Latino MultiFamily Group Program Manual

Involving Spanish-Speaking Latino Families
in Mental Health Services for Adolescents

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OVERVIEW

Purpose of the Manual

This Manual provides guidance and background information to help clinical staff and family facilitators in mental health agencies implement a program for involving Spanish-speaking Latino families in mental health services for adolescents. The *Latino MultiFamily Group (Latino MFG)* program was adapted from a program first created for families of adults with serious mental illnesses like schizophrenia.

The Manual is not intended to stand alone, but to supplement training materials already available for families of adults, since the adult MFG program provides a well-tested "shell" or organizing framework that can be adapted to a number of different populations and mental health problems. Recently completed empirical research indicates that the adult MFG program is effective for families of Spanish-speaking adults, and pilot tests also show success with families with Spanish-speaking adolescents. These studies are discussed in the manual.

For adolescents struggling with the challenges of disorders like ADHD or serious emotional disturbances like depression, support from their families often is essential to success in treatment and recovery. Access to psychological and problem-solving support from these families is desirable, especially since most adolescents live with their parents or other family members. But families need both knowledge and skill to interact effectively with adolescents who have these disorders or disturbances (which for ease of reference will be called "disorders" throughout this Manual).

What's in the Manual

The Manual provides background and practical resources for those being trained to implement the Latino MFG. As already mentioned, it is not intended to stand alone, but rather to be a supplement to standard MFG training materials.

The Manual has six sections:

Section 1 – Using the Manual provides a larger context for the system change that's needed to implement the Latino MFG program effectively.

Section 2 – About Latinos in the United States presents a very brief summary of general information about Latinos and about mental illnesses/mental disorders in this population, offering a general context for implementing the Latino MFG program.

Section 3 - Cultural and Language Challenges in Working with Latino Families summarizes eight main challenges and how to handle them.

Section 4 - Challenges of Working with Latino Adolescents presents an overview of the challenges facing providers offering the MFG program to families of Latino adolescents, and recommendations for how to respond to these challenges.

Section 5 - Implementing the Latino MFG Program outlines the steps involved in implementing the Latino MFG program; provides information on how the program is different from the adult MFG; and provides information on costs and co-facilitation of these groups by a family member (sometimes family members may be the only facilitators).

Section 6 - Resources for Further Learning includes references cited and additional websites and publications, plus program materials presented both in English and Spanish.

For those interested in the scientific background for the Manual's content, references cited throughout are presented through end-notes (with full reference citations in Section 6).

About the MFG Program

A proven way to develop family knowledge and skill (and to encourage support on an ongoing basis) is the MultiFamily Group (MFG) program, originally developed by Dr. William McFarlane of Maine Medical Center, and empirically-tested through years of research. MFG was created for families of adults with such severe mental illnesses as schizophrenia and is recommended as an evidence-based practice for this population.[1] The MFG program has been used effectively with adolescents and children as well. The program brings groups of families together for education and skill development, as well as mutual support and problem solving. The key elements of the MFG program are:

- *Five to eight families are in a group*
- *Two clinicians facilitate the group (sometimes there are also family facilitators)*
- *The group meets bi-weekly for 90-minute sessions over six months to one year*
- *Refreshments are provided*
- *Initial sessions avoid emphasis on clinical issues but provide education*
- *Initial sessions emphasize establishing a working alliance among the families by building group identity and developing a sense of mutual interest and concern, then moving on to group sharing and problem-solving*

MFG's status as an evidence-based practice is verified by a number of controlled research studies. Research on the MFG approach for family members with schizophrenia shows that there is a remarkable consistency of positive effects on rates of relapse, with minimum reductions of about 50% over the rates of relapse for control groups. In 11 of the most rigorously designed and conducted studies, the average rate of relapse for the groups receiving family psychoeducation was 27%, compared with the rate for control groups of 64%.[2]

Participation in an MFG program also results in increased employment, improved family relationships and well-being, reduced friction and family burden. And it reduces medical illness among family members, according to the research already cited.

Family psychoeducation interventions like the MFG program now have been recognized as effective interventions for adults with schzophrenia by the research collective called the Schizophrenia Patient Outcomes Research Team (PORT). Other interventions recommended are:

- *Standardized pharmacological treatment*
- *Illness management skills training*
- *Supported employment*
- *Assertive community treatment*
- *Integrated dual disorders treatment*

In their 2009 treatment recommendations, the PORT states that "persons with schizophrenia who have ongoing contact with their families, including relatives and significant others, should be offered a family intervention that lasts at least 6-9 months. Interventions that last 6-9 months have been found to significantly reduce rates of relapse and rehospitalization. Though not as consistently observed, research has found other benefits for patients and families, such as increased medication adherence, reduced psychiatric symptoms and reduced levels of perceived stress for patients. Family members have also been found to have lower levels of burden and distress and improved family relationships."[3]

Some evidence is available for applications of the MFG program to adolescents and children,[4] and clinical experience suggests that the program can be used successfully regardless of age range. Research bringing together the effectiveness data about EBPs like the MFG shows that ethnic minorities benefit in trials of EBPs as much as Whites.[5] Another large review of research on this subject indicated that cultural adaptations of mental health interventions are generally effective, and a third analysis indicated that interventions adapted for use with minority youth generally are as effective as for the original White population.[6] There is some debate about whether cultural adaptations even are necessary, although no question that translation into other languages (such as Spanish) is essential for those who do not speak English.[7] Positive evidence about the effectiveness of the MFG program with Latinos is presented below.

Underuse of the MFG Program

Unfortunately, the MFG program is not as widely used as these extraordinary research results suggest it should be. There are many reasons for this.

Some mental health workers and their agencies simply don't know that this program exists, or don't know there's sound scientific evidence supporting its effectiveness. Others have heard of MFG, but are more inclined to using medications or psychotherapy to improve outcomes. In some cases, mental health workers and families are reluctant to use programs that have been studied and used primarily with White, English-speaking families, when many of their clients and their families are Latino and their primary language is Spanish.

Whatever the reasons for its limited use at present, there is good evidence that implementation of the MFG program can be increased through systematic efforts to educate and support mental health agencies and their staff. For instance, in the San Fernando Valley region of Los Angeles, among the 40 nonprofit agencies receiving County contract funding for mental health services, only one was using the MFG approach in 2007 (either for children/adolescents or for adults). Under funding support from UniHealth Foundation, a number of additional agencies learned about and implemented the MFG program for families of adults with mental illnesses, through the Raising the Bar project. This three-year project was conducted as part of Valley Nonprofit

Resources, a management support organization for nonprofits in this region, and served as the model for creation of the Latino MFG program. [8]

Throughout the health and human services field, evidence-based practices like MFG have increasingly become the "gold standard," and in fields such as mental health, funders are starting to require their use as a condition of funding support. However, for many mental health agencies, identifying appropriate EBPs is difficult, and so is high-quality implementation of them. Also, agencies need to address long-term sustainability for these practices once in place.

How the Latino MFG Was Developed

The Latino MFG program was specifically designed for use with monolingual Spanish-speaking Latino families, whose family members with mental health problems are adolescents ages 12-16.

Although Latino MFG sessions with families are presented in Spanish, training for mental health agency personnel is presented in English, as is this Manual, for the practical reason that not everyone involved in the implementation of this program will be bilingual (but all staff being trained as facilitators are bilingual).

As with all MFG programs, the objective is to provide the families with education and problem-solving skills in a group environment with other families. The specific aim is to reduce family stress and help the family better support the adolescent who is dealing with the challenges of mental disorders (ADHD, depression, etc.).

The Latino MFG program can increase the quality of mental health services for Latino adolescents by reducing symptoms and enhancing overall quality of life for these adolescents. Other specific benefits may be better medication compliance, and reduced risk for re-hospitalization if either have been part of the adolescent's treatment history. This program is also intended to improve coping skills and quality of life for family members.

This Manual and the work behind it are supported by a multi-year grant from the Annie E. Casey Foundation. The Foundation recently has adopted a major emphasis on getting EBPs more widely used in public systems that serve children and adolescents, especially those serving high-risk populations and disadvantaged communities. EBPs whose use can help reduce congregate or institutional care also are a priority for Casey's work.

Some of the core materials used to prepare mental health workers for implementing the Latino MFG program (e.g., to describe the basic components of MFG and the research evidence behind it) are NOT contained in this Manual, or in accompanying PowerPoints described later. Rather, as mentioned earlier, those implementing the Latino MFG program are encouraged to use this manual as a "concordance" to educational materials developed by MFG's pioneer, (Dr. William McFarlane, Maine Medical Center) with some supplements customized by the primary implementer Dr. Alex Kopelowicz. These materials are described in Section 5.

The initial research establishing the efficacy of the MFG approach for Latinos was done by Kopelowicz.[9] The specific purpose of this research was to test the MFG program as an

evidence-based intervention to improve *medication adherence* among adult patients with schizophrenia. While family psychoeducation has demonstrated efficacy in improving overall outcomes in schizophrenia, empirical support for its ability to enhance medication adherence is scarce.

The specific objective of the most recent of these studies was to determine whether a culturally-adapted, multifamily group therapy would increase medication adherence and decrease psychiatric hospitalizations for Mexican American adults with schizophrenia. These patients and their families participated in a controlled study of the MFG approach (the MFG program was translated into Spanish and culturally-adapted, creating the prototype for the Latino MFG described in this Manual). A version of the MFG program specifically tailored to improve medication adherence through a focus on the beliefs and attitudes of the target population was found to be particularly effective in reducing re-hospitalization rates.

Three approaches to cultural adaptation were interwoven to create the Latino MFG program. The first involves applying research findings to shaping the intervention. For example, a fundamental goal of family psychoeducation is to improve communication and problem-solving skills within the family environment – research has shown that such activities decrease levels of expressed emotion (i.e., criticism and hostility) among family members, which in turn reduce relapse rates for people with serious mental illnesses.

However, research has demonstrated that in Latino families (particularly Mexican-Americans), high levels of criticism and hostility do not predict relapse as strongly as in the Anglo-American population[10]. Instead, the absence of warmth (that is, the expression of pro-social feelings amongst family members) is a better predictor of relapse. Consequently, family psychoeducation for the Latino MFG focuses more on encouraging engagement and inclusion of the ill relative in family activities rather than attempting to minimize aversive interactions.

