ABSTRACT

SUPPORT GROUP FOR LATINO INDIVIDUALS DIAGNOSED WITH SCHIZOPHRENIA AND THEIR LOVES ONES: A GRANT PROPOSAL

By

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The purpose of this grant writing project was to fund a two-fold support group: one for chronically ill individuals diagnosed with schizophrenia, in conjunction with one for family members providing emotional and social support outside the home. The proposed project seeks to reduce conflict and stress by providing consumers and their family members with education about schizophrenia, medications, and interventions to help them better understand and cope with the diagnosis. This program also seeks to increase awareness of the therapeutic value family support plays in fostering hope and empowerment to promote collaboration in the recovery journey.

The targeted area is Los Angeles County, specifically communities surrounding Long Beach, California which are eligible for services at The Village. The California Wellness Foundation was selected as the ideal funding source for this grant project. The actual submission of this grant was not a requirement for the successful completion of the thesis project.

SUPPORT GROUP FOR LATINO INDIVIDUALS DIAGNOSED WITH SCHIZOPHRENIA AND THEIR LOVES ONES: A GRANT PROPOSAL

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INTRODUCTION

Problem Statement

Schizophrenia can present serious health and social problems. The National Institute of Mental Health (NIMH) estimated that about 1% of United States residents have this illness (2009). According to Van Os and Kapur (2009), individuals diagnosed with schizophrenia, die on average, 12-15 years before the general population. Increased mortality rates are largely due to cardiovascular disease and suicide. In addition, Kopelowicz, Zarate, Gonzales Smith, Mintz, and Liberman (2003) suggested that the lives of people with schizophrenia are often affected by relapses, hospitalizations, poor social adjustment, and an unsatisfactory quality of life. Furthermore, the stress associated with mental illness has been linked to family caregivers' distress and burden (Marquez & Ramirez Garcia, 2013).

There are roughly 52 million Latinos living in the United States or 16.7% of the total population. They are thus the largest and fasted growing ethnic group in the country (Ennis, Rios-Vargas, & Albert, 2011). Latinos have been found to use mental health services at a lower rate compared to other ethnic groups (Alegria et al., 2002; Hackenthal et al., 2013; Vega et al., 2007) addressed the need to improve access to treatment and care for Latinos and other minority groups and reviewed barriers related to language, stigma, lack of education, uninsured status, and misinterpretation of the diagnosis and symptoms.

Marquez and Ramirez Garcia (2013) proposed that the family caregiver relationship is a strong indicator of the course of mental illness. It was suggested that Latino family members' high levels of involvement contributed to their relatives' use of mental health services.

Statement of Purpose

The purpose of this thesis project was to write a grant to implement a therapeutic support group for family members of chronically ill adults diagnosed with schizophrenia living in a board and care facility. These family members are an underserved group since most caregiver programs target those who are responsible for providing social, economic, and emotional care in the home. The goal of the support group would be to increase awareness of the importance of family support in recovery. In addition, the support group would provide family members an opportunity to express and process feelings associated with caregiver burden and to acquire the tools needed to improve their coping skills. The support group would take place within a 12-week period and be co-facilitated by two Master's of Social Work (MSW) staff members.

Furthermore, the diagnosed individuals would participate in their own support group composed of psychoeducation, peer support, and social skills training with the goal of promoting a collaborative recovery effort. In addition, the case managers of the host agency would provide enhanced case management to the individuals with schizophrenia. The case managers would visit the licensed facility biweekly to assess the clients' biopsychosocial needs and provide them with resources to meet those needs.

Definitions of Terms

Familismo: The centrality of the immediate and extended family in traditional Latino culture and to the priority of family goals over personal goals (Hackethal et al., 2013).

Family burden: The problems and strains having a mentally ill family member imposes on the family (Guarnaccia, Parra, Deschamps, Milstein, & Argiles, 1992).

Hispanic or Latino: Term used by the U.S. Census Bureau to categorize individuals who self-identify as having origins in Mexico, Puerto Rico, Cuba, Central and South America, or other Spanish cultures (Humes, Jones, & Ramirez, 2011).

Negative symptoms: Characterized by deficits in cognitive, affective, and social functions, including blunting of affect and passive withdrawal (Kay, Fiszbein, & Opler, 1987).

Positive symptoms: Characterized by delusions, hallucinations, and disorganized thinking which are superimposed on the mental status (Kay et al., 1987).

Schizophrenia: A psychotic disorder "characterized by dysregulation of thought processes" (Centers for Disease Control and Prevention [CDC], 2011, para. 1). Individuals may experience symptoms of delusions, which are false beliefs, or hallucinations involving hearing and/or seeing sensory information not actually present and not apparent to others (CDC, 2011)

Multicultural Relevance

Since Latinos comprise the largest minority group in the United States and are expected to increase in numbers in the future, more interventions should be aimed toward meeting their needs. Barrio and Yamada (2010) reported that family involvement with individuals with schizophrenia has consistently shown positive outcomes (e.g., reducing relapse rates, facilitating recovery in clients, improving family well-being, alleviating family burden, and increasing the quality of family relationships); however, the models utilized are typically based on "Western" assumptions. Many Latinos come from traditional cultures that understand mental illness from religious, spiritual, and supernatural perspectives. Thus, the social workers and others providing services should be culturally sensitive to the traditional Latino community.

Social Work Relevance

The social work profession promotes social change through community involvement by enhancing the well-being of the individual (National Association of Social Workers [NASW], 2014). Social work is based on an interrelated system of values, theories, and practices incorporating society and the individual. It emphasizes respect for the equality of people and focuses on meeting human needs and developing human potential.

Social workers have been educated about schizophrenia and therapeutic interventions to improve the quality of life of mentally ill individuals and their family members. Caregiving-related issues that may arise can create individual, family, and interpersonal relationship problems. Social workers have a role in educating family members, as well as the larger society, about mental illness in order to reduce stigma and improve the lives of those affected.

CHAPTER 2

LITERATURE REVIEW

The President's New Freedom Commission Report on Mental Health and an expert consensus panel convened by the NIMH was significant in calling for cultural competence in mental health care (Hackenthal et al., 2013). The report provided specific recommendations for the provision of empirically supported treatments to minorities. In recent years, the deinstitutionalization of the mentally ill has made way for community care in an effort to increase quality of life by integrating individuals back into society (Tan et al., 2012). This chapter examines the role values, beliefs, and culture can play in the utilization of mental health services in the community. Furthermore, it provides an overview of the burden often experienced by the family members involved in mental health treatment, as well as the concerns of those diagnosed with a mental illness.

Latinos in the United States

Latinos are the largest and fastest growing ethnic group in the United States (CDC, 2014). Among the Latino subgroups, Mexicans ranked as the largest (63%), followed by Puerto Ricans (6.2%) and Cubans (3.5%). California has the largest Latino population consisting of 14.4 million. Los Angeles County has a Latino population of 4.7 million, with a large concentration in East Los Angeles (CDC, 2014). With a majority of Latinos in Los Angeles County, it is apparent mental health services need to be specific and culturally appropriate.

Despite their bonds through the Spanish language and cultural influence, Latinos are heterogeneous in terms of their migration experience and acculturation (Office of the Surgeon General, Center for Mental Health Services, National Institute of Mental Health [OSG, CMHS, NIMH], 2001). More than 40% of Latinos are foreign born and 75% are immigrants or children of immigrants (Vega et al., 2007). Consequently, the Latino population has relatively low levels of educational attainment and income and high rates of poverty and uninsured status, all of which are linked to (a) reduced access to mental health services, (b) cultural and linguistic incompatibilities, (c) inaccurate diagnoses, (d) non-adherence to treatment and retention, and (e) dissatisfaction with treatment (Vega et al., 2007).

Latinos are identified as a high-risk group for depression, anxiety, and substance abuse (National Alliance on Mental Illness [NAMI], 2014). The National Alliance for Hispanic Health (NAHH; 2001) connected the prevalence of psychopathology to the stressors associated with social adjustment to the dominant culture. These stressors include acculturative stress, which is most common in immigrants faced with the turmoil of leaving their homeland and adapting to a new society, socioeconomic stress, which is experienced by ethnic minorities who feel disempowered because of inadequate financial resources and low social class, and minority stress, which refers to the tensions that minorities often encounter due to racism (NAHH, 2001).

