ABSTRACT

PSYCHOEDUCATIONAL PROGRAM FOR ALZHEIMER'S DISEASE CAREGIVERS: A GRANT PROPOSAL

By

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The purpose of this project was to write a grant to fund a psychoeducational program for caregivers of individuals with Alzheimer's disease (AD). The goals of this program are to: (a) increase their knowledge about AD and the caregiving role, (b) increase their skills in caregiving individuals with AD, (c) enhance their competence as caregivers, and (d) decrease caregiver distress. An extensive literature review was performed to assess the needs of caregivers and support the method of this proposed program. Archstone Foundation was identified as a potential funder for this program. Tri-City Mental Health Center (TCMHC) in Pomona is selected as the host agency for this psychoeducational program. The psychoeducational program will consist of 2-hour sessions delivered once a week for 6 weeks, providing both educational and supportive interventions. Actual submission of the grant was not required for successful completion of this project.

PSYCHOEDUCATIONAL PROGRAM FOR ALZHEIMER'S DISEASE CAREGIVERS: A GRANT PROPOSAL

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CHAPTER 1

INTRODUCTION

Caring for someone with Alzheimer's disease can be stressful (Hall et al., 2014; Scott, 2013). An estimated 80% of caregivers of individuals with Alzheimer's disease are family members (Alzheimer's Association, 2012). These caregivers need services, such as psychoeducational interventions, to increase their knowledge, skills, and confidence in caring for someone with Alzheimer's disease. The proposed project was to develop and fund a psychoeducational program for caregivers of individuals with Alzheimer's disease.

Overview of the Issue

In the United States, approximately 5.4 million Americans have Alzheimer's disease (Alzheimer's Association, 2012). Aging baby boomers will increase this number by 10 million over the next few decades. Every 68 seconds an older adult develops Alzheimer's disease, and, by 2050, a new case of Alzheimer's disease is expected to occur every 33 seconds. Alzheimer's disease is the fifth leading cause of death in adults 65 years of age and older. From 2000 to 2008, the proportion of deaths due to Alzheimer's disease increased by 66% (Alzheimer's Association, 2012).

Dementia describes a variety of diseases and conditions that occur due to nerve cells, called neurons, in the brain dying or not functioning normally. As a result, an individual’s memory, behavior, and thinking are impaired (Alzheimer’s Association, 2012; Hall et al., 2014; Scott, 2013). The most common type of dementia is Alzheimer’s disease (Alzheimer’s Association, 2012). Early clinical symptoms of Alzheimer’s disease include experiencing difficulty remembering names, events, and recent conversations as well as apathy and depression. Later symptoms of Alzheimer’s disease include impaired communication (e.g., problems with words when speaking and writing), confusion (e.g., with time or place), disorientation, decreased or poor judgment, and behavior changes. Later symptoms also include difficulty performing basic bodily functions such as swallowing and walking. Ultimately, Alzheimer’s disease is fatal (Alzheimer’s Association, 2014; Scott, 2013). Currently, there is no cure for Alzheimer’s disease (Alzheimer’s Association, 2013).

Caring for individuals with Alzheimer’s disease is challenging (Hall et al., 2014; Scott, 2013). Many caregivers of individuals with Alzheimer’s disease experience high levels of emotional stress and burden (Hall et al., 2014). In one study, 61% of family caregivers reported their emotional stress as high or very high (Alzheimer’s Association, 2012). Psychoeducational interventions, such as the Savvy Caregiver Program, have been shown to be effective in increasing caregivers’ knowledge, skills, and confidence; improving caregiver well-being; and decreasing caregiver distress (Hepburn et al., 2005; Hepburn, Lewis, Sherman, & Tornatore, 2003; Hepburn, Lewis, Tornatore, Sherman, & Bremer, 2007; Hepburn, Tornatore, Center, & Ostwald, 2001; Kally et al., 2014; Lykens, Moayad, Biswas, Reyes-Ortiz, & Singh, 2014; Menne et al., 2014).

The Savvy Caregiver Program is a transportable psychoeducational program for caregivers of individuals with Alzheimer's disease and other dementias (Hepburn et al., 2003; Hepburn et al., 2007). The program consists of six 2-hour sessions that aim to introduce caregivers to the role of caregiving; provide them with knowledge about the caregiver role, skills, and attitudes to help them carry out the caregiving role; and alert them to issues regarding self-care (Hepburn et al., 2003). The theoretical model on which the Savvy Caregiver Program is based is the stress model, which emphasizes "the importance of intrapersonal mediators in affecting the outcome of the stress process associated with caregiving" (Hepburn et al., 2007, p. 32). The Savvy Caregiver Program's curriculum includes manuals that describe the course, caregiving learning objectives, and each session's learning activities as well as a CD-ROM or videotape on caregiving strategies (Hepburn et al., 2007). The curriculum is based on the idea that the negative consequences of caregiving could be decreased by strengthening the knowledge, skills, and attitudes of caregivers (Hepburn et al., 2007).

Purpose Statement

The purpose of this project was to write a grant to fund a psychoeducational program for caregivers of individuals with Alzheimer's disease. The goals of this program are to provide education and support to Alzheimer's disease caregivers so they can successfully care for individuals with Alzheimer's disease as well as care for themselves.

The objectives of this program are to: (a) increase their knowledge about Alzheimer's disease and the caregiving role, (b) increase their skills in caregiving an individual with Alzheimer’s disease, (c) enhance their competence as a caregiver, and (d) decrease caregiver distress. Didactic presentations of information will be used to teach participants about Alzheimer’s disease and tasks associated with the caregiving role, caregiving skills, caregiving, and stress and coping skills. Additionally, modeling and role playing will be used, and participants will practice the skills they learned. Participants will also receive literature from the National Institute on Aging and the Alzheimer’s Association.

Conceptual Definitions

Alzheimer’s disease: “Alzheimer’s is a disease of the brain that causes problems with memory, thinking and behavior. It is not a normal part of aging” (Alzheimer’s Association, 2013, p. 1). Individuals progress from mild Alzheimer’s disease to moderate and severe disease at different rates. As the disease progresses, the individual’s cognitive and functional abilities decline. In advanced Alzheimer’s disease, people need help with basic activities of daily living (ADLs), such as bathing, dressing, eating, and using the bathroom. Those in the final stages of the disease lose their ability to communicate, fail to recognize loved ones, and become bedbound and reliant on around-the-clock care. When an individual has difficulty moving because of Alzheimer’s disease, he or she is more vulnerable to infections, including pneumonia (infection of the lungs). Alzheimer’s disease is ultimately fatal, and Alzheimer’s disease-related pneumonia is often a contributing factor (Alzheimer’s Association, 2012).

Caregiver burden: Caregiver burden "involves the negative consequences one experiences while caring for an adult with a debilitating condition" (Scott, 2013, p. 880). Caregiver burden can be measured either objectively or subjectively. "Objective caregiver burden is related to the specific task performed by the caregiver to or for the care recipient, whereas subjective caregiver burden involves the meaning and appraisals of the caregiving role by the Alzheimer's disease caregiver" (Scott, 2013, p. 880).