The second approach involves modifying the intervention based on clinical experience. For instance, Kopelowicz and colleagues[11] culturally adapted an illness management program for a Mexican-American population in Los Angeles. The cultural adaptation of this program included translating the trainer's manual and patient workbook, dubbing a training video into Spanish, modifying the trainers' activities during the sessions, and including family members.

Cultural considerations were incorporated into the skills training process by insuring that the skills trainers participating in the study were all Mexican-American and bilingual. Their training style was modified to allow for more spontaneity among participants, and family members were incorporated into the skills training – a particularly important element since over 80% of Latinos with schizophrenia live with their families. Family members were trained to identify opportunities for what was learned in the training to be generalized to family life.

A third approach to adapting interventions is to examine existing interventions from the perspective of cultural competence models. For instance, the model of "cultural lenses" encourages providers to work with patients and families from other cultures by integrating their own perspectives into the intervention, moving back and forth between the cultural points of view. In a study by Kopelowicz and colleagues[12] the "shifting cultural lenses model" was used

to modify the MFG approach for Latinos by integrating the perspectives of the therapist and the participants. The synthesis of these three approaches led to the creation of the adult Latino MFG program tested in the Kopelowicz research, and which has been adapted here to create a Latino MFG program for use with adolescent populations.

Early Evidence of Success for the Latino MFG Program

In its first edition, this Manual was part of a pilot test of the Latino MFG program, which was created based on the Kopelowicz work and the UniHealth Foundation-sponsored study described above. Family sessions were presented in Spanish and culturally adapted at two public mental health agencies in the San Fernando Valley region of Los Angeles. The target population for these pilot tests was adolescents with mental health problems such as depression and ADHD.

Four pilot test groups were conducted and evaluated. Three of the four groups used professional staff as facilitators; one used trained family members. All pilot groups were implemented successfully, despite operational challenges, as viewed by clinical staff and family members interviewed in two follow-up evaluation studies. [13] Interviews with family members also revealed specific examples of impact from the groups on adolescent clients (several of these are reported below). Improvements in clinical status were noted, although no inferences can be made about how much the MFG program contributed, since these were very modest, uncontrolled evaluation studies. Two more pilot groups were launched in early 2011, and will be evaluated using a more rigorous data-gathering procedure that grew out of a review of the previous two evaluation reports.

Six families were part of the first Latino MFG program implemented at San Fernando Valley Community Mental Health Center, where the facilitators of the group were a bilingual case manager from Children's Systems and a bilingual therapist from the Children's Full Services Partnership. Four families were part of the San Fernando Mental Health Center's Latino MFG program, and its facilitators were a staff licensed clinical social worker and a clinical psychologist. The second set of two pilot groups implemented at these agencies had similar profiles.

Results from interviews conducted with family members participating in the pilot groups indicated that they found the groups to be helpful in dealing with the adolescent client. Being with other families had particular impact. The groups provided a significant source of social support, were superior to individual sessions the interviewees had participated in, and provided an opportunity to express doubts, worries, and opinions, to learn from each other, and to see how others have overcome problems.

Psychoeducation about their relatives' mental illness was particularly valuable to families, especially knowledge about medications. The groups also taught families how to contribute to rehabilitation by promoting treatment adherence and providing the ill relative with social and emotional support. One interviewee emphasized the importance of knowing what to do in case of an emergency (such as a relapse). The groups helped families improve their communications specific to dealing with the mental disorder, as well as in general.

Family members gave specific examples of impact from the groups, such as the following:

- *One family member described violent behavior by the adolescent client towards another family member. Through the MFG sessions, the family learned that medication adherence is critical for the family member's treatment. Once the adolescent was stable on medication, the violence stopped.*

- *A family reported having extended arguments on various topics, all of which started as a simple disagreement between the adolescent and one or more other family members. Through the group they learned to communicate more effectively, reducing the length and "emotional heat" of arguments. Also, their overall stress levels have gone down: "now we problem solve," the family member said.*

Other family members interviewed said that the communication skills they learned in the groups reduced stress considerably. The group helped them learn about symptoms and to build communication skills. They also said the groups helped families to remind themselves that they are not "the only ones", which has reduced stigma a good deal. Medication adherence as a result of skills learned in the group has led to greater stability of symptoms. Families have also learned that setting clear and constructive rules at home that are implemented in a consistent manner is very important for their ill relative.

Implementation challenges also were reported. Transportation and child care were barriers to participation in the groups, although the two mental health agencies were able to overcome these to a considerable extent (e.g., by providing taxicab vouchers and allowing other children of the family to be brought to the agency during the sessions). Scheduling of the group sessions during the week also was an issue for some of the participating family members.

Next Steps

In October 2009, a national convening was held in Baltimore at the offices of the Annie E. Casey Foundation, organized by the Foundation and the Human Interaction Research Institute. This convening brought together a small group of experienced researchers and thought leaders concerned with Latino mental health services. Its purposes were (1) to obtain input from funders, community leaders, practitioners and researchers about the Latino MultiFamily Group program; (2) to explore uses of the Latino MFG program with adolescent populations (including a discussion of the first two pilot implementations); and to (3) discuss issues about its evaluation and dissemination (including the program's sustainability, inclusion of a family member as group facilitator, and possible further adaptations of the Latino MFG program for use with children and with adult Latinos).
Input from this convening has been incorporated into the present edition of the Manual, and into ongoing pilot testing. The convening also helped shape a national dissemination plan that has evolved into a partnership with the National Network to Eliminate Disparities in Behavioral Health (NNED) and with the Latino Behavioral Health Institute.

A workshop on the Latino MFG program was presented at the 2010 Latino Behavioral Health Institute's national conference, and 18 mental health agencies expressed interest in learning more about how to implement the program. These agencies have since been contacted to participate in

an NNED Community of Practice (CoP) focused on the Latino MFG, which will be implemented in May 2011. The CoP will include an initial online orientation session, eight one-hour webinars to teach participating mental health agencies about the Latino MFG, learning materials available online, peer-to-peer networking through the NNED website, and technical assistance.

Among the ongoing challenges of dissemination for the Latino MFG program are how to:

- Make this Manual and its supporting materials available for wider use by mental health agencies and other community-based programs to implement with adolescent populations

- Synthesize evidence about the cost-effectiveness of the Latino MFG, as derived from the extensive implementation literature on this subject (since only four pilot implementations of LMFG have been completed so far, cost data are not yet available for the Latino MFG, though some qualitatively-based estimates can be made)

- Gather further evidence about the implementation and effectiveness of the Latino MFG, to supplement what was compiled in the 2009 and 2011 evaluation studies already mentioned

Another challenge is how to implement the Latino MFG in the face of increasing budget constraints in the public system for adolescent mental health services. One innovative strategy now being tested is to conduct the MFG program with family facilitators, supervised by professional clinical staff (as mentioned, one of the four pilot programs already implemented used family facilitators). Another is to shorten the program from the traditionally-recommended one-year length to six months (the PORT recommendation for adult schizophrenics is for six to nine months, so there already is precedent for shortening the duration of MFG).

The Larger Context

Like the Raising the Bar project mentioned earlier, the Latino MFG project is part of Valley Nonprofit Resources (VNR), a center which provides capacity-building information and assistance to the more than 4,000 nonprofit organizations in the San Fernando Valley region of Los Angeles (go to www.valleynonprofitresources.org for more information). One major goal for VNR is to help nonprofit mental health agencies and their staffs in the San Fernando Valley region learn about and implement research-based mental health practices such as the MFG for adults and the Latino MFG for adolescents.

SECTION 1
USING THE MANUAL

The research and pilot tests reported in this Manual make a strong case for the quality and impact of MFG, and for the promise of the Latino MFG program in work with families of adolescents with mental health problems. Combined with the learning materials produced by William McFarlane and colleagues, the Manual and three PowerPoint presentations described further in Section 5, the "raw materials" are available to implement the Latino MFG in a mental health agency.

But just like the truism that "insight does not necessarily lead to behavior change," having all these good materials does not guarantee that the Latino MFG *will* be implemented successfully. As with any other evidence-based practice, there are many implementation challenges, and still others associated with long-term sustainability of the program once it has been successfully operated in a given setting. Section 1 addresses some of these challenges in brief.

The first step in implementation is learning "the basics" about the Latino MFG program, and getting access to the learning materials described in this Manual. What follows may vary from one implementation to another, but the five main steps leading to successful adoption of the Latino MFG are likely to be:

1 - ***Reviewing information about the Latino MFG***, ideally supplementing written information by talking with leaders of one or more mental health agencies where this program has been implemented successfully.

2 - ***Making the decision to implement the Latino MFG*** in a new setting. Typically that decision involves both program and administrative leaders, since implementation will require use of scarce personnel and financial resources.

3 - ***Implementing the Latino MFG***, following the five steps described further in Section 5:

- *Conducting a needs and readiness assessment*
- *Conducting an exploratory presentation to staff*
- *Conducting staff training for facilitators*
- *Implementing the program*
- *Gathering data on process and impact*

4 - ***Reviewing process and impact data***, and making adjustments in the program as needed.

5 - ***Making plans for sustaining the Latino MFG program***, assuming results show that this is appropriate - this means planning and conducting additional program implementations in the same setting, as well as continuing the first implementation if desired by the participants (family members sometimes decide to continue a group long after its first six to 12-month running time has been completed, and to do so with their own resources and coordination).

The needs and readiness assessment may well reveal that there is a strong need for the Latino MFG and agreement among staff and administrators (and perhaps families in the community as well) about that need, but that there also is resistance to implementing the program. Some may question whether the Latino MFG program will work, others will be concerned about the burden implementing it will impose on already over-committed staff, and still others may be uncomfortable about investing resources in work with families when they are so scarce for direct services to clients. These resistances will need to be identified and addressed, or they may sabotage the program no matter how badly it is needed.

Second, there may be problems in finding the financial resources to implement the program. In many regions, mental health services, especially those for poor people and for minority communities, are facing constant budget cutbacks. Part of the readiness assessment is to determine where funding will come from – Section 5 includes some basic information on the costs associated with MFG. If public funding is not an option, resourceful agency personnel may look to local sources (religious institutions, community groups, foundations, businesses) to provide the funding for both implementation and ongoing operation.

For poor families and clients, Medicaid funding may be an option, and billing codes for reimbursement of Latino MFG costs are available (see Section 5). Arguments can be made about the cost reductions that have consistently shown to be likely with implementation of the MFG, to counter questions about whether such a program should be implemented at a time of fiscal constraints.