The NAHH (2001) highlighted early findings showing that Mexican born United States residents had less mental illness than Mexican Americans born in this country. Furthermore, Vega and Lopez (2001) identified three studies (the Epidemiologic Catchment Area Study, the National Comorbidity Study, and the Fresno Study), all of which suggested that Mexican born Latinos have better mental health than United States born Latinos. These findings suggest that acculturation may lead to increased risk of mental disorders (OSG, CMHS, NIMH, 2001). In most research, place of birth and number of years of living in the United States have been used as proxy measures for acculturation (OSG, CMHS, NIMH, 2001).

Latinos and Mental Health Access and Utilization

Differences in usage and access to mental health services among Latinos have been well-documented (Alegria et al., 2002; Folsom et al., 2007). Compared to the general population, Latinos are less likely to enter the mental health system, more likely to use these services for a shorter period of time, less likely to report satisfaction, and less likely to receive high quality mental health care (Hackenthal et al., 2013).

In an evaluation of normative cultural values that exist within a patient-physician relationship, it was implied Latinos value *simpatía* (kindness), *personalismo* (formal friendliness), *respeto* (respect), *familismo* (familism), *and fatalismo* (fatalism; Flores, 2000). This suggests that Latinos feel most comfortable with health care providers who have good interpersonal skills, are friendly, and emphasize understanding of their cultural beliefs and practices.

In a more recent effort to understand the preferential relational styles in encounters with mental health providers, Mulvaney-Day, Earl, Diaz-Linhart, and Alegria (2011) conducted a study comparing Latinos, African Americans, and non-Latino Whites. Four themes described what patients want from their encounters with mental health providers: listening, understanding, spending time, and managing differences. The authors found that Latinos in particular wanted the provider to spend enough time with them to reach a deep level of connection. The Latino participants also stressed the importance of nonverbal messages in the process of listening. For all groups, listening was tied to understanding; however, for Latinos, to understand was to “go more in depth” (*profundizar*) by going beyond the words being used or the facts of the situation to touch deeply on the patient's feelings (Mulvaney-Day et al., 2011). In terms of social differences, Latinos welcomed a direct and authoritative approach by providers. However, providers were expected to listen first and only then provide direct advice, feedback, and solutions.

In exploring factors that could explain differences in the use of mental health services, Alegria et al. (2002) found language fluency, cultural differences, access to Medicaid in Latino neighborhoods, differences in the recognition of mental illness, and lower quality of mental health care to be significant factors. Often, collectivistic values and contextual circumstances, such as socioeconomic status, home and community environment, spirituality, opportunities for development, and systematic forms of discrimination, are ignored or minimized by providers (Griner & Smith, 2006). Furthermore, it has been documented that when providers speak a language different from that of their clients, there may be difficulty in establishing rapport in the relationship, in addition to the difficulty experienced by non-English speaking clients in completing paperwork and locating mental health services in the first place (Rastogi, Massey-Hastings, & Wieling, 2012).

Notably, given their economic hardships (e.g., disproportionate high poverty rates) 1 in 3 Latinos in the United States are uninsured (Andres-Hyman, Ortiz, Anez, Paris, & Davidson, 2006). In a needs assessment by Vega and Lopez (2001), it was found that the low rate of health insurance coverage, compounded by low socioeconomic status and a high rate of immigration, could explain the patterns in mental health care utilization by Latinos. Due to their financial circumstances, Latinos are less likely to utilize private providers for mental health care, resulting in the use of public health clinics and emergency rooms, which can be problematic in terms of diagnosis and treatment (Vega & Lopez, 2001).

In California, anti-immigrant attitudes, behaviors, and policies have instilled a sense of fear and apprehension, further contributing to the disparities in utilization of the health care system (OSG, CMHS, NIMH, 2001). Latinos with severe and persistent mental illness have been shown to have less access to services, to wait until psychotic symptoms worsen before seeking treatment, and to use inpatient services disproportionately (Lopez, Barrio, Kopelowicz, & Vega, 2012).

Latinos' Perceptions of Mental Illness

In an early work, Maduro (1983) noted that many Latinos bring with them preconceived notions and expectations about what comprises illness and what kinds of treatment procedures are compatible with their lifestyles, factors which are often overlooked in providing mental health services. The notion of *curanderismo,* a folk healing system for physiological, psychological, and social maladjustments is one such belief. According to Maduro, *curanderismo* is based on eight major premises:

> (1) strong emotional states (such as rage, fear, envy or mourning of painful loss) or (2) being out of balance or harmony with one's environment; (3) a patient is often the innocent victim of malevolent forces; (4) the soul may become separated from the body (loss of soul); (5) cure requires the participation of the entire

> family; (6) the natural world is not always distinguishable from the supernatural; (7) sickness often serves the social function, through increased attention and rallying of the family around a patient, of reestablishing a sense of belonging (resocialization) and (8) Latinos respond better to an open interaction with their healer. These nuclear ideas or attitudes about health, illness and care are culturally patterned and are both conscious and unconscious (implicit). Moreover, expectations of the nature of the patient-healer relationship have implications for medical practice in general and psychotherapy in particular. (p. 868)

Using a *curandero* as part of the treatment plan means accepting the illness and reestablishing ties within the community.

From a *curandero's* perspective, health and illness is an interactive process between three dimensions: spiritual/religious, affective-emotional, and somatic (Zacharias, 2006). This multidimensional process is conceptualized by *espiritu* (spirit), *alma* (soul), and *cuerpo* (body). *Curanderos* view the *espiritu* as a guardian of mental and somatic health; therefore, when it is unable to fulfill its protective function because of absence or weakness, the lower level of the psychic regulation, the *alma,* is affected (Zacharias, 2006). The focus of treatment is to restore balance through material, spiritual, and psychic healing (Trotter, 2001).

To bridge the gap between academic research and real-life issues, Shatell, Hamilton, Starr, Jenkins, and Hinderliter (2008) conducted a community-based participatory action study to explore factors that affect Latinos' access, use, and perceptions of mental health services at the individual, organizational, and community levels. At the individual level, it was noted that Latinos tended to express symptoms of mental illness or distress somatically. Somatization, although common in many ethno-cultural groups,

> can have different meaning for different individuals as it can serve as a means to express a disease, an indicator of psychopathology, a system of intrapsychic conflict, a culturally coded expression of distress, or a means of expressing social discontent. (Shatell et al., 2008, p. 163)

Many traditional Latinos refer to schizophrenia as *nervios,* a symptom and syndrome indicating psychological distress, somatic discomfort, and problems in the social sphere (Weisman, Gomes, & Lopez, 2003). Schizophrenia is viewed on a continuum that ranges from (a) being nervous to suffering from nerves or enduring stress (b) to a state of psychological distress (c) to losing touch with reality with little hope of recovery. Therefore, *nervios* is beyond a person's control and sympathy is suitable since the individual is not to blame for their condition. The authors suggested that Latinos' way of conceptualizing the illness helps the family cope with the loss.

Lopez and Guarnaccia (2000) reviewed the literature on cultural psychopathology as it relates specifically to the social factors affecting schizophrenia. Schizophrenia can affect individuals and communities differently, depending on their perceptions of the self as autonomous and separate from others or as interconnected and dependent on others. The authors focused specifically on the emotional climate within families and the course of the illness. Their findings suggested that schizophrenia in developing countries has a more favorable course than in developed countries.

To further understand the association between expressed emotion and interdependence Weisman de Mamani, Kymalainen, Rosales, and Armesto (2006) conducted a study with Latino and White family members of patients with schizophrenia. Expressed emotion was measured in terms of the relative’s emotional involvement with the patient and his or her condition. The results implied that groups such as traditional Latinos hold more favorable attitudes and express fewer negative emotions toward their loved one with schizophrenia. Latinos endorsed more interdependent values than Whites, suggesting that greater emphasis is placed on the needs of others to maintain cohesion, despite differences in their personal beliefs and attitudes. Strong interdependent values within Latino families seem to serve as protective factors since they offer patients a meaningful role and place in the family structure.