Informal caregivers of individuals with Alzheimer's disease: Informal caregivers of individuals with Alzheimer's disease "provide consistent help with daily needs in a comfortable and familiar environment and often are responsible for their loved ones' financial needs as well" (Scott, 2013, p. 880).

Older adults: Older adults refer to individuals 65 years and over (U.S. Census Bureau, 2011).

Psychoeducational support group: A time-limited, subject matter focused, structured group providing education and support (Turner, 2009).

Social Work and Multicultural Relevance

As the number of individuals with Alzheimer's disease continues to grow, so will the number of caregivers. As a social worker, it is important to understand the complications and symptoms of Alzheimer's disease. Social workers provide case management, therapeutic interventions, linkage to community resources, education, and other supportive services for individuals with Alzheimer's disease and their caregivers. Social workers are currently leading the clinical field for people with

Alzheimer’s disease as they implement evidence-based practice within organizations (Alzheimer’s Association, 2014).

Social workers working with the elderly are likely to work with caregivers of individuals with Alzheimer’s disease. According to the National Association of Social Workers’ (NASW) Code of Ethics (2008), one of the values of social workers is the importance of human relationships and the ethical principle is that social workers should recognize the importance of human relationships. The relationship between the caregivers and the care recipients should be of central importance to social workers. Caregivers, especially family caregivers, may experience some rewards to caregiving; however, caregivers may also become overwhelmed and stressed and need supportive services to provide quality care (Hall et al., 2014; Scott, 2013). Social workers can assist this population by developing unique psychoeducational programs, such as the proposed program, that will increase caregiver knowledge, skills, and competence and reduce caregiver burden and distress, thereby enhancing the relationship between caregiver and care recipient.

Older Latinos and African Americans are at a greater risk for developing Alzheimer’s disease than older Whites (Alzheimer’s Association, 2013). Therefore, social workers are likely to work with caregivers from minority ethnic groups. According to NASW’s Code of Ethics (2008), social workers should be knowledgeable about different cultures and demonstrate cultural competence when providing services to individuals from different cultural and/or ethnic groups.

CHAPTER 2

LITERATURE REVIEW

This chapter first provides an overview of Alzheimer's disease, including warning signs, risk factors, and protective factors. The chapter then reviews research on caregivers, predictors of caregiver burden, and protective factors of caregiving. The chapter also reviews research on effective psychoeducational programs for caregivers to help them decrease their distress and successfully care for individuals with Alzheimer's disease as well as care for themselves

Alzheimer's Disease

According to the Alzheimer's Association (2013), "Alzheimer's is a disease of the brain that causes problems with memory, thinking and behavior" (p. 1). The 10 warning signs of Alzheimer's disease include the following: (a) a loss of memory that disrupts daily life, such as forgetting information recently learned; (b) planning and problem-solving challenges; (c) difficulty completing familiar daily tasks; (d) confusion with time or place; (e) difficulty understanding visual images and spatial relationships; (f) challenges with words when speaking or writing; (g) misplacing or losing things and being unable to retrace steps; (h) decreased or poor judgment; (i) withdrawal from social activities, hobbies, or work; and (j) changes in mood and personality (e.g., apathy and depression; Alzheimer's Association, 2009, 2012, 2013).

According to the Alzheimer's Association (2013, 2014), known risk factors for Alzheimer's disease include the following. Advancing age is the greatest risk factor for developing Alzheimer's disease; for example, approximately one third of adults age 85 and older have Alzheimer's disease. Other important risk factors are family history of Alzheimer's disease and genetics; for example, the apolipoprotein E (APOE)-e4 gene increases the risk of developing Alzheimer's disease as well as developing Alzheimer's disease at a younger age. Ethnicity is another risk factor; in comparison to Whites, older Latinos are 1.5 times more likely to have Alzheimer's disease and older African Americans are twice as likely to have Alzheimer's disease. Traumatic brain injury also increases the risk of developing Alzheimer's disease. Having fewer years of a formal education increases the risk of developing Alzheimer's disease. There is an association between brain health and heart health; conditions that damage the heart and blood vessels (e.g., heart disease) increase the risk of developing Alzheimer's disease. Additionally, factors that increase the risk of cardiovascular disease (e.g., smoking, obesity, hypertension, diabetes, and high cholesterol) are also associated with a higher risk of developing Alzheimer's disease (Alzheimer's Association, 2013, 2014).

According to the Alzheimer's Association (2013, 2014), certain factors may reduce the risk of developing Alzheimer's disease. For example, factors that decrease the risk of heart disease (e.g., physical activity and a healthy diet) may reduce the risk of developing Alzheimer's disease. Additionally, remaining socially and cognitively active may reduce the risk of developing Alzheimer's disease (Alzheimer's Association, 2013, 2014).

Caregivers

Caregivers are essential in helping individuals with Alzheimer's disease (Scott, 2013). In 2011, more than 15 million unpaid caregivers, comprised mostly of family members, provided approximately 17.4 billion hours of care to individuals with Alzheimer's disease and other dementias; the value of these hours was estimated to be more than $210 billion (Alzheimer's Association, 2012). Additionally, more than half of the $100 billion spent per year for services related to Alzheimer's disease is used to treat caregivers and not patients and these costs are expected to continue increasing as the number of Alzheimer's disease patients continues to increase (Gonyea, O'Connor, Carruth, & Boyle, 2005). Caregivers of patients with Alzheimer's disease are also at higher risk for medical and psychiatric illnesses and use healthcare services more frequently than noncaregivers (Gonyea et al., 2005).

Caregivers often experience depression which negatively affects caregivers' physical health (Harwood, Barker, Ownby, & Duara, 2000). For example, in a study of 64 Caucasian family caregivers of patients with Alzheimer's disease, Harwood et al. (2000) found that 41% of caregivers experienced a significant level of depression and that self-rated health was significantly negatively associated with depression.

Caregivers of patients with Alzheimer's disease frequently experience high levels of caregiver burden, and caregiver burden has been shown to negatively affect caregivers' physical and psychological health as well as their emotional and functional health (Carretero, Garcés, Ródenas, & Sanjosé, 2009; Etters, Goodall, & Harrison, 2008; Gonyea et al., 2005; Serrano-Aguilar, Lopez-Bastida, & Yanes-Lopez, 2006). For example, in a study of 237 informal caregivers of patients with Alzheimer’s disease, Serrano-Aguilar et al. (2006) found that 83.3% of informal caregivers had a high level of caregiver burden and that a higher level of caregiver burden negatively affected caregivers’ health-related quality of life. Caregiver burden was also significantly negatively associated with the dependency level of the care recipient and the age of the caregiver.