Finally, long term sustainability of the Latino MFG program may be an additional challenge, especially in a scarce-resource environment. Families and local policymakers may be encouraged to show their support for this program, and stories of success from families that have participated may usefully be gathered.

It is only with this kind of strategic thinking that a relatively new and not highly-publicized program like the Latino MFG can have the best chances for success. This would be true for any new, research-based practice in any area of intervention. Fortunately, mental health professionals (and families of adolescents with mental health problems) have a big step up – they already have experience dealing with resistance and anxiety around change, and may be able to take a more rational view about the work of change as a result.

The companion to strategic thinking, already mentioned in this section, is input from those who already have successfully implemented the Latino MFG program. This input should not be restricted to advice about planning and program design, as important as that is. It also can be very valuable in providing ways to address concerns of staff and families about the new program – in particular, by offering dramatic stories of success and practical examples of how problems were overcome.

As with all programs for working with clients or families, the information presented here is only advisory in nature and needs to be implemented with careful regard for the circumstances of actual families, clients and the communities they live in.

SECTION 2
ABOUT LATINOS IN THE UNITED STATES

This brief section is included to provide an overview of Latinos in the U.S. for non-Latinos involved with Latino MFG implementation needing basic facts and definitions, and as a "refresher" for all who will be implementing the Latino MFG, or making decisions about its implementation. Today, Latinos are the largest minority population group in the country. The millions of Latinos in the U.S represent one of the country's fastest-growing groups.

Non-Latinos often think of all Latinos as one people, and in some ways this is true. Still, since their roots are in a number of countries around the world, they are also diverse in attitudes, customs and behaviors. In this section, both similarities and differences among Latino communities are discussed, to provide context for communicating with Latinos about mental illnesses/disorders.

Population of Latinos in the United States

The term "Hispanic" or "Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race (for convenience, this Manual will consistently use the term "Latino"). The 2000 Census asked questions to more accurately describe the growing diversity of Latinos in the U.S. This revision is described in a 2001 Census brief concentrated on this population.[14]

The 2000 Census (the most recent national data until the 2010 Census results are published) identifies race and Latino origins as two separate and distinct concepts. Respondents had to identify if they were or were not Spanish/Hispanic/Latino and, in a separate question, respond to race. The race data can be collapsed into one of seven separate categories (White, Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander or some other race) or a combination of two or more races. Almost all respondents (98%) reported only one race.

At the time of the 2000 Census, a total of 281 million people resided in the United States, and 35 million, or about 13%, were Latino (that figure in 2010 is estimated at about 15%). According to the Surgeon General's supplemental report on mental health, culture, race, and ethnicity,[15] it is anticipated that by 2050, the number of Latino U.S. residents will exceed 97 million people, nearly one-fourth of the total U.S. population.

Differences within the Latino Communities

The two largest Latino subgroups in the U.S. in 2000 were Mexicans, who made up 58% of the Latino population. Puerto Ricans constituted 10%, and resided mostly in the Northern Central part of the country. South American Latinos made up about 12%, and Cubans about 4%.[16] The ten states with the largest percentage of Latinos in the state's population were New Mexico

(42%), California (32%), Texas (32%), Arizona (25%), Nevada (20%), Colorado (17%), Florida (17%), New York (15%), New Jersey (13%), and Illinois (12%).[17]

Individuals not born a U.S. citizen are considered "foreign-born." The foreign-born population of the U.S. is described in a 2003 Census brief.[18] The foreign-born population increased by more than half between 1990 and 2000, from 19.8 million to 31.1 million. More than 16 million or 52% of the total foreign-born population was from Latin America. Mexico, representing the largest number, accounts for 9.2 million people.

Latino Americans are a largely heterogeneous population with many between-group and within-group differences.[19] For example, some Mexican-born Latinos may call themselves *Mexicano*, Mexican American, *Chicano* or Spanish American.[20] The diversity manifested in the Latino population has been identified as a major cultural consideration related to mental health issues.[21]

Although large numbers of Latinos have resided in the U.S. for many years, there are increasing numbers of more recent immigrants, with immigration rates exceeding those of any other ethnic group.[22] Although Puerto Ricans are citizens of the U.S., they are less likely to be viewed or acknowledged as such than non-Latino Americans[23], and may be more likely than non-Latino Americans to be relegated to marginal status.[24]

Socioeconomic Factors for Latino Communities

According to the 1999 U.S. Census Bureau,[25] the per capita income for Latinos in 1999 was about $11,600, compared to $23,800 for non-Latino Whites. Previous research has identified low-income status, combined with lack of health insurance, as the greatest barrier to Latinos' ability to access health care.[26] Latinos' relative poverty (23% live below poverty level[27]) and lack of health insurance (35% lack coverage[28]) suggest that economic impediments to obtaining care for physical and mental health problems are great for many in this population.[29]

Research further suggests that "relative poverty," or comparatively low earnings in a high-income society, can also be detrimental to family structure and personal life.[30] Without a proper understanding of the difficulties faced by those living in poverty, clinicians may incorrectly pathologize members of low-income populations. Clinicians need to be aware of, and carefully consider, the socioeconomic contexts facing families from different cultures, especially if these contexts involve hardship.[31] Behaviors resulting directly from poverty, which large percentages of minority populations must face, have the potential to mistakenly be designated "mental illness" or "mental disorder."[32] Research also suggests that mental health professionals need to guard against stereotyping based on socioeconomic and other key demographics.[33]

Mental Illnesses in the Adult Latino Population

While the focus of this Manual is on Latino adolescents, a brief overview of mental illnesses among Latino adults is presented to provide context. Most of the studies conducted to date of mental health problems among Latinos have been regional in nature or concentrated on just one national group. The National Latino and Asian American Study (NLASS) was the first

nationally representative study of English- and Spanish-speaking Latinos to compare lifetime and past-year prevalence rates of psychiatric disorders (half of all subjects were interviewed in Spanish). NLASS found lifetime psychiatric disorder prevalence rates among Latinos of 28.1% for males and 30.2% for females. Of the various sub-groups in the study, Puerto Ricans had the highest overall prevalence rates. Prevalence rates were higher among those Latinos who were born in the United States, those who were proficient in English and third-generation Latinos.[34]

A second national-sample study, the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) found that Mexican-Americans and foreign-born non-Hispanic Whites were at significantly lower risk of substance use and mood and anxiety disorders, compared with their U.S.-born counterparts.[35] Such findings stimulated interest in understanding more about the impact of acculturation on mental health disorders, for both adolescents and adults.

In 2001, *Mental Health: Culture, Race and Ethnicity* was released as a supplement to the 1999 Surgeon General's report on mental health.[36] This supplemental report focused on the role of culture in mental health, and highlighted disparities experienced by racial and ethnic minorities.

For example, numerous cited studies suggested that members of minority racial/ethnic groups on average are less likely to seek mental health services; stay with these services for a shorter period of time; and report being less pleased with them. Minority group members have lower engagement, retention, and satisfaction rates due to poorer access to care, but also due to lack of trust in providers and the mental health system, which they experienced as incapable of responding to cultural considerations that are important to them.

The report concluded that "treatments need to be tailored and delivered appropriately for individuals according to age, gender, race, ethnicity and culture." More specifically, the report suggested that "Mental health workers—including clinicians, administrators, program leaders, and public mental health authorities—should therefore become culturally competent in addressing factors that may affect minority racial and ethnic group members' access to and quality of treatment."

In the report, cultural competence was defined as "the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values." Although evidence-based practices are those that have been demonstrated over time to be successful with a variety of populations, it is well known that these practices are usually not tested in particular cultural groups before they are implemented. Given that significant cultural differences exist that may affect the access to and implementation of evidence-based practices as indicated above, then programs targeted to ethnic minority groups should adjust these to make them accessible and effective for cultural groups that differ from the original study populations. These findings all contributed to the development of the Latino MFG program.

SECTION 3
ADDRESSING CULTURAL AND LANGUAGE CHALLENGES FOR LATINOS IN FAMILY PSYCHOEDUCATION

Eight challenges of language and culture have been identified that apply whenever Latino families are included in family psychoeducation activities like the Latino MFG. The challenges are summarized below, followed by more detailed suggestions for how to deal with each one. These suggestions are given for educational purposes only; all interactions with family members need to be conducted in keeping with agency and community standards of practice.

- **Challenge 1 - Language barriers** *For Latino families who do not speak English or for whom it is not their primary language, getting involved in their relatives' service programs can be challenging.* This is why it's essential to begin by asking questions. What language differences are families experiencing – not only with reading or speaking English but also with understanding Spanish-speaking Latinos from other countries? What is the best way for families to discuss language barriers, particularly with regard to mental health services? (Language barriers also may exist regarding the "language of mental health" in the treatment setting, terminologies for symptoms and services may be unfamiliar to many.)

- **Challenge 2 – Level of acculturation** *Immigrants face special challenges if they are new to the U.S., or if they have not adjusted to the new culture in which they live.* Also, adolescents acculturate much faster than adults. Some questions to ask related to acculturation: What is the family's heritage? How long have they been in the U.S.? How are they adjusting and adapting to U.S. culture? How is the family dealing with their relative's mental disorder, especially if family members are not accustomed to mental health services as delivered in the U.S.? How do families handle stresses associated with the disorder in ways that fit with their culture?

- **Challenge 3 – Beliefs and perceptions about mental disorders** *Many Latino families have strong beliefs about mental disorders, (who is to blame, the role of faith healers, community and cultural values).* Some questions to consider: What is the best way to deal with strong beliefs about mental disorders? If certain misconceptions can be allayed, is it then possible to remove any sense of *verguenza* or shame associated with it? What terminology is best used to clearly communicate? What is the best way to handle beliefs in voodoo or *brujería* and working with faith healers?

- **Challenge 4 – Beliefs and views regarding medication** *Every day there are new reports on which medications are effective and which ones are not – and especially for adolescents, whether medications are even appropriate for treating certain disorders. For Latinos who may be unfamiliar with current medical knowledge, it's essential to examine how medications are viewed.* Questions to consider: How can a family best understand the role of medication in treating mental disorders? What is the best way to teach proper use of medication so that it is not abused or improperly shared? What

misconceptions do family members have about how medications interact with other forms of treatment?