Cultural Factors

Despite deprivation and inequality in their country of origin, immigrant Latinos have been found to report lower rates of anxiety and substance use disorders than non-immigrants (Alegria et al., 2008). In reviewing the National Latino and Asian American Study and the National Comorbidity Survey Replication, Alegria et al. (2008) found that Mexican Americans were more likely to use positive reframing, denial, and religion as coping mechanisms. The results were consistent with the traditional value of affiliation, as well as fatalism. Fatalism is the belief that individuals have minimal control over their environment, discrediting individual efforts (Kouyoumdjian, Zamboanga, & Hansen, 2003). Latinos who ascribe to the notion of fatalism believe that events occur due to luck, God’s will, or harmful wishes made by their enemies. Such values and beliefs can impact Latinos' willingness to seek help for their psychological needs.

Collectivism means that self-identity is based on viewing oneself as part of a community (Caplan, 2007). Within traditional Latino families, group activities and interdependence are valued. Studies conducted in collectivistic cultures demonstrate how a sense of duty toward a mentally ill family member can lead to active involvement in that person's mental health treatment (Snowden, 2007). Based on social identity theory, cultural, racial, and ethnic identity could benefit members of a society given its promotion of a group sense of belonging and attachment (Ai, Aisenberg, & Weiss, 2014). Therefore, Latinos who identify with their racial/ethnic group may cope better with discrimination, implying better overall health outcomes.

A core belief held by traditional Latinos is *familismo,* a source of emotional and instrumental support defined by feelings of loyalty, cohesion, strong connections, and the centrality of the family (Caplan, 2007). Family relationships are close and usually the first and main source of support (Kouyoumdjian et al., 2003). Latino family members provide strong support for each other at times of emotional and psychological difficulties, implying a reluctance to share their mental health challenges outside their family. For many Latinos, mental illness is a sign of weakness carrying with it considerable stigma. Therefore, seeking help outside the family structure may create a sense of guilt. Consequently, many Latinos engage in self-reliance rather than seeking treatment for mental illness (Alegria et al., 2002). According to Interian, Martinez, Guarnaccia, Vega, and Escobar (2007), stigma is interconnected with cultural values, both of which impact medication adherence.

Spirituality and religion have essential roles in recovery as they can instill a sense of hope, provide meaning for an individual’s disability, and add meaning to life in general (Corrigan, McCorkle, Schell, & Kidder, 2003). Among many spiritual or religious Latinos, problems and obstacles are treated as trials. The goal is to fulfill one's life mission by overcoming these trials (Comas-Diaz, 2006). Furthermore, Latino spirituality or religiosity has a celebratory and festive nature as it teaches that in spite of adversity, life is full of blessings. Due to the integral part religion plays in many Latinos' lives, they often seek help from religious organizations (Kouyoumdjian et al., 2003).

Recovery for Individuals Diagnosed with Schizophrenia

To come to terms with losses, an individual must go through a mourning process composed of feelings of grief and depression with the aim of finding new meaning. In an effort to understand the lived experience of grief among individuals with schizophrenia, Mauritz and Van Meijel (2009) directed a qualitative study based on grounded theory. Semi-structured interviews lasting up to an hour focused on internal loss, external loss, and grief for 10 patients receiving clinical treatment at a university hospital and in the rehabilitation phase. Mauritz and Van Meijel made reference to the theme of "not belonging," suggesting a form of detachment as the patient experiences a feeling of "being different." The results highlighted the importance of increased contact with family members and significant others, meaningful activities, and independent living to foster a sense of consolation and hope in the recovery process.

"Individuals' appraisals of their personal value is closely related to the kinds of groups to which they perceive themselves as belonging and the values they and others attach to belonging to these groups" (Lysaker, Tsai, Yanos, & Roe, 2008, p. 194). Individuals who identify with the group of persons with schizophrenia can feel empowered and validated as they recognize that they are not the only ones experiencing challenges in psychosocial functioning, thus facilitating recovery through increased awareness and treatment adherence. Simultaneously, self-identification may create problems in self-esteem, self-efficacy, and hope for the future due to the social connotations that accompany schizophrenia. Over the course of time, stigma can become internalized, thus impeding a person's ability to establish identities other than those based on the mental illness, furthermore hindering psychosocial functioning (Lysaker et al., 2008). Yanos, Lysaker, and Roe (2010) hypothesized that a high level of internalized stigma directly impacts hopefulness and self-esteem, which subsequently impacts coping, suicidality, vocational functioning, and social interaction. To test this hypothesis, Yanos et al. recruited 66 males and 12 females from a Veterans Affairs Medical Center or community mental health center currently receiving ongoing treatment and in a stable phase of their recovery. After completion of baseline assessments, participants were randomly assigned to receive either cognitive-behavioral therapy (CBT) or support services. The findings suggested that functional outcomes are influenced by the degree to which a person internalizes negative stereotypes; therefore, interventions need to focus on helping people develop a positive identity (Yanos et al., 2010).

Currently, the most effective form of rehabilitation for people with schizophrenia is symptomatic and provided through the use of antipsychotic medication (Patterson et al., 2005). Antipsychotic medications have significantly improved since their introduction in the mid-1950's, taking into consideration an individual's ability to function (Grohol, 2006). Clozapine, Risperidone, Olazapine, and Quetiapine are newer medications proven to be effective in treating symptoms related to schizophrenia (Grohol, 2006). Particularly challenging for individuals with schizophrenia is medication adherence due to lack of awareness (e.g., limited insight and incorrect beliefs about the nature of the illness), the direct impact of symptoms (e.g., depression, positive and negative symptoms, cognitive impairment, social isolation, comorbid substance abuse, and stigma), and the increasing disintegration of mental health services (Haddad, Brain, & Scott, 2014).

Research examining medication non-adherence have emphasized the use of interventions that utilize motivational interviewing techniques to promote adherence (Staring, Van der Gaag & Mulder, 2013). In an effort to understand the impact of the therapeutic relationship on medication adherence, McCabe et al. (2012) surveyed 134 clinicians and 507 of their patients. The findings suggested that a therapeutic relationship in which both parties' perspectives were viewed as important promoted medication adherence. Incorporating patients in the decision-making process and paying particular attention to beliefs, concerns, and preferences increase the likelihood of medication adherence (Haddad et al., 2014).

Since medication adherence is only one factor in rehabilitation, it is important to consider how to achieve goals related to quality of life. Psychotherapy can provide a space for individuals to explore their goals to increase life satisfaction (Mizock, Millner, & Russinova, 2012). Furthermore, psychotherapy allows individuals an opportunity to recount their stories about living with a mental illness and helps them develop a positive sense of self, better coping strategies, and preventative efforts in their recovery. CBT, in conjunction with other psychosocial interventions, can be instrumental in assisting people with schizophrenia to recognize the basic cognitive processes that underlie their thoughts in order to correct dysfunctional beliefs (Dickersen & Lehman, 2011). Specifically, CBT has shown to be effective in social skills training and coping strategy development (Mizock et al., 2012).

Feelings of Burden and Psychological Distress

Severe and persistent mental illness not only impacts the individual diagnosed, but also the family members providing support. In a survey of 85 Latino caregiver-client patient pairs, Magana, Ramirez Garcia, Hernandez, and Cortez (2007) examined the relationships between patient and caregiver characteristics and caregiver mental health, perceived burden, and stigma. The results indicated that lower levels of caregivers' education, younger caregivers' age, and higher levels of clients' mental illness symptoms were predictors of depressive symptoms among caregivers. Caregivers' perceived burden levels mediated the relationship between clients' mental illness symptoms and caregivers' depression. Lower burden levels protected caregivers from depression even in the face of high levels of clients' mental illness symptoms.

Previous studies of family members of patients with Schizophrenia have connected perceived burden with stigma and discrimination due in part to feelings of rejection by their social support networks (Koujalgi & Patil, 2013). Related to this social isolation are mixed feelings of anger, guilt, and hopelessness, which in turn can lead to denial as a defense mechanism, further adding to burden. When a young person is diagnosed, the parents often experience feelings of helplessness, anger, and anxiety (Foldemo, Gullberg, Ek & Bogren, 2005).