Ducharme, Lévesque, Lachance, Kergoat, and Coulombe (2011) examined the characteristics of caregiving and the challenges while transitioning to the role of caregiver. The sample included 122 caregivers of a relative with Alzheimer’s disease. The mean age of the caregivers was 61.4 years (*SD* = 13.6), 79.5% were women, and 43.4% were daughters. The mean age of the relatives with Alzheimer’s disease was 80 years (*SD* = 7.0). The majority of caregivers had low levels of informal support (i.e., emotional, information, and instrumental), poor knowledge of formal services that were available, a lack of preparedness for caregiving, and difficulty planning to meet the future care needs of relatives. Women caregivers in comparison to men caregivers were less able to control disturbing thoughts about the caregiver role and experienced more psychological distress and conflicts with family. Spouse caregivers in comparison to offspring caregivers were less able to respond to the disruptive behaviors of the relative, used less problem-solving coping strategies, and experienced fewer conflicts with family. According to Ducharme et al., psychoeducational interventions are effective in helping caregivers transition to the role of caregiving by supporting them in learning new caregiving skills and seeking informal and formal support.

Predictors of Caregiver Burden

Caregivers often experience high levels of emotional stress and burden due to the demands associated with caregiving (Hall et al., 2014). Some of the factors leading to caregiver burden are associated with Alzheimer's disease, such as disturbing behaviors, decreased functional independence, anosognosia, and neuropsychiatric symptoms (Clyburn, Stones, Hadjistavropoulos, & Tukko, 2000; García-Alberca et al., 2014; Hall et al., 2014; Kim, Chang, Rose, & Kim, 2012; Turró-Garriga et al., 2013). Clyburn et al. (2000) examined predictors of caregiver burden and depression in a sample of 613 individuals with dementia and their informal caregivers. The mean age of the caregivers was 58.8 (±13.5) years, and 71% of caregivers were women. The researchers found that a greater frequency of disturbing behavior by the patient and low levels of informal support were associated with higher caregiver burden, which, in turn, predicted higher levels of depression (Clyburn et al., 2000). The findings of this study indicate the important benefits of effectively managing the disturbing behaviors of individuals with dementia and providing formal services for their caregivers as well improving the caregivers' coping skills (Clyburn et al., 2000).

Kim et al. (2012) examined predictors of caregiver burden in a sample of 302 caregivers of individuals with dementia. Data came from a survey conducted by the

National Alliance for Caregiving and the American Association of Retired Persons in which individuals 18 years of age and older were interviewed. The mean age of the caregivers was 47.1 years (*SD* = 15.4); 57.0% of caregivers were female; and 75.8% were Caucasian, 12.6% were African American, 8.6% were Hispanic, 2.3% were Asian, and 0.7% were unknown. The average age of individuals with dementia was 70.9 years (*SD* = 19.8). The average number of hours caregivers provided care weekly was 25.5 hours (*SD* = 32.6). Kim et al. defined caregivers as individuals who assisted a friend or relative with at least one activity of daily living (ADL) or instrumental activity of daily living (IACL) and who were not paid for their help. The most significant predictors of caregiver burden were disease-related predictors, including impairment in ADLs (e.g., dressing, bathing, feeding, and toileting) and impairment in IADLs (e.g., managing medications, managing finances, shopping, cleaning, cooking, and driving). Other significant predictors were number of hours of caregiving, coresidence, spousal status, and gender; more specifically, caregiver burden increased as the number of hours of caregiving increased and the caregiver was female, a spouse, and living with the care recipient.

Turró-Garriga et al. (2013) examined the association between caregiver burden and the presence of anosognosia (i.e., having no awareness of deficits) in Alzheimer's disease among a sample of 124 patients with Alzheimer's disease and 124 caregivers. Of the caregivers, the mean age was 59.7 years (*SD* = 13.6) and 66.6% were women. Of the patients with Alzheimer's disease, the mean age was 78.9 years (*SD* = 6.9) and 24.2% had anosognosia. Caregiver burden levels were associated with anosognosia levels. The presence of anosognosia in patients with Alzheimer's disease was associated with physical and social burden, relationship of dependence, and emotional stress in caregivers; these caregivers felt more physically worn out, socially isolated, dependent, and stressed.

García-Alberca et al. (2014) examined the relationship between caregiver burden and neuropsychiatric symptoms in patients with Alzheimer's disease in a sample of 80 caregivers. The average age of the caregivers was 62.2 years (*SD* = 10.4), 77.5% of caregivers were female, 78.8% were married, 75.0% lived with the care recipient, and the average number of hours spent caring was 12.7 hours (*SD* = 8.3). In regard to the caregivers' relationship with the care recipient, 43.8% were the son or daughter, 38.8% were the husband or wife, 7.4% were the brother or sister, and 10.0% were other relatives. Caregiver coping strategies (i.e., more disengagement and less engagement) were the most significant predictors of neuropsychiatric symptoms. More burdened caregivers reported higher levels of anxiety and depression; use of disengagement coping mediated this relationship. These results indicate that interventions that target the coping strategies of caregivers may be beneficial. According to García-Alberca et al., psychoeducational interventions can help caregivers learn effective coping strategies for dealing with the caregiver role and increase their competence levels. "Interventions that teach caregivers cognitive and behavioral skills to actively address or cognitively reframe problems may function by replacing disengagement coping strategies with more adaptative engagement coping strategies" (García-Alberca et al., 2014, p. 359).

Caregiver attitudes can also affect burden among caregivers of patients with Alzheimer's disease (Zawadzki et al., 2011). Zawadzki et al. (2011) examined the relationship between caregiver attitudes towards Alzheimer's disease and caregiver burden. The sample included 51 family caregivers who were caring for and living with a patient with Alzheimer's disease. Of the sample, 66.7% were women and 51% were spouses. The researchers found that caregiver burden was associated with negative attitudes (e.g., high levels of authoritarianism and social restrictiveness and low levels of benevolence and community mental health ideology) and emotional reactions (high levels of anxiety and aggressiveness). The results of this study indicate that programs that educate and provide support for caregivers should not only help caregivers become more knowledgeable and develop their skills but should also address caregivers' attitudes towards Alzheimer's disease (Zawadzki et al., 2011).

Conde-Sala et al. (2014) identified 3-year trajectories of caregiver burden among caregivers caring for patients with Alzheimer's disease. The sample included 330 patients with Alzheimer's disease and their caregivers. At baseline, the mean age of caregivers was 59.7 years (*SE* = 0.8), 67.9% were female, and 45.8% were the spouse of the patient. The mean age of the patients with Alzheimer's disease was 78.0 years (*SE* = 0.3). Three groups of caregivers were identified in this study. These included Group 1 (caregivers who had initially high levels of burden but whose burden levels decreased), Group 2 (caregivers who had initially moderate levels of burden but whose burden levels increased), and Group 3 (caregivers who had initially low levels of burden but whose burden levels increased slightly). Patients in Groups 1 and 2 had more neuropsychiatric symptoms and poorer functional status than patients in Group 3, while caregivers in Groups 1 and 2 had poorer mental health than caregivers in Group 3. Adult children caregivers who lived with the patient, spouses, and sole caregivers were more likely to belong to Group 2. Adult child caregivers who lived with the patient had the highest levels of burden throughout the 36-month follow-up period (Conde-Sala et al., 2014).

