L. (2007). Distanciation and the recontextualization of space: finding one's way in a
571 small western community. *Journal of American Folklore, 120*(476), 178-203.
572 https://doi.org/https://www.jstor.org/stable/4137688
573
574 Gibbs, L., Gold, L., Kulkens, M., Riggs, E., Gemert, C. V., & Waters, E. (2008). Are the
575 potential benefits of a community-based participatory approach to public health research
576 worth the potential costs? *Just Policy, 47*(March), 54-59.
577 https://doi.org/10.3316/ielapa.022781844871809
578
579 Giddens, A. (1981). Time and Space in social theory. *Lebenswelt und soziale Probleme:*
580 *Verhandlungen des 20:* Deutschen Soziologentages zu Bremen, Frankfut am Main: Campus
581 Verl.
582
583 Giddens, A. (1990). *The Consequences of Modernity*. Polity Press.
584
585 Green, R., Gregory, R., & Mason, R. (2009). Preparing for social work practice in diverse
586 contexts: Introducing an integrated model for class discussion [Article]. *Social Work*
587 *Education, 28*(4), 413-422. https://doi.org/10.1080/02615470802109999
588
589 Harvey, E., & Jones, M. (2021). Using complex adaptive systems theory to understnd
590 complexities of hospital social work practice in rural and remote Australia. *British*
591 *Journal of Social Work*, bcab197. https://doi.org/ https://doi.org/10.1093/bjsw/bcab197
592
593 Ihlebæk, H. M. (2021). Time to care - An ethnographic study of how temporal structuring affects
594 caring relationships in clinical nursing. *Social Science and Medicine, 287*(114349).
595 https://doi.org/https://doi.org/10.1016/j.socscimed.2021.114349
596
597 Jenkins, R. (2002). *Pierre Bourdieu: revised edition*. Routledge.
598
599 Levine, R. (2005). A geography of busyness. *Social Research, 72*, 355-370.
600 https://doi.org/https://doi.org/10.1353/sor.2005.0050
601

602 Lewis, D., & Weigert, A. J. (1981, December). The Structures and Meanings of Social Time.
603 *Social Forces, 60*(2), 432-462. https://doi.org/ https://doi.org/10.1093/sf/60.2.432
604
605 Malatzky, C., Cosgrave, C., & Gillespie, J. (2020). The utility of conceptualisations of place and
606 belonging in workorce retention: A proposal for future rural health research. *Health &*
607 *Place, 62*(102279). https://doi.org/https://doi.org/10.1016/j.healthplace.2019.102279
608
609 Mason, R. (2011). Confronting Uncertainty: Lessons from Rural Social Work. *Australian Social*
610 *Work, 64*(3), 377-394. https://doi.org/10.1080/0312407X.2011.574144
611
612 Neuman, W. L. (2011). *Social research methods : qualitative and quantitative approaches* (7th
613 ed. ed.). Allyn & Bacon.
614
615 Phillips, A. (2009). Health status differentials across rural and remote Australia. *Australian*
616 *Journal of Rural Health, 17*, 2-9. https://doi.org/doi: 10.1111/j.1440-1584.2008.01029.x
617
618 Pugh, R. (2007). Dual relationships: Personal and professional boundaries in rural social work.
619 *British Journal of Social Work, 37*, 1405-1423. https://doi.org/doi:10.1093/bjsw/bcl088
620
621 Roberts, P., Cosgrave, C., Gillespie, J., Malatzky, C., Hyde, S., Hu, W. C., Bailey, J., Yassine,
622 T., & Downes, N. (2020). 'Re-placing' profesional practice. *The Australian Journal of*
623 *Rural Health, 29*, 301-305. https://doi.org/DOI: 10.1111/ajr.12717
624
625 Saltman, J., Gumpert, J., Allen-Kelly, K., & Zubrzycki, J. (2004). Rural social work practice in the
626 United States and Australia: A comparison. . *International Social Work, 47*(4), 515-531. .
627 https://doi.org/doi:10.1177/0020872804046258
628
629 Thompson, E. P. (1967). Time, Work-Discipline and Industrial Capitalism. *Past and Present,*
630 *38*(Dec.), 56-97. https://doi.org/http://www.jstor.org/stable/649749 .
631
632 Tilly, C. (2002). Historical analysis of political processes. In J. Turner (Ed.), *Handbook of*
633 *Sociological Theory* (pp. 567-588). Kluwer Academic/Plenum Publishers.
634
635 Waltman, G. H. (2011). Reflections on Rural Social Work. . *Families in Society, 92*(2), 236-239.
636 https://doi.org/doi:10.1606/1044-3894.4091
637

638