A shift in roles is often involved in the caregiving process, increasing the chances of personal distress and caregiver burden. Role distress is characterized by (a) an added role in addition to other family obligations and (b) conflicting expectations for each role

(Quah, 2014). Quah (2014) found that role distress is augmented by how the illness manifests itself, particularly when the patient has limited psychosocial functioning. This causes the caregiver to be concerned about the patient's ability to live independently after the caregiver is no longer available.

To understand the levels of burden and coping experienced by caregivers of persons with schizophrenia living in the community, Tan et al. (2012) studied 150 caregivers using a structured questionnaire. They found higher levels of burden for caregivers who had other commitments, lack of community resources, and scarce financial support. Often, caregivers felt trapped due to being unable to provide for their own basic needs while giving priority to their ill family member. According to Wai-Chi Chan (2011), the frequency of behavioral symptoms and lower perceived support from family members leads to higher levels of caregiver burden. Furthermore, Magliano et al., (2003) suggested that when relatives have a supportive network, they are more protected from stress and better able to manage a patient’s psychotic episodes. Thus, when caregivers have limited social resources, they develop more pessimistic attitudes, in turn negatively influencing the patient’s expectations about his or her own social opportunities.

In an effort to examine hope and family burden levels within Latino families, Hernandez, Barrio, and Yamada (2013) surveyed 54 clients diagnosed with schizophrenia and a family member of each client recruited from public mental health programs in Los Angeles. The researchers aimed to understand how protective factors operate in the caregiving experience of Latino families in an effort to identity sources of cultural resilience that can enhance treatment approaches for the patient and family from a strengths perspective. The findings suggested that having positive perceptions of their loved one's illness eases the burden associated with caregiving responsibilities. Furthermore, Latino families' high levels of hopefulness suggested their ability to see beyond the immediate stressful situation.

Few studies have focused on the grief associated with mental illness (Young, Bailey, & Rycroft, 2004). Grief in clients may be misdiagnosed because it is believed to be another symptom of the mental illness. In family members, grief may be misinterpreted as a personal deficit and even as what may have originally caused the mental health crisis for their loved one (Young et al., 2004). Of concern is the idea that unrecognized grief may hinder progress and recovery as it can result in self-blame, personal inadequacy, or powerlessness. For parents, the perceived loss of their child's former self and future potential may increase their sense of burden (Foldemo et al., 2005). Godress, Ozgul, Owen, and Foley-Evans (2003) examined the grief experience of parents of adult children with a mental illness and its relationship to parental health and well-being. The findings showed that parents who reported greater levels of grief (e.g., continuing emotional distress, preoccupation with the ill child, difficulties adjusting, intrusive thoughts and feelings, and attempts to avoid thoughts and feeling associated with the child's illness) also reported greater levels of emotional distress and lower levels of psychological well-being and health status. The findings shed light on the importance of validating parents' distress and grief to promote interventions to reduce emotional distress.

Despite the added pressure and challenges in caring and providing support for a loved one with schizophrenia, little research has focused on the benefits. Bauer, Koepke, Sterzinger, and Spiessl (2012) acknowledged the need to identify the potential rewards of caregiving and coping mechanisms, in addition to burden, to determine the most effective means of supporting the caregivers of people with mental illness. Most significant was the finding that caregivers primarily seek emotional relief and support from other family members. Caregivers wanted to talk about their fears, worries, doubts, and feelings of sadness and guilt in an effort to ease their burden. Simultaneously, they expressed a need for support in their daily contact with the ill relative.

Social Support as a Buffer

For Clients

Oquendo et al. (2005) identified cultural constructs that serve as protective factors (e.g., family obligations and moral objections) against suicidal behavior, suggesting that family support may buffer maladaptive coping mechanisms among individuals with a mental illness. Social support is identified by both objective and subjective factors (Corrigan & Phelan, 2004). Objective factors represent the number of people in the overall support network and the frequency of interaction. Subjective factors represent the person's perceptions about the quality of the network. To understand the relationship between objective and subjective measures of social support, Corrigan and Phelan (2004) surveyed 176 participants with severe mental illness to assess recovery, psychiatric symptoms, and social networks. It was reported that individuals who reported larger numbers of people in, or more general satisfaction with, their social networks were likely to report aspects of recovery such as greater hope and being more oriented toward goals and success.

Recovery is conceptualized as an adaptive process that incorporates four stages: hope, empowerment, self-responsibility, and having a meaningful role in life (Ragins, 2007). Corrigan and Phelan (2004) examined the relationships between objective and subjective measures of social support and recovery from serious mental illness. The findings suggested that people who report larger numbers of people in, or more general satisfaction with their networks are also likely to report hope and a greater orientation toward goals and success. Furthermore, people who reported more friends and health care professionals in their network also reported better recovery.

Even with the development of improved psychosocial rehabilitation, two thirds of individuals with severe mental illness continue to lack community involvement and experience difficulty maintaining basic roles (Davis & Brekke, 2014). To examine the mechanisms of functional rehabilitation services, Davis and Brekke (2014) interviewed and surveyed 148 individuals with severe mental illness receiving services from community treatment programs in Los Angeles. Their results suggested that social support from others represents an important coping resource that may promote proactive coping, which in turn enhances functioning by people with severe mental illness. Furthermore, social support improves role functioning by positively reframing stressors that would otherwise be considered overwhelming, thus increasing the motivation to view challenges as opportunities for growth.

For Caregivers

To understand family members' gains due to providing care for relatives suffering from schizophrenia and the influence of formal and informal social support on such positive experiences, Chen and Greenberg (2004) interviewed 560 caregivers. The results suggested that despite the challenges associated with providing care for relatives with schizophrenia, overcoming difficulties in caregiving can foster a sense of inner strength and satisfaction. In this study, mental health professionals were viewed by many as a source of formal support to family members because they provided education about the mental illness and its treatment.

In addition, forming an alliance with mental health professionals to work collaboratively on treatment planning can help families grow more resilient in coping with the challenges of schizophrenia, strengthening the family as a unit. Furthermore, the use of support groups can reduce social isolation, allowing family members an opportunity to grow by gaining knowledge about schizophrenia, sharing their experiences, learning advocacy skills, and becoming more confident about their capacity for caregiving (Chen & Greenberg, 2004).

Effective Techniques

The ultimate goal of all therapeutic interventions lies in the empowerment of marginalized and stigmatized individuals and their families (Bauml, Frumbose, Kraemer, & Pitschel-Walz, 2006). Gaining access to positive thoughts and positive conceptualizations of themselves can bring a sense of reassurance and hope in the therapeutic alliance. Family members are a key element in the patient's growth and development (Kertchok, Yunibhand, & Chaiyawat, 2011).

Although there have been many efforts in developing interventions in working with individuals with schizophrenia, it is uncertain that these can be applied in working with Latinos due to their unique cultural values and beliefs. Kopelowicz (1998) studied the impact of a social skills training model consistent with the norms and values of

Latinos. Topics included encouraging the interdependence of clients and relatives and enabling clients to be more functional members of the family household. The aim was to increase family members' abilities to offer opportunities, encouragement, and reinforcement to their mentally ill relatives while applying the skills learned in everyday life. The results showed significant effects on the acquisition and generalization of knowledge among those in the social skills training group, in addition to their utilization of that knowledge. Simultaneously, there was a significant decrease in both positive and negative symptoms among the clients. The results thus supported the notion that clients' social skills can be improved by involving family members in the rehabilitation process.

In an effort to reduce family burden and increase knowledge of schizophrenia, Barrio and Yamada (2010) developed a culturally based family intervention for Spanish-speaking Latino families. These authors piloted a 16-session multifamily group intervention. The Culturally Based Family Intervention for Mexican Americans (CFIMA) involved three stages: (a) cultural assessment, (b) cultural accommodation, and (c) cultural integration of strengths and resources. The cultural assessment entailed uncovering strengths, resilience, and culturally based coping strategies. In the cultural accommodation stage, the family's cultural strengths were integrated into cultural resources. The intent of this process was to achieve a closer fit between the family culture and the host culture. The last stage of the CFIMA was cultural integration, which involved integration of the families' positive resources into the treatment process. Results indicated that participants reported increased illness knowledge compatible with their Latino family cultural context. Furthermore, the group experience seemed to reframe participants' views of their loved one. That is, they were more likely to attribute problematic behaviors to the mental illness rather than to personal traits (Barrio & Yamada, 2010).

