THE VOLUNTEER CASE AIDE PROGRAM: AN ADVENTURE IN COMMUNITY OUTREACH

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In the past year, the Boston State Hospital Volunteer Case Aide Program has become increasingly involved in a new departure from that of its traditional hospital based services. Since its inception in 1963, "the Volunteer Case Aide Program has offered community citizens an opportunity to develop a one-to-one relationship with a mentally ill and/or emotionally disturbed patient who has been referred by the Hospital or one of its Mental Health Centers. The volunteer is asked to give four hours per week, for one year (an academic year for students). He visits with his assigned patient and participates in a group meeting with other volunteers under the direction of an experienced, trained supervisor" (Goldberg 1975). Administration and supervision of the overall program are the responsibilities of trained and experienced psychiatric social workers.

The program has developed and implemented a community outreach plan in the hospital's catchment areas. It utilizes the services and resources of several different groups of people as suppliers of volunteers to consumers of volunteer services. The following describes the background, philosophy and implications of three community based groups:

Group A: The Jewish Family & Children's Service (J.F.C.S.) Agency Program (Boston)

In July, 1973, the Director of the Case Aide Program received a telephone call from a former Case Aide Volunteer, who, since graduating from the Simmons College School of Social Work, had found employment at a large family-service agency. In discussion with her casework supervisor, the subject of her prior volunteer experience with Case Aide came up. The program aroused the curiosity of the supervisor to the point of suggesting that we three meet to discuss in greater detail the philosophy and structure of the Boston State Hospital Volunteer Case Aide Program.

As a result of our meeting, the supervisor discussed with the women's committee of the Jewish Family & Children's Service the possibility of developing a Case Aide Program within the Agency. The plan which eventuated was the following:

1. Volunteers from the Women's Committee would be asked to join in a pioneer program.
2. Clients served would be those in the J.F.C.S. caseload from the Walk-Hill District Office.
3. Supervision of the Volunteers would be given by a member of the Associate Leader Staff of the Boston State Hospital Volunteer Case Aide Program.

As a result, a flyer was sent out by the President of the Women's Committee to the board members of that organization. A meeting was held with the board members, the Supervisor of the agency, an Associate Leader of the Case Aide Program and the Case Aide Director. Three women (2 from the Board and 1 non-board member) initially decided to join in our effort to introduce the Case Aide Model into the community. Since its inception in October, several other volunteers have been added to the group.

Selection of clients has come primarily from the caseload of the Walk-Hill Branch of the Agency. The rationale in choosing cases primarily from this particular district was to offer case aide volunteer services to those JFCS clients residing in the Boston State Hospital catchment area, thereby justifying the Associate Leader's supervisory time spent away from the hospital. Referrals have come from other districts, as well, however, since the caseload of the Walk Hill Branch Office has shifted with the population shift of the area. Many predominately Jewish Agencies have moved their bases of operations in order to be closer to the population they

serve. We,therefore, have included clients from other communities that the Jewish Family & Children's Service Agency serve.

While in the negotiation period, we assumed that we would be offering services to clients primarily in the area of "secondary prevention" (cf. Caplan 1964, Chaps. 4 and 5). The supervisory and administrative staffs of both agencies discussed some of the clientele which came to the J.F.C.S. for services. It soon became apparent that we were really dealing with some acute situations where active planning and treatment would be required.

One situation included a middle aged Jewish lady who had a congenital leg problem. As a child she was pampered by guilt ridden parents with the expectation the she would be cared for by the family throughout her life. The original reason for referral (made by the client's married sister) to the agency was a need for housekeeping services for the client and her aged father, after the mother's death. It soon became apparent to the caseworker, however, that the family has considerable work to do to deal with the emotional problems of grief and loss of their mother who was the pivotal person in the family, as well as working through the anger felt towards the "useless" 53 year old sister.

After a long term relationship with the caseworker, it was felt that the client would greatly benefit from the relationship that a case aide volunteer could offer. This woman needed another adult woman, outside of the family trauma, who could befriend her and offer her support. As a result, perhaps the client could begin to learn and hopefully enjoy making herself useful around the house, making simple meals, swapping recipes, shopping for clothes, etc.