Protective Factors of Caregiving

Certain caregiver attributes, such as self-efficacy, may be protective for caregivers (Gallagher et al., 2011). Self-efficacy has been defined "as an individual's assessment of his or her ability to complete a specific task successfully" (Gallagher et al., 2011, p. 664). It is a modifiable attribute that people can learn to enhance which can improve the mental and physical health outcomes of caregivers (Gallagher et al., 2011).

Positive aspects of caregiving may help decrease the frequency and severity of negative physical and psychological consequences associated with caregiving (Cohen, Colantonio, & Vernich, 2002; Semiatin & O'Connor, 2012). Cohen et al. (2002) examined the relationship between positive aspects of caregiving and caregiver outcomes among a 289 caregivers who were caring for an older adult. The researchers found that positive aspects of caregiving were significantly associated with lower levels of depression, lower levels of burden, and better health.

Semiatin and O'Connor (2012) examined the relationship between positive aspects of caregiving and self-efficacy in Alzheimer's disease caregivers. The sample included 57 family members of patients with Alzheimer's disease. Of the caregivers, the mean age was 70.2 years (*SD* = 11.0), 76.0% were female, 68.5% were the spouse of the patient, and 94.7% were Caucasian. The mean number of hours caregiving per week was 110.5 hours (*SD* = 68.8). Depression and frequency of neuropsychiatric symptoms were found to be negatively associated with positive aspects of caregiving; self-efficacy was found to be positively associated with positive aspects of caregiving. These findings have implications for interventions for caregivers; for example, skills training has been shown to enhance self-efficacy.

Gallagher et al. (2011) examined the relationship between self-efficacy for dementia symptom management and caregiver burden and depression. The sample consisted of 84 Alzheimer's disease patients and their caregivers. The mean age of the caregivers was 63.3 years (*SD* = 13.9), 57.1% were female, and 64.3% were the spouse of the patient. The mean age of the patient with Alzheimer's disease was 74.1 years (*SD* = 8.5). Of the caregivers, 33.3% had significant depressive symptoms. Gallagher et al. found that self-efficacy for dementia symptom management was significantly negatively associated with caregiver depression and burden. Additional predictors of caregiver depression were emotion-focused coping (such as acceptance, receiving emotional support from others, positive reframing, humor, and religious coping), dysfunctional coping (denial, self-blame, substance use, self-distraction, venting, and behavioral disengagement), caregiver neuroticism, and patient function; more specifically, depression was associated with less use of emotion-focused coping strategies, greater use of dysfunctional coping strategies, greater caregiver neuroticism, and poorer patient function. Additional predictors of caregiver burden were caregiver neuroticism, patient neuropsychiatric symptoms, and patient function; more specifically, caregiver burden was associated with greater caregiver neuroticism, greater patient neuropsychiatric symptoms, and poorer patient function. Self-efficacy for symptom management buffered the effects of patient neuropsychiatric symptoms on caregiver depression and burden. Gallagher et al. concluded, "Self-efficacy for symptom management has a direct beneficial impact upon the psychological health of caregivers but may also buffer the toxic effects of patient behavioral symptoms upon symptoms of burden and depression in caregivers" (p. 668).

Psychoeducational Programs for Caregivers

Caregivers of individuals with Alzheimer's disease or dementia can benefit from participating in psychoeducational interventions (Hepburn et al., 2005; Hepburn et al., 2003; Hepburn et al., 2007; Hepburn et al., 2001). Hepburn et al. (2003) field tested the effectiveness of the Savvy Caregiver Program, which is a transportable psychoeducational program for caregivers of individuals with Alzheimer's disease and other dementias. The 12-hour program was designed to provide family caregivers with the knowledge, skills, and attitudes necessary to help them carry out the caregiving role. The program materials included a trainer's manual that described the six 2-hour sessions and learning objectives, a caregiver's manual, and a CD-ROM to help caregivers assess the performance level of the care recipient. The program was field tested in rural Minnesota; Denver, Colorado; and Anchorage, Alaska. Nearly all participants who participated in the program reported an increase in their knowledge, skills, and confidence. For example, at least 90% of participants strongly agreed or agreed that they were more knowledgeable about caregiving, learned useful strategies for caregiving, felt more confident in the caregiving role, and had more skills related to caregiving.

In another study, Hepburn et al. (2007) examined the effectiveness of the Savvy Caregiver Program using a sample of 52 caregivers; 30 were in the experimental group and participated in the program and 22 were in the control group and were on the wait list. Data were collected prior to randomization and 5 or 6 months post-intervention. The program was tested in Denver, Colorado; Anchorage, Alaska; and Oxford and Tupelo, Mississippi. The Savvy Caregiver participants improved significantly in the following areas after participating in the intervention: role captivity, competence, mastery, and distress. In comparison to the control group, the experimental group reported a greater sense of mastery and a lower level of distress.

Kally et al. (2014) examined the effectiveness of the Savvy Caregiver Program on the well-being of ethnically diverse caregivers in California. For the study, 149 Hispanic, 91 African American, and 79 Asian and/or Pacific Islander caregivers were recruited; 78% of Hispanic caregivers, 56% of African American caregivers, and 74% of Asian and/or Pacific Islander caregivers completed at least five or six program sessions. For the 6-month and 12-month follow-ups, 62 Hispanic caregivers, 43 African American caregivers, and 33 Asian and/or Pacific Islander caregivers completed the 6-month follow-up assessment and 34 Hispanic caregivers, 28 African

American caregivers, and 19 Asian and/or Pacific Islander caregivers completed the 12-month follow-up assessment. Statistically significant improvements were reported in caregiver competence, levels of depression, reaction to the care recipient's problems (e.g., memory, depression, and disruption problems), management of meaning, and management of the situation at the 6- and 12-month follow-ups.

Tompkins and Bell (2009) evaluated the effectiveness of a psychoeducational program (the Savvy Caregiver Program) and a respite grant reimbursing families up to $1,000. The sample included 367 caregivers who completed tests prior to the intervention and at a 6-month follow-up; 127 participated in the psychoeducational program, 197 received a respite grant, and 43 participated in both. Participants in the Savvy Caregiver Program were very satisfied with the program, more confident as a caregiver, and gained valuable knowledge, and they reported frequently using their manual to find information and structure activities for the care recipient. For the three treatment groups, depression scores significantly decreased from pre-intervention to post-intervention. Additionally, significant increases in support service use and support group use were found at the 6-month follow-up for the three treatment groups. Tompkins and Bell also found a significant association between higher levels of depression and lower reported overall health. The researchers concluded, "Such widespread success of these interventions is encouraging for individuals, organizations, and communities seeking to support families who deal with the consequences of dementing illnesses" (Tompkins & Bell, 2009, p. 102).

Lykens et al. (2014) examined the impact of a community-based program for caregivers of patients with Alzheimer’s disease in Texas. The Resources for Enhancing Alzheimer’s Caregiver Health (REACH) II program is an intervention to decrease burden and depression levels of caregivers of patients with Alzheimer’s disease. The sample included 494 families; 177 of these families completed the 6-month REACH II program. The intervention focused on five areas, which included burden, depression, self-care, social support, and care recipient’s troublesome behaviors. Strategies used in the intervention included didactic instructions, role playing, skills training, problem solving, and stress management techniques. The mean age for caregivers who completed the program was 63.0 years (*SD* = 13.4); three fourths were female and 58.2% were White, 26.6% were African American, 14.1% were Hispanic, and 1.1% were Asian. After completion, caregivers of patients with Alzheimer’s disease reported statistically significant improvements for caregiver burden and depression.