Multiple family group treatment (MFGT) integrates psychoeducation and behavioral family therapy (McDonnell, Short, Berry, & Dyck, 2003). MFGT is typically delivered over 2 years (bimonthly for the first year and monthly for the second year) and involves four phases: connecting with the patient and family, a psychoeducational workshop, relapse prevention, and vocational and social training. MFGT is thought to have a positive effect on family burden because it is designed to reduce risk factors for burden (e.g., positive and negative symptoms and psychiatric hospitalizations) and to increase caregiver resources such as social support and active coping. In examining this relationship, McDonnell et al. (2003) found that the caregiver's awareness of the patient's difficulties rather than the actual presence of such difficulties was associated with increased burden.

The incorporation of the relatives of Latino patients with schizophrenia in a culturally relevant management program based on social skills training techniques positively impacted social functioning, relapse rates, and hospitalizations (Kopelowicz et al., 2003). The management program was a psychoeducational group focused on teaching instrumental, social, and problem solving skills. It was divided into two modules: medication management and symptom management. Including family members as coaches served to increase the durability of the program's effects (Kopelowicz et al., 2003).

Summary

The literature review suggests that the traditional Latino community places a significant emphasis on the family unit. Within the family context, reciprocal obligations coincide with loyalty and respect. The family unit provides emotional and social support during times of distress. The literature on interdependence suggests that Latinos view caregiving with a sense of pride and fulfillment. Despite the lack of research specifically on individuals living with schizophrenia in licensed board and care facilities, the literature sheds light on the importance of social support in enhancing the well-being of both patients and family caregivers. The proposed program would bridge the gap in resources available to family members providing emotional and social support outside the home.

CHAPTER 3

METHODOLOGY

This chapter summarizes the processes used to gather the information needed for a successful grant application. Included is an overview of the target population, their needs, and the host agency intended for the program. A description of the strategies used for selecting a funding source is also provided. Lastly, this chapter explains the requirements of the grant application.

Target Population

The target population for this project is Latino family members whose loved one is receiving services from The Village in Long Beach, California. The adults enrolled in the program include those aged 18 to 59 who reside in Service Area 8. Service Area 8 encompasses the communities in the South Bay/Harbor area of Los Angeles County. Village members will have a current diagnosis of schizophrenia and be living in a licensed board and care facility. Family members participating in the program will provide some type of social and emotional support and economic assistance outside the home.

Host Agency

The host agency, The Village, is a program of Mental Health America Los Angeles (MHALA). MHALA is dedicated to promoting mental health recovery and wellness (MHALA, 2008). The Village's mission is to assist people with mental illnesses by recognizing their strengths and their power to recover and achieve full participation in community life (MHA Village, 2012). The Village is an adult integrated services recovery program emphasizing a person-centered approach focused on improving quality of life. The Village has a large menu of services: Homeless Assistance Program with a drop-in-center, Full Service Partnership Program, Wellness Center, Transitional Age Youth Academy, employment services, and a learning center. Members live in the larger community where they receive visits from the treatment team at home or are able to drop in.

The Village was selected because its programs and services are designed to meet the needs of the target population. The Village incorporates a recovery model focusing on an adaptive process that incorporates four stages: hope, empowerment, self-responsibility, and having a meaningful role in life (Ragins, 2007). In particular, The Village focuses on discovering core gifts among its members. It is believed that once individuals realize their core gifts, they feel empowered to change their lives, recognizing that they are worthy of respect, love, and acceptance of themselves and by others. Furthermore, feeling a connection to society apart from the mental illness identification is emphasized in the recovery model. Finally, The Village utilizes a collaborative approach, involving individuals in every aspect of their treatment and recovery. The fact that The Village emphasizes the need to be agents of change through education and involvement in the community makes them an ideal host for this proposed program.

Methods of Identifying and Selecting Potential Funding Sources

Searches for potential funding for this proposed project were done using multiple sources. Local, state, and federal sources were examined. Internet search engines, such as Google, Google Scholar, and Yahoo, were used to identify potential funding sources. Specific grant-related websites were also reviewed for possible funding, such as the Foundation Center, grants.gov, and the Grantsmanship Center. Several key terms were used in these searches: *mental health grants for Latinos*, *mental health grants*, *grants for Latinos*, and *Latinos and mental health treatment grants*. A final source was a document by Brousseau, Langill, and Pechura (2003), who identified leading mental health funders, of which 10 foundations were reviewed for possible funding.

In searching for potential grant funding sources, all eligibility criteria and other requirements were reviewed. The practicability of grant attainment and restrictions or limitations were also reviewed.

The search for a potential funding source led to the identification of four potential funders. The first funding source identified was the Weingart Foundation. The Weingart Foundation provides assistance to economically disadvantaged and underserved communities in an effort to offer greater access in the areas of health, human services, and education (Weingart Foundation, 2014). Of particular interest are programs that address the needs of low-income children and youth, older adults, and people affected by disabilities and homelessness (Weingart Foundation, 2014). This foundation supports a variety of nonprofit organizations across Southern California providing social services, education, and community development programs (Weingart Foundation, 2014).

The second potential funding source identified for this grant project was the California Endowment. The California Endowment's mission is to expand access to quality care for underserved individuals and communities in California (California Endowment, 2014). The California Endowment has a strong commitment to diversity and inclusiveness, advocating for culturally competent interventions (California Endowment, 2014). This foundation has previously funded programs aimed at increasing mental health and well-being for communities at risk for mental illness, specifically targeting ethnic minorities, linguistically isolated groups, and low income groups (California Endowment, 2014).

The third potential funding source identified for this grant project was the Carrie Estelle Doheny Foundation. The Carrie Estelle Doheny Foundation funds programs aimed at improving and/or advancing education, medicine, religion, health, and welfare for families and individuals within the Los Angeles area (Carrie Estelle Doheny Foundation, 2014). This foundation seeks programs that recognize individuals' dignity and spiritual needs, as well as their capacity to be leaders and mentors (Carrie Estelle Doheny Foundation, 2014).

Lastly, the fourth potential funding source identified for this grant project was the California Wellness Foundation. The California Wellness Foundation's mission is to improve the health of Californians by making grants for health promotion, wellness education, and disease prevention (California Wellness Foundation, 2010). The California Wellness Foundation's goals are to provide grants that address the health needs of traditionally underserved populations (California Wellness Foundation, 2010).

Criteria for Selection of Actual Funding Source

The criteria for selecting an appropriate funding source included making sure that the funding program supported the goals of this proposed program. This entailed reviewing each source's prior involvement in funding mental health projects. Also, consideration was placed on the amount and duration of available funding. Other criteria taken into account when selecting a funding source included the geographic location of interest, the application deadline, and the specific target population the source would be interested in serving.

Despite similar values, three potential funders were ruled out due to their eligibility criteria. The Carrie Estelle Doherty Foundation typically funds organizations with which they have a previous relationship, only approving a few new applications. The Weingart Foundation strongly advises applicants to seek support from others sources as they generally only fund 50% of the total program budget. Furthermore, the California Endowment offers support through a financing program, with the expectation of their loan being repaid within several years.

Description of Funding Source

The California Wellness Foundation was selected at the ideal funding source for this grant project as it aims to support programs that build on existing community strengths, emphasize community potential, and foster self-determination (California Wellness Foundation, 2010). The California Wellness Foundation recognizes that social, economic, and cultural factors play a role in ensuring the wellness of communities throughout California. The proposed project aims to promote wellness for both individuals diagnosed with schizophrenia and their family members through collaborative efforts with their providers to instill a sense of hope and empowerment, thus helping them to reach their full potential.