While the agency caseworker still maintains contact with the client's father and sister, the introduction of a case aide volunteer into the situation has been of considerable help to the client and has taken some of the "sting" out of the existing situation within the family constellation.

As already alluded to, supervision of this group of volunteers has been given weekly by a skilled Associate Leader of the Boston State Hospital Volunteer Case Aide Program. The supervisor herself, initially a volunteer in the hospital-based program for several years, went on into the Associate Leader Supervisory Training Program and ran a group of novice Case Aide Volunteers for two years (cf. Goldberg et al, 1973). After this experience, the leader continued to develop her skills in the out-patient department of the hospital as a member of a screening and evaluation team. She was an excellent choice to supervise the new community based program, utilizing the model upon which the hospital program is built (i.e., weekly group supervision with the requirement that each volunteer make a year's commitment to the program and submit an individual weekly written report of her activity with the assigned client). The supervisor is also responsible for individual supervision when advisable. In this specific instance,the Associate Leader supervisor discusses the relationship between the volunteer and the specific agency caseworker and is administratively responsible to the J.F.C.S. supervisor-coordinator of the program as well as to the Director of the Case Aide Program.

What are the implications of this new program? The responses from the agency and the Boston State Hospital Volunteer Case Aide Program have been enthusiastic and encouraging. There appears to be more interchange and less mistrust among the casework staff of Jewish Family & Children's Service Agency and Case Aide Program. The J.F.C.S. volunteers are most enthusiastic about the greater degree of responsibility and sharing amongst themselves, the agency caseworkers and supervisors. The supervision given is excellent and well received. The agency sees that volunteers can be very effective partners of the professional casework staff.

The traditional case aide model developed at the Boston State Hospital in 1963 has been integrated well into the structure of a family agency in 1973. The model, which provides for group supervision, offers the volunteer the opportunity of becoming familiar and knowledgeable with a variety of client-volunteer relationships. Group supervision, in turn, enables the volunteer to command a greater knowledge and expertise in handling a variety of human needs.

Furthermore, the volunteers of the J.F.C.S. have been able to develop a unique working relationship with members of the agency's case work staff, who are the referring agents of clientele served by the volunteer. As a result of her own intervention, the volunteer is learning something about the clarification of her role and the role of the social caseworker. What is becoming clearer is that the volunteer offers herself as a role model, an expeditor, an ombudsman, a support and an enabler, in behalf of her client.

Group B: St. Theresa's Church (West Roxbury)
The inception and development of a church-sponsored Community Case Aide Program came about in a different way from the Jewish Family & Children's Service Agency, previously reported. A considerable part of the Assistant Catholic Chaplain's responsibility at the hospital has been to develop community based case aide programs, recruiting volunteers and, once again, utilizing the case aide model as a means of providing a structure to the program. His training as a Jesuit Priest and experience, both as a teacher and as a supervisor in the Clinical Pastoral Education

Program at Boston State Hospital and at the Case Aide Program, enabled him to relate to both clergy and laity in a very positive and dynamic manner. As the catchment area is a heavily Catholic one, it was quite appropriate to try to interest the clergy and their parishioners in our community efforts.

We explained our program to a number of priests and ministers in the area. Several expressed varying degrees of interest in our proposal of engaging their parishioners as volunteers. One priest, whom we approached, is currently supervising a deacon assigned to his parish for the academic year. As a part of his commitment to his deacon, he is currently matriculating in the St. John's deacon supervisory training program, which the Chaplain and Case Aide Director supervise. The parish priest offered to discuss the program with a group of parishioners and nuns. As a result of his interest and the enthusiasm of his parishioners (some of whom, as it turned out, already were involved in other community-based mental health programs), a group of 15 women, including housewives, secretaries, lay-teachers, nuns, etc., met in January, 1974, with the parish priest, the assistant chaplain and the social worker, Director of Case Aide Program. The chaplain brought to their attention the issue of Christian commitment to their neighbor in need. The social worker discussed the success of a 10 year old hospital-based program, utilizing volunteers in individual relationships with the mentally ill. Together, the team articulated the needs of the socially and/or emotionally disenfranchised members of the community who need the concerned, supportive relationship that volunteers could offer.

