

Case Management: Challenges for the Rural Panhandle of Texas

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Abstract

This paper addresses certain challenges case managers face in the rural Texas Panhandle, but is applicable to a variety of human service workers with different backgrounds who practice in other nonmetropolitan areas. A brief history of case management is discussed in the context of early mental health treatment and deinstitutionalization. The Upper Peninsula of Michigan is a secondary geographical region that is mentioned, based on the author's personal background. Four specific barriers to providing effective case management in the Texas Panhandle are highlighted. In conclusion, questions are posed in dichotomous formats in order to broaden the scope in the traditional perceptions of case management.

Keywords: Case management, Rural, Poverty, Religion, Attitudes, Politics

Introduction

"Case Management" is a generic term that is used in a variety of human service agencies, and not tied to any particular discipline or profession (Sands, 1991). However, social work has adopted the practice of case management to the extent that the National Association of Social Workers (NASW) approved its own "Case Management Standards Work Group" (1992). This group not only has defined social work case management, but has also established goals, functions, and tasks of case managers. So as not to rehash each section published by this work group, some professionals view case management as "just old social work wearing new clothes" (Moore, 1990, p. 444). Rose (1992) interestingly conceptualized case management as "old wine poured into new wine skins." Whatever analogy one chooses to apply, it is apparent that case management attempts to alleviate fragmentation often seen in human service delivery systems. Continuity of service, coordination of service providers, rational decision making, timely record-keeping, and monitoring "treatment" are all essential ingredients of effective case managers (Cohn & DeGraff (1982).

Historical Perspective on Institutionalization

In order to truly grasp the significance in the emergence of case management over the past thirty years, one needs to review the historical framework that structured its evolution. By the turn of the twentieth century, the United States was becoming more industrialized. Agrarian communities were being transformed into urban centers with factories comprising the hub of everyday life. This progression has continued to through the 21st century, as only 25% of our population today is now considered "rural" (Carlton-Laney, Burwell, & White, 2013). As rural communities developed, so did a spirit of cooperative cohesion. Traditional problem-solving methods proved fairly effective until the trends of urbanization and industrialization began to manifest. With the influx of people, societal problems of sickness, poverty, and mental illness began to affect others' lives. Relationships between people were becoming more impersonal, tense, and competitive. Analogous to the chicken-or-the-egg" concept, these issues became social problems, and social problems only tended to exacerbate dysfunction (Blodgett, 1993). Large state psychiatric hospitals were built in an effort to treat mental illness, and admission rates began to increase.

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In large part, this was due to the fact that many patients were admitted not for mental illness, but rather, for other social situations. By 1940, the average state hospital housed between 500-1000 patients (Kiesler & Sibulkin, 1983). A few, like Pilgrim State Hospital in New York, approached populations of 12,000. The total county and state hospital population reached a peak in 1955, with nearly 600,000 patients (Conrad & Schneider, 1980). Again, problems that were being "treated" included mental illness, homelessness, poverty, criminality organic brain damage, and those who were in the tertiary and fatal stages of syphilis (Grob, 1983). The phrase "give me your tired and huddled masses" inscribed on the Statue of Liberty was an appropriate slogan for these institutions that even resembled the poor houses in the Colonial days. Goffman (1961) described these settings as "total institutions," as they attempted to structure everyday life.

Deinstitutionalization

With the advent of psychotropic medications in the mid-1950s, patient populations began to dramatically decline. Within 20 years, the inpatient population dropped to 174,000 (Conrad & Schneider, 1980). Currently, there are less than 100,000 people in such institutions (Sands, 1991). With the influx of discharged patients into communities, the concepts of "normalization" and "least restrictive environments" replaced the "therapeutic milieu" attempted in state hospitals. Extensive state and federal monies were dedicated to the building of community mental health centers, and by 1973, over 500 such facilities were in operation (Robin & Wagenfield, 1977). Today, there are over 700 such facilities (Skidmore, Thackeray, & Farley, 1977).

Residual Problems and Case Management

Several problems became apparent as more individuals were being discharged from state hospitals. There were many who did not keep their appointments, usually leading to the noncompliance of medication. A "revolving door syndrome" began to develop, as homelessness and poverty were often the result of deinstitutionalization, and readmissions became problematic. Particularly for those in rural areas, a label or stigma was often attached to those who had been discharged back into communities. This obviously hampered job opportunities, housing, and social interaction (Blodgett, 1993). Lack of transportation in remote areas only isolated people more. It is no wonder that case management became the vehicle to address these chronic situations. Literally, it has become similar to "Meals-on-Wheels" in an effort to forge therapeutic alliances.