The California Wellness Foundation accepts proposal in phases. Since its last open phase in November 2013, it has made 239 grants totaling more than $13.4 million. Almost $3 million went to grants aimed at supporting efforts to educate and enroll hard-to-reach and under-informed populations about the Affordable Care Act and approximately $800,000 went to organizations providing health care and support services to unaccompanied minors migrating from Central America (California Wellness Foundation, 2010). The foundation accepts online submissions of letters of interest through its grant portal, a computer program that streamlines letters of interest, grant proposals, and grant reports. After preliminary review of letters of interest, full applications are provided to qualified organizations.

CHAPTER 4

RESULTS

Executive Summary

The purpose of this proposal is to develop support groups for individuals diagnosed with schizophrenia and their family members, in order to reduce stress and conflict. This twofold project will provide support and education to individuals challenged with schizophrenia to promote healthy psychosocial functioning. In addition, it will provide an opportunity for family members to participate in a psychoeducation support group to help them understand and cope with their family member's mental health condition.

The development of support groups focused on the needs of severely mentally ill individuals and their family members is expected to have positive outcomes on the family unit. Both support groups will be held in English and Spanish, depending on language preference. The proposed project will provide a unique supportive environment for group members to enhance their role in the journey to recovery.

The goals of the support groups are to increase the quality of life for family members involved in their loved one's recovery, increase the well-being of the individual diagnosed with schizophrenia, and enhance the relationships among all family members. The support group members will be empowered to accept their diagnosis or their family member's diagnosis to help in coping with their situation.

Organizational History and Purpose

The host agency, The Village, is affiliated with MHALA. MHALA was founded in 1924 to create opportunities for youth and adults with mental illness to recover and live full lives through the use of services, education, training, and advocacy (MHALA, 2008). The Village, located at 456 Elm Avenue, Long Beach, California, was founded in April 1990. Originally called The Village Integrated Services Agency, their mission statement reflected their focus on hope and persistence. The Village opened after it was selected by California's Department of Mental Health to design a new mental health model built on an integrated services approach.

The integrated services approach provides all services and supports individuals need to lead independent lives in their community. The Village's integrated services approach began as a pilot study; however, after the passage of the Mental Health Services Act in 2005, it became a permanent program. Known as one of California's greatest mental health reforms, this act created systems of care for adults, youth, and children based on recovery principles and practices (MHALA, 2008). The Village focuses on the whole person, assisting individuals in their journey toward recovery from mental illness. The Village's vision is driven by recovery expectations, leadership, community inclusion, and advocacy.

Problem Statement

Schizophrenia is a severe mental disorder characterized by distortions in thinking, language, perception, emotions, sense of self, and behavior, causing disruptions in psychosocial functioning. The World Health Organization (2014) stressed the importance of care at the community level through active family and community involvement. A national survey conducted in 2010 found that 18.3% of Latinos in the United States suffer from mental illness (U.S. Department of Health and Human Services [USDHHS], 2010). In 2012, about 4.4% of Latinos had a serious mental illness (Substance Abuse and Mental Health Services Administration, 2014).

Despite the prevalence of mental illness within the Latino population, the National Healthcare Disparities Report (USDHHS, 2005) found that fewer Latinos are receiving mental health services when compared to other ethnic groups. According to the National Alliance on Mental Illness (2014), fewer than 1 in 11 Latinos with a mental disorder receive specialty mental health care. In an effort to understand the disparities that exist, research has focused on system-level barriers and patient-level barriers (Cardemil et al., 2007). The underutilization of mental health services can be related to acculturation levels, especially in terms of an inability to speak English (Alegria et al., 2002). Furthermore, traditional Latinos tend to seek out services from non-mental health settings (Vega & Lopez, 2001). This may stem from their lack of awareness of services, lack of proximity to treatment centers, and low economic status (Aguilar et al., 2002). In addition, the stigma associated with mental illness contributes to disparities in the use of mental health services since issues tend to be handled within the family structure (Lopez & Guarnaccia, 2000; Weisman et al., 2003).

As the Latino population continues to expand, so too the need for culturally sensitive and family-oriented treatment approaches to increase the quantity and quality of services provided to those with mental health challenges and their family members.

Goals and Objectives

The purpose of the proposed project is to provide support groups for family members and their loved one diagnosed with schizophrenia. The program will provide family members an opportunity to express their feelings and concerns regarding their supportive role for the mentally ill person. The group will also serve as a learning environment, in which family members will learn more about symptoms, causes, and treatments, as well as provide each other with mutual aid. Additionally, the group will enable family members to acquire strategies to empower their loved one in the journey toward recovery.

The program will provide those with schizophrenia an opportunity to learn more about their diagnosis and provide a place to process feelings, thoughts, and changes since their diagnosis, in addition to sharing their experiences with peers and developing a sense of community. Furthermore, the group will provide an opportunity to strengthen interpersonal relationships through social skills training.

There will be one group offered during a 12-week period three times a year for each targeted population. A total of 36 sessions will be held and approximately 45 family members and individuals with schizophrenia will be served in a 1-year period. Since these support groups will be incorporated into the programs offered by The Village, this organization will be providing in-kind donations, including office space for staff and use of a conference room to hold the support groups. The support groups for families will be called Journey as a United Family or *Jornada como Familia Unida* in Spanish. The support group for the individuals diagnosed with schizophrenia will be called Who Am I:

Finding Solid Ground or *Quien Soy: Encontrando Terreno Firme* in Spanish. The support groups will have the following goals and objectives:

Goal 1: Within the 12-week cycle, the support groups will provide members with valuable information pertaining to schizophrenia, such as biological components, medication and symptom management, the recovery process, and advocacy.

Goal 2: Members will enhance their support networks through interactions with others faced with similar experiences.

Goal 3: Members will improve their communication and social skills in terms of interpersonal relationships, community participation, and engagement in treatment.

Goal 4: The support groups will enhance members' ability to cope with the diagnosis, thus enhancing their well-being.

Objective 1: To recruit and select 45 Latino families whose loved one is receiving services from The Village and reside in Service Area 8. Individual clients, referred to as members by The Village, will have a current diagnosis of schizophrenia and be living in a licensed board and care facility. Family members participating in the program will provide some type of social and emotional support and economic assistance outside the home. The Program Director and one MSW facilitator will screen families and individuals to conduct an intake assessment. To ensure eligibility, potential group members will be asked about struggles related to the diagnosis and its impact on family dynamics. The Program Director will then choose appropriate families that are committed to attending the 12 sessions.

Outcome 1: The 45 families with be recruited and screened and 90% and will attend all 12 sessions.

Objective 2: Family group members will become more empowered, increase their knowledge of the symptoms of schizophrenia, decrease their sense of burden, and increase their hope.

Outcome 2: Families will show a significant increase from pre-test to post-test on the Positive and Negative Syndrome Scale (PANSS; Hernandez et al., 2013), Family Burden Interview Scale (Hernandez et. al, 2013), and Hope for the Patients scale (Hernandez et al., 2013).

Objective 3: Group members will expand their support network to include others experiencing similar issues.

Outcome 3: After the sixth session and at the end of the 12-session group program, at least 90% of the members will report at least one contact with another group member outside of the group sessions.

Objective 4: Consumer group members will show improvement in interpersonal relationships through Social Skills Training (Bellack, Mueser, Gingerich, & Agresta, 2004).

Outcome 4: After the 12 sessions, at least 90% of the group members will report improved social and communication skills in their interpersonal relationships with family, community, and mental health treatment staff.

Objective 5: Consumer group members will receive follow-up services by Personal Service Coordinators (PSCs) to help facilitate appropriate revisions of their treatment plan based on challenges, needs and goals.

Outcome 5: After the 12 sessions, at least 90% of the consumer group members will report improved well-being relative to social support network, mental health symptoms, and community involvement.

Program Description

The support groups will be meeting once a week for 2.5 hours each session, for a total of 30 hours in each 12-week cycle. Topics and activities will be pre-determined prior to each session. Group members will be educated on schizophrenia, treatment, family support, coping mechanisms, and the recovery process. However, the curriculum will be flexible enough to allow time to discuss any concerns or issues encountered as a family member or individual diagnosed with schizophrenia. The Program Director will be responsible for developing a semi-structured curriculum to cover the 12 sessions and will be assisted by the assigned group facilitator. Prior to start of each cycle, the Program Director and social workers will administer the PANNS to each qualified individual consumer.

