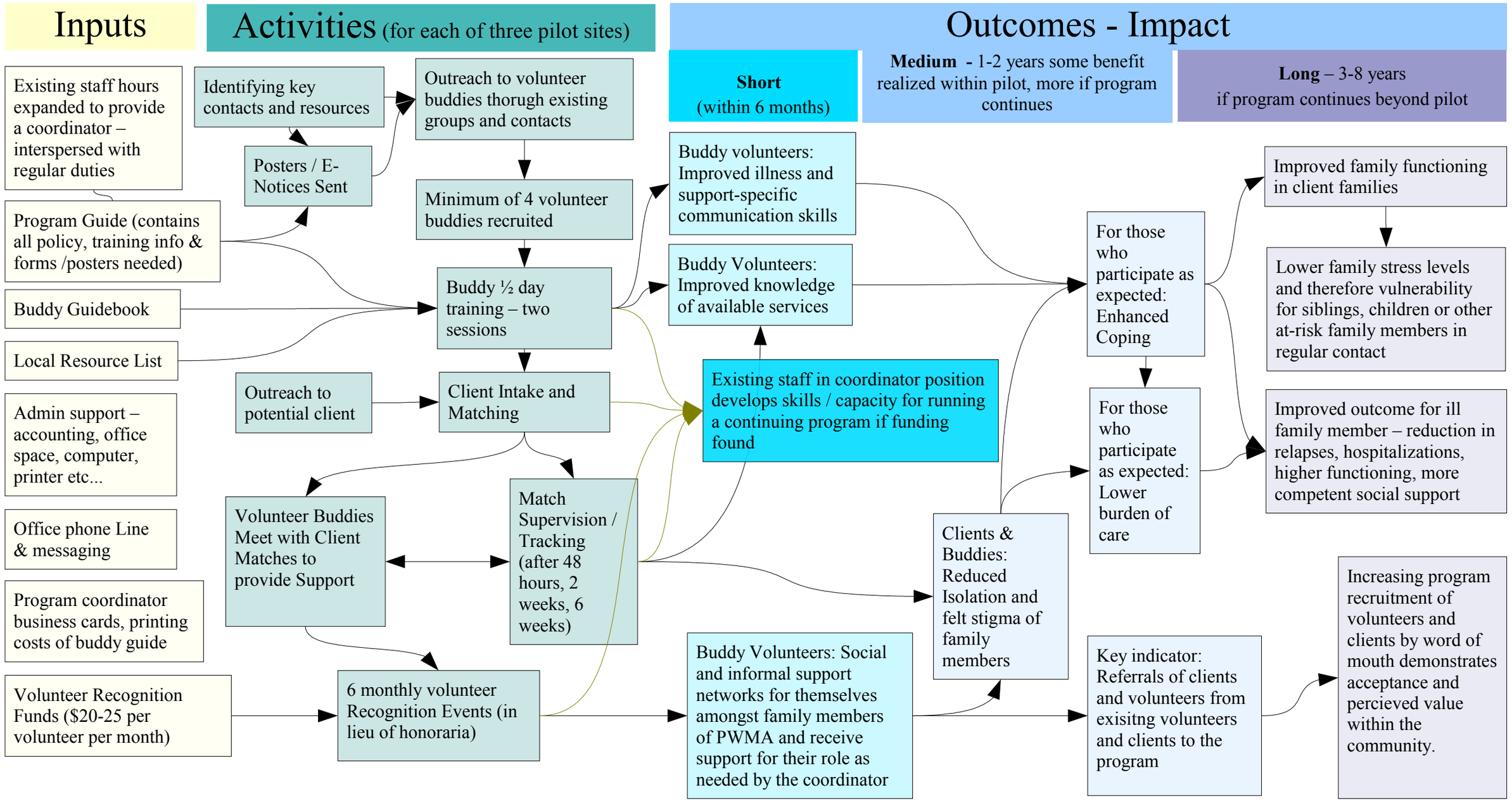
Program Action-Logic Model – Family Peer Support Buddy Program



Situation, Priorities and Assumptions

Situation

Families of person's with serious and persistent mental illness are affected by stigma, isolation, caregiving burden and stress. They may be isolated from others who have had similar experiences. Some, particularly men, are uncomfortable sharing their feelings or situations in a group format, or may not have access to a suitable support group. Families often provide a large proportion of regular, crisis and after-hours care to persons with mental illness, and provide a quality and breadth of care that is difficult or expensive to duplicate with paid providers. Their sense of burden and stress is a factor in their rates of burnout and has been shown to affect readmission rates and other outcomes of their ill family member.