Two Rural Areas

Many people have defined the term "rural" in different ways, but seldom is there agreement on the precise terminology. For some, the quantitative number of inhabitants in a particular region determines whether the area is urban or rural. For others, the term "rural" signifies a subjective state of mind

(http://www.nal.usda.gov/ric/ricpubs/what_is_rural.shtml). Sociologists who study demography often apply the terms "metropolitan" and "nonmetropolitan." Often, rural communities are viewed as having little industry, an agrarian economy, high in religious values, conservative political views, and little cultural diversity (the large majority being "WASPs"). As an example, this author lived 17 years in the Upper Peninsula of Michigan. This region covers over 16,000 square miles, but only has a total population of around 300,000 (about 18 people per square mile) (http://en.wikipedia.org/wiki/Upper_Peninsula_of_Michigan). The largest city in this region is Marquette, which has a population less than 25,000. The variables mentioned above that characterize rural communities certainly apply to this region.



Presently, this author lives in Amarillo, Texas, which is located in the state's "Panhandle." Often referred to as the "High Plains," this region too possesses many of the qualities of the Upper Peninsula in terms of high religiosity, little cultural diversity, and an agrarian economy (though more dependent on farming and ranching than timber, mining, or fishing). The total population of this area is over 400,000, with a density of only 17 per square mile (http://en.wikipedia.org/wiki/Texas_Panhandle). The largest city in this region is Amarillo, with a population of approximately 200,000. Twenty-six counties represent this northern-most region of Texas.



For the purposes of this discussion, Amarillo will be the focus of case management services. Though the population of this city may not suggest a rural community, it indeed contains the subjective elements of a rural "mindset" and way of life. Actually encompassing two counties (Potter and Randal), the needs of the area continue to present a challenge for human service delivery programs.

Texas Case Management

The Texas Department of Mental Health and Mental Retardation (1984) has defined case management as "a system in which a single accountable individual performs activities in the service of the client, ensuring to the maximum extent possible, that the client has access to and receives all resources and services which can help the client reach and maintain his/her optimal level of functioning. Case management is also the relationship between a client and a specific professional which allows immediate intervention to prevent and/or to resolve crises, and to support adaptive behavior which allows the client to remain within the community" (p.1). While this definition pertains to only one major component of human services in the state of Texas, it arguably is applicable to Medicaid, Medicare, Home Health, services to the aged, services to children, TANF, and a range of disability services.

Challenges in the Texas Panhandle

Based on the definition above, as well as the demographic qualities already cited for this region, case managers face a variety of challenging issues when it comes to a range of human service delivery programs. The Texas Department of Health and Human Services (2012) has listed eleven primary responsibilities of case managers: (1) ensuring eligibility of services; (2) coordinating access to services; (3) assessing needs; (4) locating available services; (5) working with family when appropriate; (6) coordination of services; (7) developing a plan or care or individualized service plan; (8) monitoring of services; (9) crisis intervention; (10) authorizing services; and (11) reassessing consumer need. In addition to these functions, several other considerations are unique to this region. Four particular issues will be discussed here.

Poverty

In the two counties that comprise the city of Amarillo (Potter and Randal), approximately 32,000 recipients receive Medicaid. About this same number also receive services from TANF (Texas Department of Health and Human Services, 2012). Twenty percent of the population in Amarillo is receiving SNAP benefits (U.S. Department of Agriculture, Food, and Nutrition Service, 2011). Almost 1500 families in Amarillo receive subsidized housing benefits (https://www.amarillo.gov/?page_id=328). These two counties are arguably the “richest” in the Texas Panhandle, as the other 24 counties are even sparser in population, as well as opportunities. Rural poverty is certainly not limited to the Texas Panhandle. The recent credit crisis, unemployment, recession, and foreclosures have disproportionately affected rural areas. In fact, there were almost eight million people in nonmetropolitan areas that lived below the poverty line in 2010 (Housing Assistance Council, 2011). For the Texas Panhandle, the rural poor are perhaps the most socially and geographically isolated. Oppression through rigid class stratification, racial segregation, and marginalization continues to be a barrier to residents and a challenge for case managers.