The first 15 minutes of each session will be devoted to guest speaker introductions, review of the previous session when applicable, and icebreakers. The agenda for the session will include the purpose, topic(s) to be discussed, and any planned activities. This will be posted and read out loud so that members will know what to expect. During the next 45 minutes, the facilitators will begin the discussion, engaging group members in a specific topic. In an effort to empower group members, specific activities such as review of vignettes and role-playing will be incorporated into each session. The next 15 minutes will be reserved for any questions, comments, or concerns about the topic discussed. A 15-minute intermission will facilitate transition to the last part of the session. Refreshments will be provided during this time. The next 45 minutes after intermission will be used to promote mutual aid and support among the members of the group. The last portion will be less structured and open for any discussion that can promote empathy and a sense of understanding each other's concerns. This part of the session will be led by the group members with support from the facilitators to incorporate social skills that will help fulfill the purpose of the group for consumers. During the last 15 minutes, the facilitators will summarize the group session and answer questions or address concerns.

During the first group session, members will be provided with a binder outlining the topics to be discussed within the 12-week cycle. Within the binder there will be a journal, promoting an opportunity for group members to process thoughts or feelings they would like to discuss. Furthermore, the journal will provide a safe space for group members to gain awareness of their feelings. In the first session, group members will be educated on the biological mechanisms of schizophrenia. The group facilitators will incorporate culture into the discussion, engaging group members to identify cultural perceptions related to mental illness. At the beginning of the first session, the group facilitators will distribute the PANSS, Family Burden Interview Scale, and Hope for the Patients scale as a pre-test for family members.

In the second group session, members will learn about the symptoms of schizophrenia, specifically the impact of symptoms on behavior. Members of the Journey as a United Family or *Jornada como Familia Unida* group will participate in a shortened version of the Hearing Distressing Voices exercise (Deegan, 2015) in an effort to develop empathy as they get to experience a bit of the challenges faced by their loved one. Members of the Who Am I: Finding Solid Ground or *Quien Soy: Encontrando Terreno Firme* group will identify the impact of symptoms on their psychosocial functioning.

In the third group session, members will discuss medication, highlighting their effects, along with the role of drugs and alcohol. Members of the Journey as a United Family or *Jornada como Family Unida* group will learn how to develop a collaborative family-professional relationship to promote medication adherence for their loved one. Members of the Who Am I: Finding Solid Ground or *Quien Soy: Encontrando Terreno Firme* group will participate in a social skills training activity with the goal of developing assertive communication skills when meeting with their treating psychiatrist to discuss medication concerns and/or needs.

During the fourth group session, members will discuss society's perceptions of mental illness and identify ways they deal with the stigma associated with schizophrenia. Group members will complete exercises related to identity with the goal of defining themselves. Family members will discuss feelings associated with their perceived losses, identifying techniques to build on their loved one's strengths. Those with schizophrenia will participate in a social skills training activity with the goal of improving their ability to express unpleasant feelings.

The fifth group session will consist of a discussion of support systems. Group members will learn about the role of family, highlighting emotions and learning how to build healthy relationships. Family members will learn how to communicate verbally and non-verbally with their loved one. Group members with schizophrenia will participate in a social skills training activity to practice the ability to listen to others, along with compromise and negotiation skills.

During the sixth group session, members will learn about coping skills. Group members will discuss stress, identifying the influence of stress on physical and emotional well-being. The facilitators will help group members identify behaviors they can perform to help maintain their wellness. Group members will engage in relaxation techniques and breathing exercises. In the course of the session, group members will develop their wellness plan to identify triggers, responses, and coping skills.

In the seventh group session, emphasis will be placed on the recovery model. Moreover, group members will learn about available treatments. Group members will review the menu of available services, thereby promoting autonomy and control. A panel of consumers will be present in both groups in an effort to instill a sense of optimism toward recovery. Family members will discuss their expectations and goals for their loved one. The members with schizophrenia will identify services of interest to them, thus creating a recovery action plan.

During the eighth group session, an emphasis will be placed on self-advocacy. Group members will learn assertive communication skills with the goal of taking a more active role in their care. Group members will be educated on their rights and responsibilities regarding speaking up for themselves. Family members will participate in vignette discussions and role-playing. Individuals with schizophrenia will be given an opportunity to develop a power statement, with the goal of advocating for themselves with their psychiatrist in finding the best medication to achieve their recovery goals.

They will also participate in a social skills training activity, during which they will learn how to make requests appropriately.

The ninth group session will consist of group members discussing choice making. Group members will learn about effective choice making in order to increase self-determination and self-responsibility. Family members will explore how they can support their loved one in effective choice making. Members with schizophrenia will learn how values can impact choice making and review past experiences. They will also explore techniques to develop self-control.

During the tenth group session, group members will discuss how they spend their time. Group members will identify pleasurable and meaningful activities. They will elaborate on personal contributions and pleasant life events with the goal of enhancing hope.

In the eleventh group session, members will learn about community resources. Focus will be placed on vocational and educational opportunities to promote a life not defined by the illness. Family members will hear from a vocational rehabilitation specialist and discuss how they can support their loved one in this effort. Group members with schizophrenia will participate in social skills training to develop interviewing skills.

For the ending session, group members will be given an opportunity to process their responses to the group. Group members will be encouraged to share learned skills, reviewing how they have been applied in their daily lives. Group members will be provided with information related to self-care, family time, community integration, and other empowering tools. The family group will terminate with a potluck meal, in which each group member can share a dish significant to his or her family culture. Individuals with schizophrenia will engage in a cooking activity to practice their independent living skills. Prior to end of their final session, family members will complete the PANSS, Family Burden Interview Scale, and Hope for the Patients Scale as a post-test. In addition, group facilitators will schedule follow-up meetings with individual clients, to be facilitated by the PSCs. The PSCs will be responsible for interviewing individual clients using the PANNS, after which the social workers will assess the impact of the program and how to incorporate any further needs into the treatment plan.

Evaluation

The goals of the support groups are to improve quality of life for family members and individuals diagnosed with schizophrenia through knowledge and coping skills enhancement. Families will thus be empowered to work together in dealing with their family situation, guided by recovery principles.

In order to measure the severity of the symptoms of schizophrenia, the PANSS will be utilized as a pre-test/post-test (Hernandez et al., 2013). The scores will then be compared to determine whether there were any changes in positive, negative, or generalized symptoms for family members and/or consumers.

For the family members, scales will be used to measure family burden and hope. The semi-structured Family Burden Interview Scale is a shortened 20-item version of the original scale consisting of a composite burden score and five subscales (e.g., family financial burden, routine family activities, family leisure, family interaction, and effects on physical and mental health of others (Hernandez et al., 2013). Burden is measured using a 3-point scale, ranging from 0 (no burden) to 2 (severe burden). In addition, the

Hope for the Patients scale adapted from the Miller Hope scale will be utilized to measure hope for the person with schizophrenia (Hernandez et al., 2013). The Hope for Patients scale contains 20 items ranked on a 5-point Likert-type scale, ranging from 1 (no hope) to 5 (a lot of hope). All scales will be administered prior to first group session and 1 week after last group session.

Attendance at each group session will be tabulated. All members will be asked to complete a satisfaction survey at the end of the final session, which will include suggestions for improvement.

Budget Narrative

The dual support groups will require a project budget of $153,825. Funding will include salaries and benefits for needed staff and operating expenses (see Appendix A). Operating expenses for the support groups include telephone, postage, supplies, computer, printing, travel vouchers, and refreshments. Meeting room and office space, utilities, tables, chairs, a projector, and PSC services in the amount of $31,120 will be provided in-kind through The Village.

Program Staff

One full-time bilingual program manager will be required to oversee the budget and supervise other project staff. The program manager will collaborate with other staff to develop the curriculum. The program manager will co-facilitate all group sessions with the assigned MSW. The program manager must be bilingual in English and Spanish, be a licensed social worker, and have at least 2 years of experience working with support groups in a mental health setting.