- **Challenge 5 – Attitudes and beliefs about mental health practitioners and services** *It may be difficult to put complete trust in mental health practitioners if there is uncertainty about their practices and prescriptions. Again, culture plays a role. For immigrant Latinos living in a new country, speaking a new language, the challenge is even greater. Issues of mistrust and relationship need to be addressed, particularly regarding support for the program.* Since trust is a key factor of sharing personal information, what is the best way to earn it? What is the best way to become aware of reasons for insecurities Latinos have in this area? How can traumatic events be discussed in a safe way?

- **Challenge 6 – Family structure and support** *Within Latino communities, there is a strong sense of support for and from family. Family members, especially those living in a new culture, may not feel comfortable sharing what has and has not worked for them. Their willingness to talk about family issues relies heavily on trust and open communication with mental health practitioners.* What is the best way to discover how families have been let down by previous systems, and how this affects their apprehensions about MFG? Is there simple language that will help families deal with practitioners? What is the best way to discuss support for families, their friends, their culture and expertise? How can practitioners respond to family time constraints? What roles do family hierarchy and the extended family typical in the Latino family play?

- **Challenge 7 – Community points of view** *Mental health practitioners need to become familiar with the family's community, talk openly with people, help them to be comfortable with discussion; and demonstrate interest in their culture and understanding of their issues (including adolescent peer groups).* What is the best approach to outreach within the Latino community? How can practitioners most successfully demonstrate genuine interest in and understanding of Latino community issues?

- **Challenge 8 – Latino families with few economic resources** *When families do not have a lot of economic resources, they are limited in what events they are able to attend that go beyond immediate, necessary functions. Issues include time, transportation and childcare.* Before planning meetings, what is the best way to determine who will come? How much time and money must families expend – and can they afford to do so? Do they have small children who might need child care while they participate in groups?

Challenge 1: Language Barriers

Language barriers take different forms, and so do the interventions that can help reduce them. In this sub-section the following specific topics are addressed:

- *Regional and generational differences*
- *Varying educational levels and language proficiency*
- *How services are provided*

- *Language and protocol*
- *Telephone behavior*
- *Professionalism and personal connection*
- *Awareness of family hierarchy*

Regional and generational differences Within the diverse Latino community there are likely to be regional and generational differences, for instance, among those born in the U.S. and those born in Mexico, Central South America, Spain or other locations. These create language barriers due to differences in use of idioms or other expressions of the common language.

Figuring out the language to be used in workshops is not simply a matter of translation; key words are sometimes used differently across subpopulations (e.g., *pena* means "sorrow" in Puerto Rico but "shame" in Central America; it can also mean "pain" or "penalty"). It helps to ask clinicians from the culture in question to help translate. And it is important to be aware of linguistic variation among subgroups, as well as such common sayings as: *Que sea lo que Diós quiere* (It is in God's hands), or *Esto es una prueba o una causa* (There is a reason for this; this is a test I had to go through).

Good practices

- Be aware of these generational, national, and individual differences, particularly during group sessions where multiple recipients and/or families meet for support or problem-solving activities
- Be sensitive to language distinctions, including clarification and validation of regionalisms
- To ensure respect and understanding, be cautious about using colloquialisms and dialects employed by Latino subgroups
- Make staffing decisions with awareness that clinicians need to be bilingual, culturally competent, and, if possible, indigenous to the culture of the recipients with whom the clinicians will be working[37]

Varying educational levels and language proficiency Sometimes Latinos have difficulty understanding written materials for a number of reasons – familiarity with language, cultural distinctions, or lack of formal education. Some acculturated Latinos do not speak Spanish fluently, but many nonetheless function bi-culturally in that they frequently interact with both Spanish and English speakers.

Good practices

- In developing translations of treatment materials, ensure that the materials are both linguistically accurate and culturally relevant for Latinos; allow flexibility for improved adaptation
- Assess family member language proficiency before beginning treatment, to determine whether they speak English well enough, or therapists speak Spanish well enough, for families and therapists to work together[38]
- Accommodate the level of language used to the educational level of the participants (e.g., elementary school-level Spanish may be appropriate in some cases)
- When running groups, consider a variety of language preferences, both monolingual and bilingual

- Use simple language and avoid medical jargon (this applies regardless of which language is being used).
- Be sensitive to the verbal and reading abilities of participants so that no family member feels ashamed by being unable to understand the discussion or to read; this kind of reaction can easily prevent people from returning (one strategy may be to assume everyone can't read so that all information is presented, or at least summarized, verbally)
- Be aware that audio versions of handouts can be distributed, but are useless and can produce shame if the family does not have a suitable player for them

How services are provided All too often, a situation is not assessed to determine whether or not the language spoken is being fully understood. For example, speech difficulties or silence may be related to a lack of understanding English and not be related to a mental health problem.[39] Many Latinos have had negative experiences with doctors or other service professionals who do not speak Spanish. If programs do not seem sensitive to these language needs, mistrust can be the result.

Good practices

- Assess whether or not an interpreter is required - Latino adolescents may provide translation services for monolingual parents, which tends to keep the parent isolated from the service system, and also may place strain on the adolescent; if possible, independent interpreters should be provided
- Post a bilingual greeter at the door to help new families
- Make sure staff members are committed to being helpful to families
- Specify the rules about confidentiality related to families and their adolescent family member
- Use an "interception" strategy; that is, spontaneously greet families as they come into the agency's lobby
- If a family complains about bad treatment, take the complaint seriously and follow it up to determine what action to take, if any, and then inform the family

Language and protocol Most cultures have standards for proper address and language choices related to them. A lack of knowledge of these formalities can cause embarrassment and sometimes mistrust.

Good practices

- Be conscious of the varying levels of familiarity a family may expect based on their cultural background and experiences
- Remember that in the U.S. speakers tend to be very casual and address people immediately by their first names; in almost every other culture, there are specific forms of address for various family members, and for meeting people for the first time
- When first introduced, remember that it's always safe to address a family member by using Mr., Mrs., Ms. or Miss (*Señor, Señora, Señorita*) followed by a person's last name; this formality is best continued until an agreement for more familiarity is mutually established
- Make an effort to use the formal "you" (*usted*) rather than the informal, more familiar "you" (*tu*) at first; and to use surnames until directed otherwise

Telephone behavior There is only one chance to make a first impression. The first phone call to or from a family member is important. Greater effort may be required to overcome the consequences of mismanaged first contacts, and on occasion relationships have been lost due to improper phone behavior.

Good practices

- Begin a phone call by asking, "Is this the Rivera family?", and then ask for a family member
- If the person contacted is not a key support person like a parent, do not reveal any information about the client; ask that the key support person come to the phone
- If the person who answered the phone wants more information on the reason for the call before summoning the requested family member to the phone, emphasize that this is not a commercial solicitation, that the call is important and politely ask that the requested family member come to the phone
- When the appropriate family member is on the line, state exactly the reason for the call

Some good telephone practices for predominantly Spanish-speaking clinicians:

- Begin the conversation by using the more formal address — *Señor, Señora, Señorita* Rivera and *usted* (you)
- Later on in the conversation, if appropriate, switch to the more familiar – Don or Doña with the first name, e.g., Don Hector or Doña Maria, but be cautious about using first names only, and continue to use *usted*
- Do not use the first name alone or *tu* (you) on the phone, since these are both informal: Wait until there is a face-to-face meeting and more familiar terms with the family members have been developed

And some good telephone practices for predominantly English-speaking clinicians:

- For clinicians whose first language is English, consider simply using Mr. and Mrs., since families may not be expecting them to use Spanish titles or terms (the exception might be if a predominantly English-speaking clinician is speaking in Spanish with an elderly family member whose primary language is Spanish)
- Since certain Spanish words have different connotations across subgroups, consider offering some type of clarification or example for critical words or phrases

A checklist for guiding initial telephone calls, summarizing and extending some of these tips, is presented on the next page.

Checklist for Initial Outreach Phone Call

1 - Ask the adolescent client to suggest one family member who can act as a key support person, and telephone that person.

2 - When calling, identify self as a counselor who is helping the adolescent client.

3 - Note to the family member that this call follows a conversation recently conducted with the adolescent client, in which the client indicated that it is okay for the person to be contacted.

4 - Explain the purpose of the call – to discuss the possibility of the family participating in a new family education program.

5 - Mention that the client is interested in this new family psychoeducation program, and has requested family involvement.

6 - Briefly describe the program: It has an educational focus, involves learning about the client's disorder, ways the family can help, and how the family's involvement can increase the client's coping ability and chances for recovery.

7 - Specify that many families have found this program to be helpful, and that it is well established, though it has been used more with adults than with adolescents. This is one of the first programs for Spanish-speaking families.

8 - If a family information night is scheduled, ask if the family would be willing to come to an information night at the mental health agency to learn more about the program and how it might help their loved one.

9 - Ask to speak to any other family members the client has identified as key support people.

10 - Repeat steps 2 through 8 for these additional family members.

Note: If an information night event is held, but family members are not interested in attending, schedule an initial session, individually, with only one or more additional family members, to describe the program in greater depth.

Professionalism and personal connection The relationship with a family always needs to be professional, but there are opportunities to make the connection more personal. Sometimes a decision may need to be made as to what may be considered over-the-line in terms of a personal relationship. Once a bond is established with the family, a certain degree of "closeness," (both physical and emotional) as well as an informal style, is both the cultural norm and the more effective therapeutic approach.

Good practices

- To help establish *personalismo*, emphasize the role of the clinician as a helper for the family's loved one rather than as a representative of a mental health center or other type of institution. (But be aware that there are certain boundaries and comfort levels that need to be observed)
- Make sure that the level of closeness achieved (eye contact, hand lightly on the shoulder to show support, etc.) is perceived and understood by families to be helpful, proper and always professional
- Help families work to convince the adolescent that their participation in the MFG session is desirable; challenges in this regard are dealt with in the joining session (see below)

Awareness of family hierarchy Within many Latino cultures, there is a traditional family hierarchy. Specifically, the father is the head of the family. Sometimes it may be difficult to create a relationship with the family if this hierarchy is not recognized.