Priorities

Reducing isolation and stress, providing positive peer role members, improving knowledge about available local services.

Assumptions

1) Coordinator is existing staff person and is expected to be present within the organization after the pilot term. This means that any capacity gained stays with the organization and that the person is already connected with existing resources and volunteers.
2) Pilot programs will attempt to retain the program in some form after the pilot term.
3) Framing the program as a 'buddy' program will avoid the expectation of professional support in the minds of clients and referal sources, and avoid the expectation on the part of volunteers that they are performing a paraprofessional counselling service. The intent is to foster peer community linkages.
4) Coordinators must have existing relationships and contacts with local services in contact with families, and with existing family support groups to use to recruit volunteers and get the word out. Without such existing contacts, recruitment of volunteers and outreach to potential client 'matches' will be much slower.
5) Ill family member outcomes assume that the family members involved as volunteers or client matches have regular contact with their ill family member and are in a position to influence that person's daily life and support systems.
6) Buddy volunteers stick with the program for 6 months at least, with at least one match assigned for the duration of their involvement and attend the monthly volunteer recognition meetings.
7) Client matches receive at least 6 sessions with their buddy and do not have unmet crisis needs during the time of involvement with the program.
8) Sufficient buddy volunteers are located (a group of 8-12 is optimum, 4 is a minimum) and retained in the program.
9) It is expected that the program will be slow to recruit volunteers and buddy matches, due to family members' reduced amount of contact with care providers or other sources of referrals. It is expected that at least two years of continuous program service would be required to reach optimal capacity in terms of volunteers and awareness and impact with the client population (families of persons with mental illness).
10) Initially recruited buddy volunteers will be existing volunteers known to the coordinator and have a high enough commitment to the organization to stick out the initial pilot period. If they are pleased with their involvement with the program, they will be an important source of word-of-mouth referrals of clients and volunteers as they are already connected to the existing family member services and networks.
11) Coordinator already familiar with and ideally has a relationship with key contacts and resources: ie: sympathetic or influential service providers, community notice boards, community newspaper listings, influential volunteers and support group members.
12) People learn well by teaching others, and the capacity of the volunteers will be improved by the training, coaching from the coordinator and exposure to other peer helpers, in addition to reducing their own felt sense of stigma by being in contact with high functioning others in the same situation.

Measurable Outcomes and Brief Case for Continued Funding

Measurable Indicators of Success

Program success during Pilot

•More buddy volunteers at end of pilot period than beginning.
•Steady increase in referrals to program over pilot period.
•Buddy /Client matches endure on average more than 3 sessions / contacts.
•Volunteer appreciation dinners well-attended by over 75% of volunteers.
•Ex-clients become buddies or volunteer with the organization in another capacity.
•Post-pre testing at close of pilot period reflects participants and volunteers sense of improved knowledge, connection and coping.
•Post-pre testing of clients reflects increase in felt sense of coping and reduction in sense of burden.

Testing of Program Materials

•Program coordinator expressed satisfaction with the guide and program, after using it correctly throughout the pilot period.
•Participant feedback generally positive about program structure issues.

Case for Continued Funding

The bulk of longer term goals are not realizable unless the term of the program is extended to 3-5 years. Resources built within the pilot program in the form of networks, volunteer relationships and capacity within existing staff will drift unless continuously maintained and fostered. A sustained improvement in family functioning is needed to improve ill family member's situation, which is best fostered by continuing support. In short, community takes time to build, and a resource takes time to build trust with stigma-affected populations so that they may become connected and affected by the benefits.

The pilot is intended to test the program guide and materials and determine whether the program as constituted can be sucessful. If so, to realize program goals, the existing pilot sites, or additional sites would need to obtain operating funding to begin or continue with the program.