Attitudes

Texas is considered to be “The Lone Star State” for good reason. The symbol of the star on the state flag represents a spirit of independence and rugged individualism. There is a tendency to have a “pull yourself up by the boot strap” ideologue. Consequently, the thought of relying on some human service agency, much less, the dependence on a case manager for fulfilling certain needs, is an indication of weakness for potential clients. Just because a person may qualify for assistance does not mean that this is a welcomed service. This sense of autonomy makes it difficult for case managers to engage certain clients in the willingness to receive entitlements. In fact, many do not want to be entitled to anyone or any service, even though they are qualified for such benefits.

Politics

It is no misnomer that in order to understand social work, it is imperative to understand politics. Social welfare policy is a required course for all BSW and MSW Programs. Inherent in this topic is the study of liberal and conservative points of view, as well as the political parties that espouse each philosophy. In our two-party system in the United States, the liberal or progressive stance tends to espouse large government programs with “institutional” forms of social welfare). The conservative side of the political coin wants to de-emphasize the role of government, and promotes a “residual” safety-net for welfare recipients (Poppo and Lehninger, 2010). With these contrasting views, it is important to note that Texas has been a Republican “red” state since it gained independence in 1845. In the last two Presidential elections, the Republican candidates garnished approximately 80% of the vote (http://en.wikipedia.org/wiki/Texas_Panhandle#Politics). The Texas Panhandle, if possible, is even more politically conservative than other regions of the state. Whether it be Medicaid, SNAP, or “Obama Care,” Texas residents are skeptical of government intervention. After all, a region known more for its beef and horses than its people, would predictably be hesitant to receive a helping hand that is extended through any form of government. Perhaps the best synopsis of this political climate is stated as follows: In the modern era, the various strands of Texas political culture could be boiled down to three main ideological tendencies: economic liberalism (faith in the “free market” economy) combined with social conservatism (favoring traditional values and moralism), overlaid with populism (promoting the rights and worthiness of ordinary people). These ideological tendencies have found their expression in a dominant political culture that tends to favor low taxes, low government services, and pro-business policies (Texas Politics, 2013).

Religion

Social work has deep roots in religion. Most social service agencies began functioning through churches, synagogues, and temples, as Judaic principles emphasize the responsibility of helping others in need. It would seem that high religiosity would be compatible with high consumption of human services. However, often intrinsic within high religious values is the notion of fatalism. That is, people get the sense that all good and bad is God’s will. In other words, events that occur are predestined to occur, so it is pointless to prevent or even prepare for personal misfortunes (Henslin, 1997). Indeed, the “Protestant Ethic” and the “Spirit of Capitalism” become ingrained philosophies that often cause people to refrain from seeking help, especially from government sources (Weber, (1946). Case Managers may represent an alternative that is not especially accepted by Panhandle residents.

Horizontal or Vertical Giving?

Castelloe, White, Butterworth, Arias, and Hemstreet (2009) describe horizontal giving as “the giving and giving back that occurs between friends and family within a community, among people who know and trust each other” (p. 9). Unlike vertical giving, where the exchange of money or services is between individuals and institutions, horizontal giving tends to characterize rural communities generally, and the Texas Panhandle in particular. This type of giving is characterized by reciprocity, mutuality, cooperation, and interdependence (Carlton-Laney, Burwell, & White, 2013). It tends to be informal, often under-recognized, and may actually dwarf the services provided formally by human service institutions. It is important for case managers to understand and recognize the significance of horizontal giving. As helpful as this practice is, horizontal giving may exacerbate any shame or embarrassment in receiving institutional support. In other words, if one feels natural support systems were not sufficient, a sense of failure becomes more pronounced (Carlton-Laney, Burwell, & White, 2013).

Case Management or Community Practice?

A recent report from the Texas Department of Health and Human Service Commission (2012) indicated that case management services tended to be duplicative, uncoordinated among agencies, and not often meeting the needs of consumers. In some agencies, case management is more of a recordkeeping and referral service, where emphasis is placed more on burdensome bureaucratic rules and procedures. It is becoming apparent that case managers who are trained to provide one-on-one services are not seeing the forest for the trees. Not to minimize individual recipients of case management services, but a larger focus could serve to maximize the potential of rural communities. Community organizing allows people to claim a stake in revitalization efforts. Where services do not exist, neighborhood coalitions can organize and advocate for expanding services. For instance, access to acute health services have declined radically for rural residents over the past twenty years. Not only has this resulted in a decrease in services, but also has created shortages of rural health care professionals (Bull, Krout, Rathbone-McCuan & Shreffler 2001; Doelkerf & Bedics, (1989). Clearly, a case manager who works only with individuals and families cannot meet long-term needs if a deficit of services continues to exist.