Good practices

- Respect the possible patriarchal structure of the family
- If a male answers, and a female is the party being contacted, explain the reason for the call (unless there are confidentiality concerns) before even requesting that she come to the phone
- Talk further with the male if he has questions

Challenge 2: Level of Acculturation

Level of a family's acculturation has an impact on the MFG process in at least two ways, which are addressed in this sub-section:

- *Understanding of mental disorders and associated stresses*
- *Addressing cultural issues*

Understanding of mental disorders and associated stresses Less acculturated Latinos may have difficulty recognizing symptoms of mental disorders, such as depression in adolescents, and as a result these adolescents may use mental health services less often. Also, in cases where inpatient treatment has been needed, some may equate a discharge with full recovery.

Some of the stresses that may affect some immigrants are adjustment to an unfamiliar environment; lack of understanding of the U.S.; living in an uprooted/weak support system; lack of opportunity to speak Spanish; downward occupational mobility; changing general roles; and a loss of self-confidence.

Good practices

- Increase knowledge, engage in education and outreach efforts in Latino communities regarding symptoms and services, so that those less accustomed to their current culture can learn
- Conduct outreach when treatment is completed, so that every Latino family understands that there is a suggested ongoing process to utilize - and benefit from - once a loved one has finished receiving services, or has been discharged in the case of inpatient services
- Explore these stresses individually, helping the family understand how they fit with their overall family circumstances, and what options they have for addressing them

Addressing cultural issues Acculturation is a social process in which people's attitudes, beliefs and behaviors change as a result of moving from one culture (the one they were born in, or that is the culture of their parents or other relatives), to another one in which they now live. Two main theoretical frameworks have been developed to describe what happens to individuals and families during the acculturation process. *Assimilation theory* holds that individuals tend to lose much of their original cultural identity as they identify with the culture they now live in. *Alternation theory* says that individuals can be bi-cultural – that is, they can retain their original cultural identity while establishing a positive relationship with the culture they now live in.[40]

There is tension within the Latino population between those of foreign birth who often see themselves as temporary guests in the U.S., and their descendants, who are born in the U.S., are acculturated with the norms of broader U.S. society in public schools, and are not motivated by the same ties that bind the migrant generation. This creates a "niche" of descendants of immigrants who are full-fledged U.S. citizens, but who typically do not get access to all the rights and privileges of citizenship. This is both because of the strong cultural identity resulting from their upbringing, and the discriminatory reaction of the majority population against a non-assimilated and easily identified sub-population.

This group of people feels a great need to distinguish itself from both its U.S. environment and its "mother culture." They believe they are a unique set of people, who endure both strong ties and strong discrimination from both U.S. and foreign mainstream parent cultures. There are often similar generational divides of Latinos from other countries.

Much has been made of the differences among Mexican-Americans, Cuban-Americans, Puerto Ricans, and other sub-groups within the Latino population, but it is also crucial that recognition be given to intra-subgroup differences, in terms of level of acculturation, socio-economic status, English language proficiency, religious affiliation and spirituality, and rural or urban background. For example, the superficial similarities between a Salvadoran peasant who recently arrived in the US illegally and the middle-class refugee who fled Cuba 35 years ago (both ostensibly fleeing political repression) are likely to be far outweighed by differences in level of education, economic opportunities, level of acculturation and political circumstances, to name a few. Similarly, a first generation Mexican immigrant who grew up in a rural village is likely to share little cultural identity with a Mexican-American rancher whose family has been in the US since before the establishment of this country.

Family members may also have to deal with acculturation issues specific to the adolescent client. For example, it can be difficult for teenagers to "fit in" under the best of circumstances, and this

is made more complicated if they come from an unassimilated family but have friends and classmates who are well-assimilated. As mentioned above, there are competing theories about the impact of living in two cultures simultaneously - at the least, clinicians need to be sensitive to the realities for a particular family and for the adolescent client.

This can be even more complicated in the fairly typical multi–generational Latino family. The adolescent may be well-acculturated and speak mostly English, his or her parents somewhat less so and mostly Spanish-speaking, and the grandparents still unassimilated - with parenting styles that reflect the "old culture" as well.

Good practices

- Get basic information about the family's cultural origins
- Find out whether families come from urban or rural environments, and about the education and occupations of family members
- Look for signs that some family members are not familiar with the mental health system, and may need information or orientation to the services the adolescent client may receive
- If needed, take time to explain the basics about health insurance, how coverage works for their particular situation, and the best ways to assess what services may be helpful
- Before moving forward, take time getting to know where the family is culturally

Challenge 3: Beliefs and Perceptions about Mental Disorders

Every culture has its own set of beliefs and perceptions about the nature of mental disorders and how to treat them. In this sub-section the following specific topics are addressed:

- *Perception about the origins of mental disorders*
- *Choice of language used to describe mental disorders*
- *Respect for folk and faith healers*
- *Practicing ongoing prevention*

Perception about the origins of mental disorders Some Latino families and consumers have been found in research studies on this subject to hold negative and stigmatizing views about mental disorders. These views often are complicated by lack of knowledge about mental disorders and their origins. Latino family members often use the term *nervios* (nerves) to describe a relative's disorder. In fact, *nervios* is a common way to conceptualize suffering in general. Stress from working, poor diet or excessive studying often are cited as causes of mental disorders by Latino families.

Some families believe they should ignore the symptoms until the person "comes out" of it; and still others, that their family caused the mental disorder, perhaps by spoiling a child. Some families also define the symptoms of mental disorders in negative terms, for example seeing them as a sign of "laziness." Of course, many of these beliefs are common in the general population as well, as is lack of knowledge about the biological basis of mental disorders like depression.

Good practices

- Emphasize that no one who has a mental disorder deserves personal blame for being ill
- Also stress that the family is not to blame
- Explain some basic biological aspects of mental disorders like depression or conditions like ADHD, carefully using language that is non-stigmatizing (see next section)
- Before commenting about family members' views, validate their feelings

Choice of language used to describe mental disorders Sometimes clinicians may use diagnostic terms that are quite foreign and even threatening to a family upon first contact. This can result in the family leaving the MFG session or leaving the service agency entirely.

Good practices

- Emphasize the role of biological factors in some disorders, such as depression
- Suggest that there is hope, and that solutions for dealing with the disorder are possible and workable
- Consider referring to the loved one's "nerves" or *nervios* when doing outreach or first meeting with families
- Gently disagree if the term *locura* or "craziness" is used to describe the disorder
- Emphasize that the disorder is an "emotional problem" — *problema emocional*

Within the context of a relationship with providers, as well as ongoing education about mental disorders, many families are actually relieved to hear that the problem is something like depression or ADHD, because, at last, they can identify the problem and hopefully take action to correct it.

Respect folk and faith healers Some families believe symptoms are the result of voodoo or *brujería* (evil spirits), although this may be common only among poor families. Still, some families seek alternate sources of treatment such as with *santeros* — folk or faith healers.

Good practices

- Acknowledge basic respect for everyone's spiritual beliefs
- Do this in a way that shows an understanding of these beliefs rather than an affirmation of them
- In a workshop, begin with a brief discussion acknowledging some of these beliefs before moving into a discussion of mental disorders
- Work with *santeros* if they are part of the family's situation, and reassure them that no power will be taken away from them
- Ask *santeros* to work together to encourage clients to adhere to treatment that will help the client, along with the practice of their spirituality
- Say to the *santero*, "We understand and respect the culture and the role of the *santero*. We do not wish to interfere with this, but instead offer a process in which everyone can work hand-in-hand, to help people overcome their problems"
- Be sure to discuss spirituality with families if they do not bring it up
- Strongly consider adding a section to any educational workshop for families about alternative remedies, including faith healing

- Integrate spiritual with biopsychosocial perspectives - which provides a broader, more encompassing view of the world

Practicing ongoing prevention If a client improves, the family may not believe further prevention efforts are necessary. So the facilitator needs to emphasize the importance of prevention, both to maintain current progress and to deal with new stresses and challenges as they come up.

Good practices

- Encourage families to maintain their preventive strategies
- Ensure that educational materials are provided to emphasize the importance of continuing treatment, even when the adolescent is doing well
- Anticipate the possibility of dropout or discontinuation when an adolescent is doing well; try to prevent it
- Teach families to learn how to identify early warning signs of relapse

Keep in mind that not all families recognize the symptoms of mental disorders or the likelihood of ongoing treatment to keep the adolescent client stabilized. Anticipate the challenges, and prepare to meet them.

Challenge 4: Beliefs and Views Regarding Medications

Cultural issues may affect how medications are regarded (*Note:* many adolescents with mental disorders do not require medication, but a substantial number do*).* In this sub-section the following specific topics are addressed:

- *Discussing ramifications of mental disorders for medication*
- *Dealing with use of folk remedies or non-prescribed medications*

Discussing ramifications of mental disorders for medication Many families believe that a mental disorder is similar to a medical problem, so that it can be quickly treated and/or cured. Also, some families are uncomfortable bringing up the topic of medication compliance. On the other hand, some family members may be quite interested in hearing about how medications and their side effects may be different for their group (Mexican, Puerto Rican, etc.) than for the population at large.

Good practices

- Teach families that mental disorders often are similar to a long-term, persistent medical condition such as diabetes — one that may not be curable and one that requires extensive and ongoing prevention efforts to keep symptoms under control
- Ask questions in a respectful fashion about medication compliance – including what if anything the family does to promote compliance for the adolescent client, as well as what the client may do for him or herself

- Become familiar with medications used with adolescents so that if asked any questions, clear, intelligent responses will be easy to provide (referral to a psychiatrist can be made if the question is more complicated – or a note can be written to ask the adolescent's current psychiatrist a question)
- Consider bringing a psychiatrist to an educational workshop to discuss the specifics of medication
- Offer materials that explain issues surrounding medication in a simple and direct way

Dealing with use of folk remedies or non-prescribed medications Folk healers may offer consumers herbs, teas or other substances to help treat mental or physical problems. Also, families sometimes take prescribed medications without medical authorization and share medications within their social networks.

Good practices
- Make sure that substances an adolescent receives from folk healers will not interact with prescribed medications in negative ways; ask families what medications, if any, the adolescents are taking, to find out everything they are using
- Help families seek assistance from a psychiatrist if there are questions about how medicines and non-prescription substances can harmfully interact with one another

Challenge 5: Attitudes and Beliefs about Mental Health Practitioners

Similarly, different cultures have varying beliefs and attitudes regarding mental health services and the people offering them. In this sub-section the following specific topics are addressed:

- *Addressing concerns about use of personal information*
- *Accentuating the positive*
- *Teaching families how to communicate with clinicians*

Addressing concerns about use of personal information Some Latinos have strong concerns about possible misuse of personal information. These concerns may have resulted from being in a country different from their point of origin. They may also result from experiences in their home countries where governments curtailed free expression, or traumatic experiences of torture and/or imprisonment.