Menne et al. (2014) examined the effects of an evidence-based program—Reducing Disability in Alzheimer’s disease—on caregiver outcomes (e.g., caregiver strain and unmet needs) in Ohio. The program teaches caregivers (a) exercises for individuals with dementia to improve their functional ability and quality of life and (b) techniques for managing the neuropsychiatric behavioral symptoms of individuals with dementia. The mean age of caregivers was 67.8 years (*SD* = 12.4), 69% of the caregivers were women, and 91% of the caregivers were Caucasian. Overall, after completion of the program, there was a significant decrease in caregiver unmet needs, from a mean of 11.44 (*SD* = 7.63) at baseline to a mean of 7.49 (*SD* = 7.23) after completion, and a significant decrease in care-efficacy strain. Additionally, participating in more exercise training sessions was associated with significant decreases in relationship strain and physical health strain, and participating in more behavior management sessions was related to a significant decrease in caregiver unmet needs.

Samia, Aboueissa, Halloran, and Hepburn (2014) evaluated the Maine Savvy Caregiver Project that incorporated the RE-AIM framework, which stands for reach, effectiveness, adoption, implementation, and maintenance. The core topics of the Savvy Caregiver Project included the following: dementia information (week 1), caregiver self-care (week 2), contented involvement (week 3), managing care and behaviors (week 4), decision making (week 5), and resources (week 6). All six sessions included caregiver mastery in which caregivers participated in exercises to practice skills learned, followed by a group debriefing. The sample consisted of 676 caregivers residing in rural areas. The mean age of the caregivers was 62.1 years (*SD* = 12.3), 82.6% were women, 97.5% were Caucasian, and 58.6% lived with the care recipient. The participants were followed for 3 years. At the 3-year posttest, caregivers had significant improvement in the following areas: caregiver competence (i.e., self-efficacy), caregiver personal gain (i.e., recognizing inner strengths), management of the situation (i.e., directing behavior, doing essential tasks and letting nonessential tasks slide, and finding ways to keep the care recipient busy), and management of expectations (i.e., acceptance of the care recipient’s condition). Other significant improvements reported were caregivers’ reaction to disruptive behaviors and depressive symptoms.

Summary

The literature review has shown that caregivers are essential in helping individuals with Alzheimer’s disease (Scott, 2013). However, caregivers of patients with Alzheimer’s disease frequently experience high levels of caregiver burden and depression which can negatively affect caregivers’ physical and psychological health (Carretero et al., 2009; Etters et al., 2008; Gonyea et al., 2005; Harwood et al., 2000; Serrano-Aguilar et al., 2006). Research has shown that some of the factors leading to caregiver burden are associated with Alzheimer’s disease, such as disturbing behaviors, decreased functional independence, anosognosia, and neuropsychiatric symptoms, and caregiver attitudes (Clyburn et al., 2000; García-Alberca et al., 2014; Hall et al., 2014; Kim et al., 2012; Turró-Garriga et al., 2013; Zawadzki et al., 2011). Certain caregiver attributes, such as self-efficacy, may be protective for caregivers (Gallagher et al., 2011). Research has shown that positive aspects of caregiving may help decrease the frequency and severity of negative physical and psychological consequences associated with caregiving (Cohen et al., 2002; Semiatin & O’Connor, 2012).

Caregivers of individuals with Alzheimer’s disease or dementia can benefit from participating in psychoeducational interventions (Hepburn et al., 2005; Hepburn et al., 2003; Hepburn et al., 2007; Hepburn et al., 2001). For example, research has shown that participants who have participated in the Savvy Caregiver Program have reported an increase in knowledge, skills, confidence, and competence and improvement in levels of distress and depression (Hepburn et al., 2003; Hepburn et al., 2007; Kally et al., 2014; Samia et al., 2014). The purpose of this project was to write a grant to fund a psychoeducational program for caregivers of individuals with Alzheimer’s disease. The goals of this program are to provide education and support to Alzheimer’s disease caregivers so they can successfully care for individuals with Alzheimer’s disease as well as care for themselves.

CHAPTER 3

METHODS

Intervention and Nature of the Program

The Nature of the Program

Tri-City Mental Health Center (TCMHC) is the host agency for this psychoeducational program. The psychoeducational program will consist of 2-hour sessions delivered once a week for 6 weeks. This 6-week program will be repeated three times over 6 months. The meetings will occur at TCMHC on Saturday mornings from 9:00 a.m. to 11:00 a.m. The first hour will be an educational component and the second hour will be a support group. Participants will also receive a copy of Caring for a Person with Alzheimer's disease: Your Easy-to-Use Guide from the National Institute on Aging (2013). Free copies are available online through the National Institute on Aging (http://www.nia.nih.gov/alzheimers/publication/caring-person-alzheimers-disease/about-guide). Other resources from the Alzheimer's Association will be used, including literature on recognizing and managing caregiver stress; tools, support, and resources available online; behaviors associated with Alzheimer's disease and how to manage them; and a respite care guide. These are available from the Alzheimer's Association's website (http://www.alz.org/Alzheimer_disease_publications_care_topics.asp).

Target Population

The target population is caregivers caring for older adults with Alzheimer's disease. These caregivers can be family members or other individuals who are caring for older adults with Alzheimer's disease. This program also targets caregivers who reside in Pomona, Claremont, and La Verne, California.

Alzheimer's disease caregivers are at risk for experiencing high levels of emotional stress and burden (Hall et al., 2014). This population will benefit from the program by decreasing their stress and increasing their knowledge, skills, and confidence related to caring for an older adult with Alzheimer's disease.

Host Agency

TCMHC is a public agency that serves the cities of Pomona, Claremont, and La Verne. TCMHC was established in 1960 and conceptualized as a provider of comprehensive mental health services, helping families as well as children, youth, and adults reach their full potential. TCMHC's integrated system of care ensures that individuals in the community have access to services that enhance their mental and emotional health. Services provided by TCMHC include psychotherapy, psychoeducation, clinical case management, community outreach, medication support, linkage and referral, peer support, vocational support, and socialization activities (Tri-City Mental Health Services, 2014a). The mission statement of TCMHC is: "By understanding the needs of consumers and families, Tri-City provides high quality, culturally competent behavioral health care treatment, prevention, and education in the diverse cities of Pomona, Claremont, and La Verne" (Tri-City Mental Health Services, 2014b, para. 1).