Case Management or Community Coaches?

It is true that case managers enact a variety of roles. Depending on the setting and field of practice, specialized skills may be in order. Some would say that social workers and case managers are a “jack of all trades, and a master of none.” A variety of authors have enumerated functions and roles of case managers, including: advocate, counselor, mediator, planner, evaluator, coordinator, and broker, just to name a few. Interestingly, the term “community coach” recently has come into vogue, and has provided enlightenment to traditional definitions. The role of community coaches “is not to do things for the community, but rather learn with community members about how to build their capacity to do things more effectively” (Emery, Hubbell, & Polka, 2011, p. 11). These coaches can envision and facilitate the change process within communities. Establishing goals, planning, and convening important stakeholders become essential duties of the coach. Overcoming and/or reframing barriers that communities may face in the change process also are important functions. Carlton-Laney, Burwell, and White (2012/2013) noted that “several programs have used community coaches, including the Northwest Area Foundation’s Horizons Project on poverty reduction and the Program for the Rural Carolinas, which sought to increase employment in rural areas and to strengthen leadership assets” (p. 471). The concept of community coaches blends nicely with “grassroots” organizing on a community level. Again, this adds to the argument that case managers perhaps can be more effective with macro targets rather than micro-level intervention. It is interesting to note that no such concept of community coaches in Texas has been found in literature. Also intriguing is the fact that the Panhandle of Texas (as with most of the state) is fanatical about high school football. The term “coach” may be a more inviting metaphor than a social worker or case manager.

Professionalization or Declassification?

It has been well documented that social work (and case managers) are becoming more professionalized. In addition to degrees, certification and licensure are usually required criteria for practitioners. Although not all case managers are social workers, it is apparent that social work as a profession tends to claim “professional turf” when it comes to case management. In rural areas such as the Texas Panhandle, degreed social workers with added case management credentials may be few and far between. Blodgett (1992) has argued that other disciplines such as Sociology may have a lot to offer in training and graduating potential case managers.

Clinical Sociology and Sociological Practice are two branches of the American Sociological Association (ASA), which have attempted to translate theory into actual intervention. In fact, it could be argued that historically, the roots of sociology may provide more relevance to case management than even social work. Glassner & Freedman (1979) explain: Because social work has barely developed theories of its own, training usually borrows from developmental psychology (normal and pathological) and psychiatry. Training in other social service concepts is something of a rarity. Social workers differ from clinical sociologists in that they stick primarily to the psychological tradition, usually defer their own critical judgment to that of the agency or client, and tend to be unable to vary the methods in which they are trained in order to meet the needs of the person, group, or situation (p. 15). It perhaps is treason for a social work academician to even suggest such notions. However, if one considers the four potential barriers described earlier in this paper (poverty, attitudes, politics, and religion), it is at least questionable if social work does a better job in educating students in becoming potential case managers than sociology.

False Dichotomies?

The three dichotomies discussed above may be false representations. Clearly, the questions asked do not have to result in "either-or" answers. The point is that historical and current perceptions of case managers in rural areas may be limiting in practice. First, case managers can also be community practitioners. Second, case managers could also be referred to as "coaches," or at least be considered as yet another role and/or function. Third, case managers do not necessarily have to be trained in social work, and often are not. The suggestion here is that the profession of social work may benefit from broadening its perceived turf, and be more accepting and open to other disciplines having merit. It perhaps is obvious that case managers who practice in rural areas differ from their urban counterparts. Services may be few, travel distance for services may be great, and roles may be more eclectic. Whether one practices in the Upper Peninsula of Michigan or the Panhandle of Texas, rural barriers need to be overcome, regardless of method, discipline, or philosophy.

Conclusion

Though this paper focused on the Panhandle of Texas with a secondary reference to the Upper Peninsula of Michigan, the concepts provided is applicable to any rural region. Deinstitutionalization and the "least restrictive environment" are terms that have meaning throughout this country. "Normalization" too is a frequently used notion that guides social workers, case managers, and other human service professionals in their respective interventions. If in fact case management is here to stay, so is the permanency of rural practice. The plight of certain metropolitan areas and inner cities has received great attention in human service literature over the years. It is now time to focus on so-called nonmetropolitan areas in order for successes, challenges, and questions to illuminate the uniqueness of rural practice in America.

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