Good practices
- Be aware that minority status may have created a sense of insecurity among some Latinos
- Be prepared to spend time and energy earning families' *confianza* or trust, and *respeto* or respect, before trying to obtain information from them
- Be aware that Latino community members especially value clinicians who have knowledge of their personal cultural identity and needs
- Assess past experiences of traumatic events, especially those that could have been misdiagnosed; make a referral if appropriate

- Be sure to provide assurance regarding confidentiality, and also to honestly discuss the limits of confidentiality and "gray areas," such as with legal reporting duties that mental health workers have
- Show sensitivity to larger issues, especially for Latinos who are not fully acculturated to American practices and attitudes about mental health services. It is critical that facilitators show they are aware that their services are offered in a larger context for both the family and the adolescent. Some adolescents or families may drop out of treatment due to stressful life events that have nothing to do with mental health problems, e.g., a relative (sometimes a principal caretaker for the adolescent) who is deported or voluntarily returns to their country of origin. Economic realities such as the need to work may also limit availability to participate in services
- Be aware that there generally are higher dropout rates from services for Latinos, and be alert for signs that dropout might happen
- Be sure to incorporate Latino customs and values into dealing with the issue, if raised by the family or adolescent treatment programs

Accentuating the positive A strong cultural norm among Latinos is to respect experts – including being attentive, listening closely, and waiting for them to start any discussion and ask appropriate questions. This may lead to some reluctance on the part of families to initiate a discussion. But it also means that family members will be able to hear basic information, and will participate if encouraged to do so in a positive way.

Teaching families how to communicate with clinicians On the other hand, some families have had negative experiences with the treatment system – or are new to mental health services and simply don't know how to communicate with the group facilitator or other mental health professionals. For them, a little skill development and gentle encouragement will go a long way towards helping them become effective communicators within the MFG sessions.

Good practices

- Teach family members how to talk to clinicians about their loved ones — what questions to ask and what language to use
- Families may find this intimidating at first, so begin with a small step that will likely be successful for them
- Initiate discussions with families
- Ask specific questions
- Establish a teacher-student-like relationship (but realize that the "students" can teach the facilitator a lot about families and their experiences!)
- Explain things at families' level
- Ask families for feedback
- Repeat information in order to solidify the partnership

Some Latino families may interpret frequent "check-ins" by clinicians as empathic, and not bothersome. Consider periodically calling and checking up on families participating in a group, which may help the bonding process. Also consider calling group members the night before each multifamily group to remind them to attend, at least at the beginning, and emphasize that each family member is an important part of the group.

Rather than emphasizing the role of the clinician as a representative of an institution, emphasize the role of the clinician as a helper for the family's loved one. Let families know if other services such as counseling are available for them at the agency offering the MFG program.

Challenge 6: Family Structure and Support

Particularly because of the importance of the family in Latino cultures, there are many opportunities for the family to be positively engaged in supporting the adolescent client, and is participating actively in the MFG process. In this sub-section the following specific topics are addressed:

- *Creating a team environment*
- *Promoting a safe, respectful environment*
- *Encouraging a proper emotional living situation*
- *Exploring both family and friends as a support team*
- *Dealing with patriarchal structure/machismo*
- *Acknowledging family expertise*
- *Balancing the personal with the professional*
- *Maintaining awareness of family time constraints*
- *Clarifying the role of family and the role of staff members*
- *Being realistic about the mental health system*

Creating a team environment Clinicians who run multifamily groups typically have found few tensions among families, even those from different subpopulations, but some actions may be needed to facilitate healthy teamwork within the group.

Good practices

- Focus on what families have in common - the mental disorder of their adolescent family member
- Point out and help families recognize the commonalities among them
- Reframe considerations or problems that are being discussed to include everyone in the group
- Focus on group efforts to solve family problems

Promoting a safe, respectful environment There may be differences in cultural and generational orientation among members of a single family. Families may not immediately feel comfortable discussing their problems with, or disclosing personal information to, strangers for a number of reasons. One of them may be that families are concerned about *orgullo* or pride, and may prefer handling private issues with family or friends before talking with outsiders. Family members may feel uncomfortable about putting themselves "ahead" of the loved one who is in need of help.

Good practices

- In approaching family members about their loved one's disorder, consider differences in acculturation and attitudes about intergenerational respect
- Create emotional safety for families

- Give families a place where they feel they can talk freely – establish a climate of acceptance and tolerance
- Make it clear to families that the program focuses primarily on their loved one's goals and needs – and that participation may also help the family
- Emphasize the many positive outcomes to the adolescent client
- Add that their loved one will be helped and that they, too, will be helped by the fact that their loved one is being helped

Encouraging a proper emotional living situation It is essential to reduce the level of expressed emotion in the family household. For some adolescents, this may include having a private space in which to withdraw. However, to some extent this reflects a "middle-class" assumption. Many poor families live in crowded households or have several generations of people living together, so this may not be materially possible.

Good practices

- Discuss the kind of living environment that the family prefers; explore how privacy is valued
- Consider creating activities that provide an appropriate emotional environment
- Keep in mind that Latinos generally experience a great degree of "familism" — a strong connection and loyalty to family
- A high level of family warmth has been found to reduce relapse rates among Latino populations; keep this in mind when focusing on expressed emotion
- Rather than attempt to show expressed emotion as criticality or hypersensitivity, focus on enhancing and improving family bonds within the family

Exploring both family and friends as a support team Sometimes there are barriers associated with family participation in a loved one's treatment, and friends (particularly from the adolescent's peer group at school or in the neighborhood) can be a desirable alternative or supplement.

Good practices

- Rather than assuming who might be best to join a family group, ask whether a grandmother, or an aunt or even a close family friend should be part of the group?
- Remember that the people who are most important to the family and to the adolescent client are the best people to invite
- Acknowledge the role of extended family in Latino communities — grandparents, aunts and uncles, cousins, godparents — and their potential to support treatment; talk about how to integrate these family members into the Latino MFG process
- If family obligations and responsibilities make it difficult for them to get involved, explore others who are available

Dealing with patriarchal structure/machismo Within many Latino families, there is a definite patriarchal structure, wherein the oldest male in the family is the one in charge, the one who represents the rest of the family.

Good practices

- Respect the family hierarchy — for example, address the father or other adult male in the family first, if he seems to be positioned as the main representative of the family
- Even when there are more females than males in the group, which is common, take care to show full respect to the men in the group, especially if they are in the minority

Acknowledging family expertise Many families believe – with justification! - that they are experts about their loved one's disorder, because they are the ones who live with this person. Clinicians can acknowledge this in a number of ways.

Good practices

- Rather than overemphasize clinician expertise or authority to family members, acknowledge family members' expertise in living with and caring for an adolescent with a mental disorder
- Express a personal desire to simply help the family handle the treatment of their loved one and help relieve them, as much as possible, of the stress involved
- Remember that some Latino family members perceive it to be *their* role to support their loved ones; family involvement is consistent with this role, and can be promoted by emphasizing support for a loved one

Balancing the personal with the professional A family's role in treatment may be positive or negative — there is no way to know which it will be until work begins. Close family involvement may influence treatment in a number of ways, ranging from being negatively hypercritical or overly sensitive to being positively supportive and loving.

Good practices

- Validate families' suffering or their experience of the burden, if they are the ones to bring these up
- Feel free to express warmth, genuineness, concern, empathy, and interest in people's personal lives, while behaving in a professional manner
- Be aware that some Latinos prefer being physically close to another person when interacting — sitting closer and leaning forward to indicate interest in their conversation partners; anyone not accustomed to this may tend to lean backward, away from the person; (it is best to stay close if this person initiates this closeness)
- Be cautious about appearing to be too pushy or forceful
- Use the group to deal with a hypercritical or overly sensitive family member

Maintaining awareness of family time constraints There are a number of reasons for a family's lack of participation in a program. Exploring these sensitively and helping to deal with them is an important part of engaging the family.

Good practices

- Proceed slowly; and give families time to decide if they want to participate
- Make follow-up calls
- Consider offering a home visit to discuss the program in more depth, and realize that families may understand this as a sign of respect and genuine interest in the family

- Demonstrate awareness that families have busy schedules and conflicting priorities, which are respected and appreciated
- A family's failure to become immediately engaged does not necessarily reflect a lack of interest in the program
- While practical barriers may prevent some people from becoming engaged in the ongoing process, be sure to provide language-appropriate materials, to ensure that whatever involvement and time they can afford is more easily attained

Clarifying the role of family and the role of staff members Family members often are confused about what they should be doing and what clinicians should be doing as part of the treatment and recovery process. Helping them clarify appropriate roles on both sides can be very helpful.

Good practices

- Discuss with staff and group members the importance of encouraging all family members to speak up, rather than one person in the family speaking on behalf of another (presumably all present in the group will be fluent enough in Spanish that translation will not be necessary)
- This emphasis on speaking up must be done, especially when face-to-face with families, in a respectful way, acknowledging every family's purpose for being there
- Sometimes the facilitator may ask the adolescent to speak first, if he or she has seemed hesitant to speak up

Being realistic about the mental health system What the MFG program and other services can and can't do for their family member needs to be communicated honestly to the family. If results are overpromised or the program is made to seem responsible for outcomes that are not really likely to occur, the result can be unwillingness to participate.

Good practices

- Emphasize to families, with great care, that this program is not family therapy - it is different from other programs they may have tried and that it seeks to benefit both the adolescent client and the family
- Emphasize concrete, practical advantages to participation - such as fewer behavioral problems, improved medication adherence and generally improved quality of life at school and home
- Rather than focusing on recovery and therapeutic aspects of the program, emphasize the educational and problem solving aspects instead
- Remember that not everyone may see the program as a priority; however, the ability to communicate the program's value may be the primary reason families are persuaded to participate
- Encourage family members that have already been involved in an MFG program themselves to serve as "ambassadors" to introduce the concept to other families initially. Also encourage adolescents whose families have participated in the MFG program to help recruit other families

Challenge 7: Community Points of View

Programs like MFG depend upon larger community support to be successful. In this sub-section the following specific topics about community engagement are addressed:

- *Conducting community outreach*
- *Demonstrating interest and understanding*
- *Getting creative with time*

Conducting community outreach Before beginning to plan and implement an MFG program in a Latino community, local clinicians should consider conducting outreach efforts first.