Two full-time bilingual MSW group co-facilitators will be needed. They will each be assigned to one support group to facilitate both Spanish and English sessions. One part-time administrative support specialist will be needed to assist other project staff with making phone calls, answering questions, making copies, and putting materials together for the sessions.

Operational Expenses

Telephone: Approximately $200 per month will be spent on making phone calls to recruit potential participants and answer questions related to the support groups, totaling $2,400.

Envelopes and postage: Approximately $41 per month will be spent on mailing information, totaling $592.

Transportation: Approximately $83 per month will be on travel vouchers, totaling $993.

Supplies: Approximately $166 will be spent on folders, notebooks, dry erase markers, dry erase board, pens, pencils, paper clips, staples, and other office supplies needed for the program, totaling $1,992.

Printing: Approximately $416 per month will be spent in printing resource handouts, session materials, flyers/post cards, and educational information, totaling $4,992.

Refreshments: These will be provided at each session for both support groups at $100 month, totaling $1,100 for the duration of the program.

In-Kind Resources

The Village will provide the rent and utilities for the meeting room where the support groups will be held. The Village will make available an office for the program manager, along with two additional cubicles. The two social workers will share one cubicle and the administrative support specialist will use the other. The Village will contribute $10,500 in the form of access to a laptop, three desktops, two printers, three landline telephones, one fax machine, and services by two PSCs.

CHAPTER 5

LESSONS LEARNED

Grant Writing Process

Given the writer's experience in mental health services, she opted to focus the needs she had observed within the Latino population. However, despite the writer's awareness of issues related to access and availability of services, she was able to identify further needs through an extensive review of the literature. Through continuous research efforts, the writer became motivated to develop a program that would serve to improve mental health services for Latino families and their loved ones.

The grant writing process requires perseverance, time, and dedication. Moreover, it requires attention to organization in order to create a compelling written argument supporting the need for the proposed program.

Host Agency Selection

The writer originally intended to utilize her employment site since after a discussion with the Program Director, it was concluded that the proposed program would be a perfect match with agency's guiding values. However, due to the agency's for-profit status, which limited the funding options available, the writer was instructed to identify additional community agencies.

Based on the writer's prior experience with chosen host agency and its adherence to recovery principles, it was determined that this would be the best alternative. It was learned that the selection of a funder with eligibility criteria suitable for a particular host agency can be challenging.

Identification of Funding Sources

Locating a funding source was a challenging task as the initial key terms used in the search failed to return appropriate funders. The writer was able to gather more information from discussions with others and from a journal article identifying the top funders of mental health programs (Brosseau et al., 2003).

After these steps, the writer completed a thorough review of several foundation websites. She assessed their mission and goals, in addition to previous projects funded.

Professional Development

The grant writing process provided an opportunity for the writer to grow both personally and professionally. Through the process this writer was able to learn how to plan a new program.

With support from the writer's advisor, as well as other colleagues, she was able to become better acquainted with each step of the grant writing process, along with strengthening her professional writing skills. These skills will be transferable in creating and implementing new programs addressing other unmet needs in other populations and in other communities.

Multicultural Relevance

It is imperative that all individuals, regardless of culture or ethnic background, have equal access to culturally sensitive mental health services. Due to the growing Latino population, social workers are likely to come into contact with Latino clients suffering from a mental illness.

It is significantly important to address barriers, such as the ones described in the literature review that impede access to mental health treatment for Latinos. Through the recognition of contributing factors in service availability, social workers can better develop strategies to improve the quality of life of Latino clients and their families.

Implications for Social Work Practice and Policy

Developing a program aimed at empowering Latino clients and their families through psychosocial workshops and skills development instills a sense of hope for the future. Social workers have a responsibility to advocate for marginalized communities to empower individuals to take part in the process of change. Through collaborative efforts, social workers can bridge the gaps between needs and services, minimize socioeconomic disparities, and create systematic changes. Moreover, social workers have a responsibility to call for equal and adequate treatment, which is respectful of individual rights.

Social workers play an integral role in enhancing the lives of underserved populations; thus, knowledge of the grant writing process is vital. Often, social workers are limited in the assistance they can provide to their clients due to financial barriers. Grant writing is a way for social workers to become involved in developing and implementing programs tailored to meet the needs of the populations they are serving.

Conclusion

Grant writing is an integral part of enhancing services for underserved populations. Through grant writing, social workers are able to create change for individuals, families, and communities.

APPENDICES

APPENDIX A

PROPOSED PROGRAM LINE ITEM COSTS

Program Budget Expenses for 1 year	Amount
Salaries and Benefits	
Program Manager (100%), LCSW Bilingual Spanish	$60,00
Employee-Related Benefits (@30%)	$18,000
MSW Co-facilitator, Bilingual (20% FTE salary of $60,000)	$12,000
Employee-Related Benefits (@25%)	$3,000
MSW Co-facilitator, Bilingual (20% FTE salary of $60,000)	$12,000
Employee-Related Benefits (@25%)	$3,000
Administrative Support Specialist (10% FTE salary $25,000)	$2,500
Employee-Related Benefits (@25%)	$625
TOTAL SALARIES AND BENEFITS	$111,125
Direct Program Expenses	
Telephone	$2,400
Envelopes and Postage	$592
Supplies	$1,992
Printing	$4,992
Refreshments	$1,100
Travel Vouchers	$993
TOTAL DIRECT PROGRAM EXPENSES	$12,069
In-Kind Donations	
Rent and Utilities	$19,000
Office equipment	$10,500
Personal Service Coordinators	$1,620
TOTAL IN-KIND DONATIONS	$31,120
TOTAL PROJECT EXPENSES	$154,314
TOTAL REQUESTED FROM FUNDER	$123,194

APPENDIX B

TIMELINE

Timeline

Month 1:

1. Recruit program staff.
2. Develop curriculum and group schedule.
3. Develop pre- and post-surveys.
4. Advertise group through distribution of flyers/postcards.

Month 2:

1. Finalize arrangements for group sessions.
2. Obtain consent forms.
3. Interview potential participants.
4. Administer pre-test to members of consumer support group.
5. Administer pre-test to members of family support group during first session.
6. Conduct sessions one and two of first cycle.

Month 3:

1. Continue to advertise group.
2. Conduct sessions three, four, five, and six of first cycle.
3. Continue to interview potential participants for next cycle.

Month 4:

1. Conduct sessions seven, eight, nine, and ten of first cycle.
2. Continue to advertise group.
3. Continue to interview potential participants for next cycle.
4. Review referrals.
5. Obtain consent forms.

6. Administer pre-test to members of consumer support group.

Month 5:

1. Conduct sessions 11 and 12 of first cycle.
2. Administer post-test and terminate during session 12 of first cycle.
3. Modify curriculum, if needed, based on staff debriefing and post-test results.
4. Conduct sessions one and two of second cycle.
5. Administer pre-test to members of family support group during first session.
6. Continue to advertise group.
7. Continue to interview potential participants for next cycle.

Month 6:

1. Conduct sessions three, four, five, and six of second cycle.
2. Follow-up home visits by PSCs.
3. Continue to advertise group.
4. Continue to interview potential participants for next cycle.

Month 7:

1. Conduct sessions seven, eight, nine, and ten of second cycle.
2. Continue to advertise group.
3. Continue to interview potential participants for next cycle.
4. Review referrals.
5. Obtain consent forms.
6. Administer pre-test to members of consumer support group.

Month 8:

1. Conduct sessions 11 and 12 of second cycle.

2. Administer post-test and terminate during session 12 of second cycle.
3. Modify curriculum, if needed, based on staff debriefing and post-test results.
4. Conduct sessions one and two of third cycle.
5. Administer pre-test to members of family support group during first session.

Month 9:

1. Conduct sessions three, four, five, and six of third cycle.
2. Follow-up home visits by PSCs.

Month 10:

1. Conduct sessions seven, eight, nine, and ten of third cycle.
2. Explore sources for continued funding.

Month 11:

1. Conduct sessions 11 and 12 of third cycle.
2. Administer post-test and terminate during session 12 of third cycle.
3. Explore sources for continued funding.

Month 12:

1. Follow-up home visits by PSCs.
2. Analyze data from all three cycles and complete final report for funder.
3. Submit application for continued funding.

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