At that initial meeting, four women offered to engage in the new parish-based community out-reach Case Aide Program. Several others expressed a desire to participate in the weekly supervisory meetings without a specially assigned client. While these interested people had other commitments to families, jobs or school, they offered to do public relations for the program. Since that January meeting, several new men and women have been recruited into the program by these very able public relations people. We also spoke to a group of 250 women in the parish Sodality, in March. This promotional effort gained four or five more volunteers for our ranks. As of this writing, we now have 12 men and women engaged in the group. There is a good possibility that another case aide group will be formed in this parish.

Referrals of clients to the church group have come from several sources. The primary referral agent has been the West-Ros Park Out-Patient Clinic, which has referred a number of "clinic patients" to the Case Aide Program.

One such referral is a 47 year old woman, whose husband is an alcoholic. The couple has three teen-aged children who are experiencing varying degrees of difficulty in school or jobs. The woman was seen for several months and treated for her depression with psychotherapy and medication. Referral to case aide was made as the clinic staff felt that a long-term relationship would be most supportive and beneficial to this isolated and lonely woman. The volunteer could relate to the woman as a friend. They could "compare notes" on a variety of topics such as child rearing and shopping; in other words, the volunteer could relate herself through the mutual roles of wife and mother as well as being a friend to the client.

Another referral is that of a 26 year old young man who is a single child. As a youngster the boy was very withdrawn, had no friends, and his parents over-indulged his every whim, this being their only child. As the child became more isolated and autistic, he was shuttled from one psychiatric clinic to another, finally being placed under the care of the Adolescent Service of the Boston State Hospital for many months. While he was very intelligent, having passed the high school equivalency program with flying colors, his hostility and belligerence towards his parents and peers kept potentially meaningful relationships at a distance. While he was in the hospital, the Adolescent Service, and upon his discharge, the West-Ros Park Clinic as well as the young man's father, all made direct appeals to the Case Aide Program for volunteer intervention. For two years, no volunteer assignment could be made as no man was available to see the patient at his home at the times he had free from work; no one, that is, until a vigorous 70 year old man in the church group volunteered. While he has only met with "his young friend" two or three times, the rapport that has been established is truly unbelievable. Each takes turns in going to the other's home. Common interests in the relationship include swapping stories of baseball and sports personalities. The volunteer has lent "his friend" a copy of The Jimmy Piersall Story with the idea that Piersall's biography offers a great deal of hope to those beleaguered by mental illness. Thus far the relationship has been most exciting and gratifying to the patient, his volunteer, his peers in the group, and especially to the supervisors and parish priest.

In other instances, the priest who has acted as the coordinator of the Case Aide Program in his parish has suggested people whom he feels could profit from the intensive and extended individual relationship that the program offers. His awareness of some of his parishioners' needs has come out of his monthly communion calls to homes of the elderly or infirm who are unable to come to church. He has become increasingly aware of several isolated people in the parish who could benefit from the relationship that our volunteers offer.

While the group has only recently begun, there are some interesting implications which have captured our attention. In our initial discussions with the parishioners and in a question period that followed our presentation to the Ladies' Sodality, it became increasingly clear that there was tremendous anxiety on the part of the audience about "mental health." The parish community tended to view "mental health" issues in terms of mental illness. We tried to make it clear that we were asking people to join in a community effort and were not asking people to come into the hospital Case Aide Program. There were several people who were traumatized by the prospect of having to relate to a "crazy person - running around loose."

One question asked was to describe the client referrals in terms of their psychiatric diagnoses. In this instance, it seemed appropriate to respond with discussion of life crises, the traumas of normal life such as birth, child-rearing, marriage, death of a loved one, as customary problems that we all, in one way or another, experience during our life time. Additionally, we suggested that often an extended hand and listening ear can make an enormous difference to people in times of stress....that many serious emotional illnesses might be prevented if someone cares. The issue of isolation and loneliness as destructive forces in our fragmented society was stressed. The significant issue in this instance was to alleviate the audience's anxiety about mental illness by focusing on life situations rather than diagnostic categories.