Good practices

- Advertise family-oriented events at the mental health agency, such as informal events with refreshments that offer a speaker talking about a mental health-related topic of broad interest
- Hold a "Latino Day" at the agency or in the community
- Ask for help in these efforts from trusted and respected individuals in the community (these can be identified by Latino staff members who live in the community)

Demonstrating interest and understanding Because many Latino cultures have social norms about inducing shame for transgressions, special care must be taken to avoid confronting Latino families in a way that could induce shame in terms of their role in the larger community.

Good practices

- Demonstrate an inquisitive, concerned, empathic stance
- Work toward discovering and understanding real problems and working on their resolution
- Inquire about a missed appointment instead of blaming anyone
- Train members to phone ahead when they cannot make an appointment

Getting creative with time Different cultures often have different interpretations of scheduling. Time, in some cultures, is more fluid than is true for Americans in general. Facilitators running MFG sessions often can deal with the impact of these differences with some fairly simple re-structuring of the group's operation, so that all can be comfortable.

Good practices

- Be somewhat flexible about start times
- Structure sessions so as to accommodate differences in time sense. For instance, if the plan is to start a meeting at 7:00 pm, knowing that many families may run late, schedule a 6:30 pm social period that precedes the meeting (let families know that soft drinks and snacks will be served during this time)
- Rather than establishing any formal structures for these gatherings, let them be loose and learn from them what works and what doesn't. Then plan the next gathering accordingly

Challenge 8: Latino Families Who Have Few Economic Resources

As already stated, Latinos collectively are among the poorest subgroups in the United States population. In this sub-section the following specific topics related to dealing with limits in economic resources are addressed:

- *Considering what economic issues prohibit families from attending meetings*
- *Inventing ways to overcome such barriers*

Considering what economic issues prohibit families from attending meetings Some families have so few economic resources that the price of bus fare may prohibit them from attending a group. Travel may not be safe in their neighborhood or in the areas that they must pass to get to a meeting. There may be no one available to supervise the client or other children while parents attend a group. Single parents or parents with multiple jobs and several children may be overwhelmed by competing responsibilities. MFG facilitators need to be aware that some or all of these challenges may be present among the families in a group.

Inventing ways to overcome barriers MFG programs can become more accessible to low-income families by overcoming these barriers – families and MFG facilitators can work together on devising creative strategies.

Good practices

- Provide food at sessions (this may be especially important for evening sessions)
- Provide transportation (e.g., taxicab voucher or bus fare)
- Suggest car-pooling
- Provide childcare if younger children need to be at the session with a parent
- Invite participants to contribute in money, time or food; make sure they understand that no one needs to contribute – only those who wish to do so

SECTION 4
CHALLENGES OF WORKING WITH LATINO ADOLESCENTS

In any culture, adolescents face problems in living, both in terms of their environment and their psychological functioning. There is evidence that, as a group, Latino children and adolescents may be affected by a greater amount of emotional and behavior problems, when compared with some other racial and ethnic groups. Their mental health issues are discussed further in this section.

As with all children and adolescents, these problems have somewhat different characteristics, both for diagnosis and treatment, than mental health disorders of adults. And even more than adults, many young people with mental health problems do not get treatment - less than 20% of those who need it, according to one recent estimate.[41] Whatever can be done through interventions like the Latino MFG to get families more powerfully involved in mental health services for adolescents is of great importance to improving the success of these interventions.

Mental Health Problems of Latino Children/Adolescents

The Surgeon General's Report[42] concluded that Latino children and adolescents are a high-risk group for poor mental health outcomes. Studies reviewed in the Surgeon's General Report provided evidence that Latino youth are more likely to have difficulties finishing school, manifest more symptoms of depression and anxiety, and contemplate suicide more often than non-Latino youth. The National Comorbidity Survey[43] and the Hispanic Health and Nutrition Examination Survey[44] found higher rates of depression among Latinos than for other groups.

The Centers for Disease Control's Youth Risk Behavior Surveillance Survey,[45] based on 16,262 high school students of various ethnic groups, shows that, relative to other ethnic groups, Latino male and female adolescents reported higher rates of suicidal ideation and attempts than both White and Black male and female adolescents. A large-scale study, the 2005 Youth Risk Behavior Survey from the Centers for Disease Control and Prevention,[46] also demonstrated that Latinos are at higher risk than Caucasian, African-American, or Asian-American, for suicide. In this study of thousands of youth, Latinos had a significantly higher risk for suicidal ideation, suicide plans, suicide attempts, and suicide attempts requiring medical treatment

Little is known about the mental health status of immigrant versus United States-born Latino children. Data from the National Longitudinal Study of Adolescent Health,[47] a nationally representative study of adolescents in schools (grades 7 through 12), point to a similar pattern to the one found for Latino adults. Immigrant adolescents (across several ethnic groups) experience fewer physical health problems, have less experience with sex, are less likely to engage in delinquent and violent behavior, and are less likely to use controlled substances than United States-born adolescents.

A number of smaller studies have also indicated that Latino youth have a higher risk of significant mental health problems. These include depression, anxiety disorders, substance

abuse, eating disorders, and disruptive behavior disorders such as Attention Deficit Hyperactivity Disorder (ADHD).

There are multiple stressors that aggravate any biological vulnerability that Latino youth may have to mental health problems. Some come from the current environment, as discussed in Section 3. For immigrants, traumas in their home nations prior to immigration (war, terrorism, disasters, poverty, famine) and traumas in the process of immigration (risky journeys, witnessing death, victimization by smugglers, undocumented status, separation from extended family and even parents) all contribute significant stress.

For all Latino youth, immigrant or U.S.-born, added stressors include poverty, discrimination, and domestic or community violence. Additionally, parents and extended family are often not available to supervise and monitor behaviors as a result of long work hours. Nor are they available to help them with the difficult task of acculturation, resulting in increased risk for disruptive behavioral problems.

Acculturation presents special challenges and stressors for Latino children/adolescents and their families. Latino youth do learn the language, customs, and values of mainstream American culture faster than their parents, due to their exposure to peer culture and education. However, they often are torn between these new values and customs and the more traditional ones of their parents and elders. Parents and elders often feel left behind and threatened by their children's rapid acculturation and fear losing them to American culture.

Such tensions often lead to intergenerational acculturation conflicts that, according to researchers such as Szapocznik[48], lead to an increased risk for substance abuse and disruptive behavioral disorders. Increased acculturation to mainstream culture also contributes to the loss of natural protective values, which include taboos against suicide, *familismo* (strong orientation towards both the nuclear and extended family as opposed to orientation to individualism), spirituality, and a more traditional body image orientation. The loss of these traditional cultural values and beliefs has been associated with increased levels of mental health problems such as suicide, substance abuse, disruptive behavioral problems, and eating disorders.

More recently, research about acculturation has identified significant advantages of bi-culturalism for Latino adolescents, in which ties to both the old and new culture are encouraged. For instance, findings from a 2010 study showed that Hispanic teenagers who hold on to their culture and whose parents get more involved in life in the United States have less anxiety and fewer social problems, as well as less chance of alcohol or drug abuse. More specifically, the study found that for every one-point increase in parents' involvement in US culture, there was a 15% to 18% decrease in adolescent social and behavior problems.[49]

Interventions with Latino Children/Adolescents

A number of investigators have carried out research to develop innovative, culturally appropriate treatments for at-risk Latino youth populations and their families. These are part of the historical background for the Latino MFG, as adapted here for Latino adolescents. Two types of research-

based interventions for working with Latino children and adolescents are discussed in this sub-section:

- *Family Effectiveness Training*
- *Cuento and Hero/Heroine Modeling*

Family Effectiveness Training Szapocznik and his colleagues have designed interventions for Latino families in Miami. These authors combine structural and strategic family approaches with attention to the ecosystems in which families live. The treatments are typically targeted at changing family interactions, with the goal of reducing behavior problems in children/adolescents. Special attention was given to reducing drug use in these interventions.

There are three specific components to accomplish these goals in the program called Family Effectiveness Training (FET): family development, bicultural effectiveness training, and strategic structural family systems therapy. In one study with high-risk 6- to 12-year-olds, children were found to have fewer behavior problems and higher self-esteem than children in the minimal contact condition. In addition, improvements in the family structure of families in the FET condition were observed.[50] The approaches used have many similarities to the Latino MFG, including cultural specificity.

***Cuento* and Hero/Heroine Modeling** Malgady, Rogler and Constantino developed an intervention for Latino children and adolescents in the New York City area.[51] Their framework draws on social learning theory, where positive models are presented to children and adolescents in addressing problem areas such as anxiety, low self-esteem and acting out. One program is called *Cuento* (storytelling) therapy and uses Puerto Rican folktales. A second, called Hero/Heroine Modeling, uses metaphors (*metáfor*a) as a teaching tool. Both treatments have helped in the reduction of depressive symptoms, as well as improving self-esteem and social functioning. The interactional qualities of these programs, through focus on the adolescent rather than the parents, are still similar to the MFG approach in that they focus on specific problems.

Other recent research has shown that adjunct interventions incorporating parents into the treatment process for their children are likely to enhance the effects of treatment and strengthen the adolescent's commitment to a treatment program. Involving parents may help address treatment resistance, enhance treatment effects, alleviate the stigma of being the identified patient, and maintain therapeutic changes within a family that is more sensitive, supportive and knowledgeable. Several studies already have identified the need for parental involvement when treating depression in youth.[52]

Problems in Service Delivery

Adolescents and the providers serving them face a number of challenges in the service delivery process that, if not addressed well, can lead to significantly poorer outcomes. In this sub-section, the following challenges are addressed:

- *Limited training for providers about appropriate developmental stages*
- *Diagnostic labeling*
- *Limited access to mental health services*
- *Limited access to interpreters for Spanish-speaking adolescents and families*

Limited training for providers about appropriate developmental stages The emphasis in this manual has been on cultural factors specific to Latino communities, families and adolescents, but clinicians also need to have good training about adolescent development and the various stages their clients have been or will be moving through. While most providers will hopefully have been given pre-service training on this subject, mental health agencies often do not have the resources or the time to supplement with additional training that focuses on the particular cultural and life circumstances of their client population. Under these conditions it is easy for clinicians to misunderstand behaviors of their adolescent clients, and/or reactions of families. At the least, such context needs to be addressed in supervision.