TCMHC was established based on funding from the Mental Health Services Act. "The Wellness Center is a hub of community activities that promote recovery, resiliency, and wellness for people confronting mental health issues" (Tri-City Mental Health Services, 2014c, para. 1). Staff members include clinical staff as well as family members and peer advocates. They provide culturally competent groups, workshops, and socialization activities that promote wellness for children, young adults, and adults. Services for children include mentoring, groups, skills building classes, leadership training, recreational activities, art, and music. For young adults, services include self-help groups, specialized supports, peer support, assessment and linkage, recreational activities, independent living skills coaching, job and vocational training, and leadership development. Services for adults include educational resources, support networks, assessment and linkage, recreational and cultural activities, and services to promote independence (e.g., educational, employment, and housing). TCHMC has several support groups, including anxiety and depression groups, a schizophrenia support group, a bipolar group, a dual recovery anonymous group, an anger management group, a day-socialization support group for young adult's ages 16-25, a socialization group, an arts group, a music group, and Spanish groups (Tri-City Mental Health Services, 2014c).

Strategies for Identifying Potential Funding Sources

The grant writer explored possible funding sources through the Long Beach Nonprofit Partnership Online Grant Search (http://www.lbnp.org/librarygrant-search). Search engines such as Google Scholar, Google, Yahoo, and Bing were also used to locate funding sources. Additional online searches using the State of California Grants website (and Grants.gov/ Grants.html) and Grants.gov were explored. Keywords used during the searches include *Alzheimer's disease*, *older adults*, *caregiver*, *caregiving*, *support groups*, *support program*, and *psychoeducational groups*.

The following funders were identified. The Weingart Foundation was identified as one potential funding source. This foundation awards grants to nonprofit organizations that provide services to people in need in the following areas: human services, health, and education (Weingart Foundation, 2014a). The Weingart Foundation also provides funds for programs and activities that "improve the quality of life for all individuals in Southern California" (Weingart Foundation, 2014a, para. 2). This foundation reviews grant proposals throughout the year. The foundation has two types of funding programs, which include the regular grant program for funds more than $25,000 and the small grant program for requests of $25,000 or less (Weingart Foundation, 2014b).

Another potential funding source that was identified during the search was the S. Mark Taper Foundation. This foundation is a private family foundation that was established in 1989. The foundation's mission is to enhance the quality of life of individuals through supporting nonprofit organizations (S. Mark Taper Foundation, 2015a). The S. Mark Taper Foundation funds general operating support, capital support, and program support (S. Mark Taper Foundation, 2015b). This foundation has one grant cycle per year and has three grant sizes, which include small (up to $50,000), medium ($50,001-$249,999), and large ($250,000 and up; S. Mark Taper Foundation, 2015b). Some of the fields of interest that the foundation supports include aging, disabled individuals, women, and economically disadvantaged individuals (Grants Office, 2015). This foundation was not selected since it has a 3-year grant-cycle ineligibility after receiving funds.

Archstone Foundation was another potential funding source that was identified. This foundation has funded projects that improve older adults' well-being for the past 30 years. One of its funding priorities is in the area of "developing innovative responses to support family members caring for older adults" (Archstone Foundation, 2015a, para. 2). Archstone Foundation accepts funding requests on an ongoing basis (Archstone Foundation, 2015a). This foundation was selected as the funding source.

Criteria for Selection of Actual Grant

Archstone Foundation was selected as the funding source based on the following criteria. The foundation focuses on caregivers of older adults. The foundation accepts funding requests on an ongoing basis. Additionally, the foundation focuses on the needs of older adults in California.

In addition the mission statement of Archstone Foundation matches with the host agency's mission statement and the purpose of this grant application. These mission statements focus on contributing to the society considering the needs of an aging population. Archstone Foundation has awarded similar programs in the past and provides the amount this grant requires.

Archstone Foundation

Archstone Foundation was established in 1985 and, in 1995, it focused only on aging. The mission of Archstone Foundation "is to contribute towards the preparation of society in meeting the needs of an aging population" (Archstone Foundation, 2015b, para. 1). Archstone Foundation has awarded approximately $90 million to more than 900 grants since the establishment of the foundation (Archstone Foundation, 2015b, para. 1).

Archstone Foundation accepts Letters of Inquiry (LOIs) on an ongoing basis. An LOI should be three pages or less and include the following: (a) a description of the program, including its rationale; (b) the goals and objectives of the program; (c) the population which will be served by the program; and (d) the process of evaluation and outcomes (Archstone Foundation, 2015c). After staff review, if the LOI matches the foundation's interests and requirements, the foundation will request a full proposal from the organization (Archstone Foundation, 2015c).

Needs Assessment

According to the Alzheimer's Association (2012), 13% of people aged 65 years and older and 45% of people aged 85 years and older has Alzheimer's disease. For every person with Alzheimer's disease, there is a caregiver. Based on these statistics, there is a need for services to help caregivers. TCMHC currently has no support services for caregivers of individuals with Alzheimer's disease.

The proposed psychoeducational program will provide caregivers of older adults with Alzheimer's disease information as well as emotional and practical support. The psychoeducational program will benefit caregivers. For example, research has shown that psychoeducational interventions are effective in increasing caregivers' knowledge, skills, and confidence; improving caregiver well-being; and decreasing caregiver distress (Hepburn et al., 2005; Hepburn et al., 2003; Hepburn et al., 2007; Hepburn et al., 2001). Also, participation in community-based programs can allow caregivers to care for their loved ones at home longer (Voisin & Vellas, 2009).

Projected Budget Range and Categories

The proposed budget will be $41,656.25. The money will be used for the salaries and benefits of two staff (one program director and one case manager); direct costs, including office supplies (e.g., pens and paper), office equipment (a computer and a printer), educational materials, and snacks; and in-kind costs, including use of a room at the center and utilities (see Appendix A).

Evaluation

The program will be evaluated using pre- and post-tests. The tests will assess caregivers' levels of knowledge, skills, and confidence. Likert-type responses will be used. Additionally, on the post-test, participants will be asked to provide their feedback regarding the program and include their perceptions regarding the program's strengths and weakness as well as areas that need improvement. Their comments will be reviewed and modifications will be made to the program accordingly. Because Archstone Foundation can award funds for a project continuously for 3 years, additional grant requests will be submitted to this foundation. After 3 years, the host agency will search for other funding sources by hiring a grant writer to locate appropriate future funders and /or event coordinator to plan for future fundraising events.

CHAPTER 4

GRANT PROPOSAL

Introduction

The Archstone Foundation was selected as the funder. This foundation accepts Letter of Intents (LOIs) that include the following: (a) a description of the program, including its rationale; (b) the goals and objectives of the program; (c) the population which will be served by the program; (d) the process of evaluation and outcomes; (e) a preliminary budget; and (f) a budget narrative (Archstone Foundation, 2015c).

Program Description and Rational

The purpose of this grant is to fund a psychoeducational program for Alzheimer's disease caregivers. The program will consist of group sessions that meet weekly for 2 hours over the course of 6 consecutive weeks. There will be three cycles of this course over 6 months. The first hour will be an educational component and the second hour will be a support group. The groups will include 10 caregivers. The group facilitators will include one Licensed Clinical Social Worker (LCSW) and one case manager with a Master of Social Work (MSW). There will be six cycles of groups per year. All group sessions will be held at Tri-City Mental Health Center (TCMHC) located in the city of Pomona in the conference room on Saturday mornings from 9:00 a.m. to 11:00 a.m.