Another significant by-product of this particular community based program has been the general curiosity and interest aroused in other community mental health programs. Several groups in the West-Ros Park Catchment Area have asked for meetings to discuss the focus and rationale for our "out-reach" programs. In one instance we have been approached by a representative of a Housing Project for the Elderly, to come and speak to some of their "club members" with the aim of recruiting a group of senior citizens as volunteers to relate to their socially isolated peers.

Group C: St. Patrick's Church Program (Roxbury)

A third group with which the Program has most recently become involved is located at St. Patrick's Church in Roxbury. The Church serves a tri-cultural neighborhood of the inner-city, its population made up of blacks, Spanish speaking Portuguese, and whites. It is one of the most economically and socially deprived neighborhoods in the city. We were told by the priest that the highest incidence of fires is in this area, and by way of a further half-hearted joke, he indicated that the neighborhood was so bad that the police had moved out of the station across the street several months ago. The neighborhood is a very transient one; for many families it is their first place of residence upon arrival to this country. As soon as they become economically able, they move.

As a result of the chaplain and social worker supervising priests at St. John's Seminary in Brighton, the priest from St. Patrick's inquired as to our availability and interest in supervising a group at his church. We learned that 18 nuns connected with the parish school and 3 parish priests had undertaken an effort in "making themselves known to their parishioners." After a recent parish census, the clergy decided to divide the census up into streets and each assigned him/herself the task of developing an on-going relationship with 8 to 10 families.

In this particular instance, recruiting volunteers and selecting "cases" was already accomplished. The group of religious professionals were "set to go" -- each of them having a clientele already assigned. The chaplain and social worker were asked to supervise the group in terms of thinking about issues of relationship building, establishing a climate for trust, appropriate goals in the relationship, etc. The most immediate concern of the group has been developing ways of "getting in the front door."

As of this writing, we have met with the whole group twice. We are planning to meet for 1 1/2 hours once every three weeks, rather than the weekly supervisory model already described for other groups. We see our role more as supervisors-consultants, that is, meeting less frequently with this group, and, as a result, having less responsibility in working through individual relationships. More importantly perhaps, we will be dealing in the area of "primary prevention." It will be most interesting to see how this new exciting departure for the Case Aide Program develops.

Summary

In the past year, the Boston State Hospital Volunteer Case Aide Program has become increasingly involved in a new departure from that of its traditional hospital-based services. The program has developed and implemented a community outreach plan in the hospital's catchment areas. It utilizes the services and resources of several different groups of people as suppliers of volunteers to consumers of volunteer services.

Three different groups have been formed:

1. The Jewish Family and Children's Service, which utilizes volunteers from the agency's Women's Committee and is referred cases by the agency's social service staff.

2. The St. Theresa's Church Community Case Aide Program, which recruits volunteers from the parish and is referred cases from both the catchment area out-patient clinic and the parish priest.
3. The St. Patrick's Program which utilizes nuns in the parish school and priests in the parish in an effort to make themselves known and available to the parishioners they serve.

We have found that the Volunteer Case Aide model developed at the Boston State Hospital in 1963 has been replicated, transplanted and integrated into various community settings today. The model which provides for group supervision offers the volunteer the opportunity of becoming familiar and knowledgeable with a variety of client-volunteer relationships. Group supervision, in turn, enables the volunteer to command a greater knowledge and expertise in handling a variety of human needs.

Further, we have found that interpretation to the community of mental health needs should focus on life situations rather than diagnostic categories. The focus on health rather than pathology alleviates a great deal of anxiety on the part of the public.

Our model of supervision has been expanded to include consultation to an already formed group, with a new emphasis on primary prevention.

Interest has been aroused in other community programs resulting in invitations to speak to potentially interested groups. The small ripple made in three settings has begun to make waves in the larger community!

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