This psychoeducational program will be based on the Savvy Caregiver Program, which is a transportable psychoeducational program for caregivers of individuals with

Alzheimer’s disease and other dementias (Hepburn et al., 2003; Hepburn et al., 2007). The program introduces caregivers to the role of caregiving; provides them with knowledge about the caregiver role, skills, and attitudes to help them carry out the caregiving role; and alerts them to issues regarding self-care (Hepburn et al., 2003). The Savvy Caregiver Program is based on the stress model, which emphasizes “the importance of intrapersonal mediators in affecting the outcome of the stress process associated with caregiving” (Hepburn et al., 2007, p. 32). The premise of the Savvy Caregiver Program curriculum is that the negative consequences of caregiving could be decreased by strengthening the knowledge, skills, and attitudes of caregivers (Hepburn et al., 2007).

The rationale for the program is as follows. Alzheimer’s disease is the most common type of dementia (Alzheimer’s Association, 2012). In the early stages, individuals with Alzheimer’s disease experience difficulty remembering names, events, and recent conversations as well as apathy and depression. In the later stages, individuals with Alzheimer’s disease experience impaired communication, confusion, disorientation, decreased or poor judgment, and behavior changes. Additionally, these individuals will experience difficulty performing basic bodily functions such as swallowing and walking. Ultimately, Alzheimer’s disease is fatal (Alzheimer’s Association, 2014; Scott, 2013). Currently, there is no cure for Alzheimer’s disease (Alzheimer’s Association, 2013).

As a result of the debilitating symptoms of Alzheimer’s disease, caring for individuals with Alzheimer’s disease is challenging (Hall et al., 2014; Scott, 2013). Many Alzheimer’s disease caregivers experience high levels of emotional stress and burden (Hall et al., 2014). The Alzheimer's Association (2012) cited one study that found 61% of family caregivers reported their emotional stress as high or very high.

Psychoeducational interventions, such as the Savvy Caregiver Program, have been shown to be effective in increasing caregivers' knowledge, skills, and confidence; improving caregiver well-being; and decreasing caregiver distress (Hepburn et al., 2005; Hepburn et al., 2003; Hepburn et al., 2007; Hepburn et al., 2001; Kally et al., 2014; Lykens et al., 2014; Menne et al., 2014).

Program Goals and Objectives

The goal of this program is to provide education and support to Alzheimer's disease caregivers so they can successfully care for individuals with Alzheimer's disease as well as care for themselves.

Objective 1: To increase caregivers' knowledge about Alzheimer's disease and the caregiving role.

A didactic presentation of information will be used to teach participants about Alzheimer's disease and tasks associated with the caregiving role. Participants will also receive a copy of *Caring for a Person with Alzheimer's Disease: Your Easy-to-Use Guide from the National Institute on Aging* (National Institute on Aging, 2013), which is available online from the National Institute on Aging (http://www.nia.nih.gov/alzheimers/publication/caring-person-alzheimers-disease/about- -guide). Participants will also receive literature from the Alzheimer's Association on behaviors associated with Alzheimer's disease and how to manage them (http://www.alz.org/alzheimers_disease_ publications_care_topics.asp). Participants' knowledge will be assessed with a pretest and posttest.

Objective 2: To increase caregivers' skills in caregiving individuals with Alzheimer's disease.

A didactic presentation of information will be used to teach participants about caregiving skills. Additionally, modeling and role playing will be used. Participants' skills will be assessed by observing caregivers during group sessions and with a pretest and posttest.

Objective 3: To increase caregivers' competence as a caregiver.

A didactic presentation of information will be used to teach participants about caregiving. Discussions will be used. Also, participants will practice the skills they learned. Participants' competence will be assessed with a pre-test and post-test.

Objective 4: To decrease caregiver distress.

A didactic presentation of information will be used to teach participants about stress and coping skills. Participants will learn different coping strategies; modeling of coping skills will be used and participants will practice the coping skills in the group sessions and at home. Participants will also receive literature from the Alzheimer's Association on recognizing and managing caregiver stress; tools, support, and resources available online; and a respite care guide (http://www.alz.org/alzheimers_disease_publications_care_topics.asp). Participants' distress will be assessed with a pre-test and post-test.

Timeline

Month 1:

Hire the program staff and prepare for the psychoeducation program.

Recruit the participants for the first cycle of the psychoeducation program and register them for the program. Conduct the pre-test and start the first cycle.

Month 2:

Continue recruiting the participants for the second cycle.

Conduct the post-test and complete the first cycle.

Adjust the program based on the result of the post-test.

Month 3-4:

Repeat Month 1 and 2 (second cycle).

Month 5-6:

Repeat Month 1 and 2 (third cycle).

Evaluate the overall success of the program.

Target Population

The target population is Alzheimer's disease caregivers. These caregivers can be family members or other individuals who are caring for older adults with Alzheimer's disease. This program also targets caregivers who reside in Pomona, Claremont, and La Verne, California.

According to the U.S. Census Bureau (2013), for the city of Pomona, 70.5% of the population is Hispanic. For the city of Claremont, 19.8% of the population is Hispanic (U.S. Census Bureau, 2013). For the city of La Verne, 31.0% of the population is Hispanic (U.S. Census Bureau, 2013). The participants of this proposed program will reflect on these data.

Evaluation and Outcomes

The program will be evaluated using pre-tests and post-tests. The tests will assess caregivers' levels of knowledge, skills, and competence as well as their distress levels. Likert-type responses will be used. Expected outcomes include the following: participants' knowledge, skills, and competence will increase and distress levels will decrease upon the completion of the program. Additionally, on the posttest, participants will be asked to provide their feedback regarding the program and include their perceptions regarding the program's strengths and weakness as well as areas that need improvement. Their comments will be reviewed and modifications will be made to the program accordingly. Because Archstone Foundation can award funds for a project continuously for 3 years, additional grant requests will be submitted to this foundation when the program is evaluated and found to be successful through these evaluations. All objectives of this proposed program will be measured using pre- and post-tests. They are also evaluated through the participants' attendance record and weekly reports completed by the Program Director and Case Manager. The results of these evaluations will be reflected on the following sessions.

Budget

The proposed budget will be $125,500. The money will be used for the salaries and benefits of two staff (one program director and one case manager) and direct costs, including office supplies, office equipment, educational materials, and snacks. The in-kind costs, including use of a room at the center and utilities, are provided in the line-item budget table (see Appendix).

Budget Narrative

Personnel

Program director: The program director will be a bilingual (English and Spanish) LCSW who will oversee the implementation of the program. This is a part-time position (30 hours/week). The program director will be responsible for developing the curriculum, conducting the psychoeducational sessions, facilitating the support group, and developing and analyzing data from the pretests and posttests. The salary will be $16,875 ($45,000 annual salary x .5 year x .75 FTE plus $4,218.75 benefit).

Case manager: The case manager will be a social worker with an MSW. This is a part-time position (20 hours/week). The case manager will be responsible for assisting with the psychoeducational sessions, administering the pre-tests and post-tests, providing snacks, and co-facilitating the support group. The salary will be $6,250 ($25,000 annual salary x .5 year x .5 FTE plus $1,562.5).

Administrative assistant: The administrative assistant will be provided in-kind by TCMHC. This person will assist the program director and perform a variety of administrative tasks, including scheduling, managing the budget, and downloading and printing online resources for participants.

Benefits: Benefits are paid at 25%. The combined total requested for benefits for the program director and case manager is $5,781.25. The benefits of the administrative assistant will be provided in-kind by TCMHC. Also, $1000 for stipend, and the evaluator of the program.

Direct Operating Costs

Office supplies: The amount of $750 will be used for office supplies, including notebooks, paper, pens, staplers, and staples.

Office equipment: The amount of $1,750 will be used for office equipment, including one computer and a printer.

Educational materials: The amount of $2,500 will be used for educational materials.

Snacks: The amount of $1,500 will be used for snacks.

In-Kind Resources

In-kind resources: The psychoeducational program will be hosted by TCMHC and the in-kind services used will include the personnel expense of $5,000 for an administrative assistant, rent of their conference room for the group sessions at $1,000 per month for a yearly total of $6,000, and utilities at $250 per month for a yearly total of $1,500. The total cost is $12,500 per year.

CHAPTER 5

DISCUSTION

Lessons Learned

The grant writer learned several lessons about the grant writing process. One challenge that the grant writer experienced was time management. Writing a grant proposal is time consuming; therefore, the grant writer learned to set early deadlines and allow for time to make revisions. Although gathering articles for the literature review was also time consuming, information learned from the articles was helpful in designing a psychoeducational program based on evidence-based practice.

Completing a literature review on caregivers of individuals with Alzheimer's disease and psychoeducational support groups for caregivers was also challenging. During the process of researching scholarly articles for the literature review, the grant writer realized that there was limited information on Alzheimer's disease caregivers despite that there are approximately 5.4 million Americans with Alzheimer's disease and that more than 15 million unpaid caregivers provided care to individuals with Alzheimer's disease and other dementias in 2011 (Alzheimer's Association, 2012). Based on knowledge learned from writing the literature review, the grant writer gained greater insight into the challenges caregivers of individuals with Alzheimer's disease experience. The grant writer realized the needs of these caregivers and how to address those needs. For example, caregiver burden is common among caregivers of individuals with Alzheimer's disease; however, there are only a few psychoeducational interventions designed to decrease caregiver burden and increase caregiver knowledge, skills, and competence (Hepburn et al., 2003; Hepburn et al., 2007; Kally et al., 2014; Samia et al., 2014). Yet, research has shown that psychoeducational programs such as the Savvy Caregiver Program are effective in increasing caregivers' knowledge, skills, confidence, and competence and decreasing levels of distress and depression (Hepburn et al., 2003; Hepburn et al., 2007; Kally et al., 2014; Samia et al., 2014). Therefore, this grant writer designed a psychoeducational program based on the Savvy Caregiver Program to address the needs of caregivers of individuals with Alzheimer's disease.

Analysis of Process

The Process

The process of selecting a funding source was another challenge that the grant writer experienced. Each foundation has its own funding priorities, guidelines, and applications. The grant writer spent a lot of time navigating through websites and researching each foundation to ensure that the funding source matched the values of the proposed program. Ultimately, Archstone Foundation was selected since it matched with the host agency's mission statement and the purpose of the grant application.

The strengths of the program are that it addresses a need in the community (i.e., providing resources and support to caregivers of individuals with Alzheimer's disease) and is based on evidence-based research (the Savvy Caregiver Program). The limitations are that the program only targets a small number of caregivers and is limited by the geographic focus of the host agency.

Strategies to Enhance the Project and Recommendations

The grant writer believes that all steps in the grant writing process are important. Having a solid literature review is important in assessing the needs of specific populations as well as determining the strengths and limitations of available evidence-based programs that seek to address those needs. Additionally, having clear goals and objectives is important in regard to finding a funder and determining if the program is successful.

When reviewing the literature, a lack of ethnic diversity was found. For example, only one study examined the effects of a psychoeducational program (the Savvy Caregiver Program) among an ethnically diverse sample of participants (Kally et al., 2014). It is recommended that more evidence-based programs addressing the needs of caregivers of individuals with Alzheimer's disease be developed, used, and evaluated among ethnically diverse caregivers.

Implications for Social Work and Multicultural Practice

Grant writing is an important skill that all social workers should have since many programs need funds to start and/or continue. Social workers with skills in grant writing can develop new programs based on a thorough needs assessment, write a grant proposal to fund the program, and implement and evaluate the program. With these skills, social workers can continue to address the needs of underserved populations, such as caregivers of individuals with Alzheimer's disease.

This program is relevant to social work practice and policy since the importance of human relationships, an ethical principle of the NASW *Code of Ethics* (2008), is emphasized. The relationship between caregiver and care recipient is of central importance in this program. With this program, social workers can assist caregivers, thereby enhancing the relationship between caregiver and care recipient. Additionally, this program will also address the needs of caregivers from different cultural and/or ethnic groups as research has shown that older Latinos and African Americans are at a greater risk for developing Alzheimer's disease than older Whites (Alzheimer's Association, 2013). Social workers in this program will be knowledgeable about different cultures and demonstrate cultural competence when providing services to caregivers from different cultural and/or ethnic groups.

Conclusion

The purpose of this project was to write a grant to fund a psychoeducational program for caregivers of individuals with Alzheimer's disease. To complete this project, the grant writer had to find and make a connection with a host agency, find a funder for the psychoeducational program, and write a grant to fund the psychoeducational program.

The literature demonstrated the high levels of burden caregivers of individuals with Alzheimer's disease experience and the importance of providing resources and support to these caregivers. This program is important in providing caregivers of individuals with Alzheimer's disease with the knowledge and skills they need to increase their competence, decrease their distress, and successfully care for individuals with Alzheimer's disease as well as care for themselves.

APPENDIX: PROPOSED PROGRAM BUDGET

APPENDIX

PROPOSED PROGRAM BUDGET

Proposed Program Budget

Expenses	Amount
Salaries and Benefits	
Program Director/LCSW (30 hours/week for 6 months)	$16,875
Benefits @ 25%	$4,218.75
Case Manager (20 hours/week)	$12,500
Benefits @ 25%	$1,562.5
Stipend	$ 1,000
Evaluation	$ 5,000
TOTAL SALARIES AND BENEFITS	$41,156.25
Direct Program Costs	
Office Supplies	$750
Office Equipment	$1,750
Educational Material	$2,500
Snacks	$1,500
TOTAL PROGRAM DIRECT COSTS	$6,500
In-Kind Resources	
Salary and Benefits for the Administrative Assistant	$5,000
Facility ($1,000/month)	$6,000
Utilities ($250/month)	$1,500
TOTAL IN-KIND RESOURCES	$12,500
TOTAL PROJECT COSTS	$47,656.25

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