Diagnostic labeling Clinicians often are concerned about assigning a diagnostic label to an adolescent client, even though such identification may be necessary to make funding available for services. It is common practice to use somewhat less-stigmatizing labels such as "disruptive disorder" or "oppositional-defiant disorder" when in fact a more serious diagnosis (e.g., "conduct disorder") may sometimes be appropriate. In assessment and treatment planning, careful decisions need to be made about how to use these labels, and some discussion in MFG family sessions also may be in order. Cultural differences also should be weighed, since Latino families may have stronger and more negative emotional reactions to some diagnostic categories than to others.

Moreover, care needs to be taken to look at culturally-relevant circumstances that lead to situational problems, such as adjustment disorders that are rooted in a reality such as a key caregiver (e.g., a grandmother) returning to a country of origin - sometimes under very negative circumstances such as deportation. Under such circumstances, emotional reactions may be quite appropriate, and brief interventions effective in resolving the problem.

For other adolescents, emotional challenges come from having experienced multiple transitions in culture and country during their developmental years. They may live first with their parents and then with extended family either in the United States or in the family's country of origin. Moving back and forth, especially if some or all in the family are undocumented, can be extremely stressful and produce situationally-based adjustment disorders.

Limited access to mental health services A major problem in addressing the mental health needs of Latino youth is their lack of access to mental health services. Studies show that Latino youth are able to use these services about half as much as youth from other ethnic/racial groups.[53] The general shortage of child and adolescent mental health services disproportionately affects Latino youth due to the young age of the Latino population in the U.S. (36% of Latinos are under age 18). Lack of insurance coverage also may be a factor in limiting access as well (problems associated with lack of coverage for MFG services are covered in Section 5).

Limited access to interpreters for Spanish-speaking families and adolescents In the pilot projects described in the Manual for the Latino MFG, and in the agencies where they were conducted, fully bilingual clinical staff are readily available. In many other mental health settings, bilingual staff may be in limited supply, making necessary interpreters for some clinical staff and their clients or families. But especially in the current tight budgetary times, interpreters also may be in short supply, and this reality needs to be figured in to service planning.

SECTION 5
IMPLEMENTING THE LATINO MULTIFAMILY GROUP PROGRAM

The Latino MFG program is designed for use with Spanish-speaking Latino families of adolescents, ages 12-16, who have disorders like ADHD or serious emotional disturbances like depression, and who are receiving services from a public, or private nonprofit, mental health agency. In most cases, these services are being given on an outpatient basis, although in one of the pilot test settings, about 10% of adolescent clients have required hospitalization as well. Medication may be a part of treatment both for outpatient and inpatient services. In this section, information and suggestions are provided for the actual implementation of the program.

First, a decision needs to be made to adopt the program (see Section 1 for more detail, and for the larger context of systems change that applies when Latino MFG programs are implemented). Next, the program needs to be implemented, following a five-step process.

Five Steps to Implement the Latino MFG Program

The following steps need to be taken to implement this program, after the initial decision to adopt has been made:

1 - Conduct a needs and readiness assessment to determine whether the resources and motivation necessary for a successful implementation are present in an agency. If the needs assessment indicates that there are problems likely to interfere with successful implementation, then a decision can be made to intervene with these problems, delay the implementation until they are resolved, and/or decide not to move forward. Information on costs of the LMFG implementation is given in a separate section below.

Before investing financial and human resources to implement the Latino MFG program, a readiness assessment for the organization considering adoption also is desirable. This can be done formally using a readiness assessment instrument, or less formally by a group discussion (perhaps with a written summary done later that all participants can read and agree to) about factors such as:

- Can fully bilingual staff or family members serve as facilitators for the Latino MFG program?

- Are there families who may be willing to participate in the program?

- Are the necessary financial resources available for implementation of the program, including staff training?

- Are the necessary financial resources available for operating the program?

- Is the organization's CEO (and if relevant, board of directors) supportive of the program?

- Is there a champion for the Latino MFG program who will guide the implementation process?

- Are there resources and structure available to support gathering of data about the process and outcomes of the Latino MFG program once it is implemented?

Sometimes the financial factors can be complex. For instance, in some states Medicaid billing codes will only support physicians as the providers of an MFG program. In all the pilot implementations discussed here, family participants are from poor families that do not have insurance, so some sort of public payment is needed. Training often is the most difficult part of the MFG process to get paid for - in some cases, a local foundation, corporation or other charitable organization might be approached to pay for the training.

In some cases, particularly given budget constraints in many public mental health agencies, professional staff may decide to recruit volunteer family facilitators to actually lead the groups, as discussed above. Agency resources still are needed for training of the facilitators, mechanical costs of the groups (food, transportation, meeting room, etc.) and for some supervision, but the costs can be reduced significantly in this way.

Promotoras (these indigenous health care workers go by other names in some parts of the country) might be engaged as co-facilitators in some cases, if they are familiar with the family issues surrounding the types of clients whose families will be included in the Latino MFG.

Another issue that needs to be settled: will the family co-facilitators be paid for their work or are they volunteers? There is no one right answer, but this question needs to be addressed up front.

Implementation also needs to focus on setting the goals of the groups depending upon the adolescents whose families are to be included. Goals for adolescents with disorders like ADHD are different than for serious and persistent emotional disturbances like depression. Also, some adolescents may need assistance with medication compliance, and regardless, in many cases, it may be valuable for the adolescent client to be part of the MFG.

The MFG program is quite flexible - in essence, it forms a "shell" of process activities (joining, problem-solving etc.) that can be used to address many different types of populations and problems. In the end, each variation requires independent evaluation to be sure that the program works for that particular purpose. Variations also may be undertaken in some of the process dimensions of the program (how long it lasts, who facilitates, etc.), and again evaluation is needed to learn whether these adaptations appear to be viable.

2 - Conduct an exploratory presentation to staff, to introduce the MFG concept and its adaptation for Spanish-speaking Latino families. If possible, the Latino MFG adopters should identify a local professional who's already implemented an MFG, and/or or a researcher who's studied families of adolescents with ADHD, depression or other disorders, who can serve as facilitator for such a session. On the Valley Nonprofit Resources website (www.valleynonprofitresources.org, Resources Section) there is a Latino MFG Program PowerPoint which can be used to guide this presentation.

At the end of the exploratory presentation, a decision can be made about whether to implement the Latino MFG in the agency setting. Then, decisions need to be made about how to conduct the staff training (step 3) and who the facilitators will be. Considerations related to co-facilitation or facilitation by a family advocate are presented below.

3 - Conduct staff training for facilitators, including clinical staff and/or family advocates. This in-service training program typically is given over one day, following a format laid out in a staff training PPT, also available on the VNR website (see above). This PPT first introduces the MFG program and its extensive research background, then the LMFG and its adaptations of language and cultural context for Spanish-speaking Latino families. The educational workshop for staff is presented in English, but the actual sessions are presented in Spanish - so all those who will be actually facilitating groups must be bilingual.

The section below on "Adaptation of the MFG Program for Latino Families" helps to provide context for how the MFG program actually will operate with Latino families. Sections 2 and 3 of this manual should be helpful in that regard as well.

The Latino MFG Staff Training PPT provides much of the information needed to develop basic knowledge and skills, along with the material in this Manual. For those who want more detailed background on MFG, the McFarlane book overviewing this program can be consulted;[54] however, it should be noted that this book is oriented to MFG programs for families of adult schizophrenics, not to Spanish-speaking Latino adolescents. Brief information on MFG and on the larger topic of evidence-based practices is available in three short documents that can be downloaded from www.valleynonprofitresources.org (Resources section, Raising the Bar page):

- ***Background on the MFG Program*** – a brief overview of MFG in a format suitable for sharing with staff training participants

- ***Evidence-Based Practices: Frequently-Asked Questions –*** definition and discussion of the concept of EBPs

- ***Implementing and Sustaining EBPs: An Overview*** - a discussion of the central factors in systems change related to successful implementation of an EBP like the Latino MFG, and a brief summary of the research literature about effective practices for implementation and sustainability

Trainers should be clinical staff who are familiar with the Latino MFG program and have run it. In some cases, implementers might contract with MFG creator Dr. William McFarlane's training and consulting entity to provide professional training onsite about MFG. Information about possible costs is given in the section on costs. Dr. McFarlane can be contacted at mcfarw@mmc.org or by telephone at (207) 662-2091.

4 - Implement the LMFG program, beginning with the joining process. When sufficient families are recruited, the one-day family psychoeducation session can be conducted, using of the topical PPTs on the VNR website, Resources section, Latino MFG Program page (see above). The topical PPTs, all presented in Spanish, cover Depression, ADHD and

PTSD/Anxiety. Also, the Family Guidelines for Latinos, Six Important Messages for Latino Families, Problem-Solving Steps and Family Education Workshop for Latinos: Suggested Schedule handouts included as appendices to this Manual can be reproduced for this session. This serves to initiate the MFG program, as described at the beginning of the Manual.

5 - Gather data on process and impact once the LMFG program is fully implemented, and on its way to twelve (or six) months of operation. Indications about how this evaluation can be done are contained within the two Latino MFG Pilot Evaluation Reports (also available on the VNR website).

Adaptation of the MFG Program for Latino Families

In this sub-section, the following specific topics are addressed:

- *Changes in engagement*
- *Changes in joining*
- *Changes in format and content of educational workshop*
- *Changes in multifamily group sessions*

When the MFG approach is used for monolingual Spanish-speaking Latino families, changes need to be made in each of these components of the original MFG program. The following provides an overview of these changes, which may be particularly useful (along with other material in this Manual) for clinicians who have previously been trained in the implementation of MFG with non-Latino populations.

Changes in engagement Although in the Latino culture, caring for a family member may be seen as the mother's domain, it is critically important to engage fathers and other key male family figures. Special efforts are advisable in reaching out to the male authority figure (including home visits) as his participation often puts an imprimatur of legitimacy on the entire psychoeducational enterprise. One effective method to engage any family member, as mentioned, is to acknowledge that the family has a level of expertise about their ill relative that would be very useful to the treatment process.

Thus in the engagement process it is essential to listen carefully to what families have to say about the disorder of their adolescent relative. It is critical to use their language rather than biomedical jargon it. A common mistake made by therapists is to assume that family members will accept a biomedical model of the disorder. A preferable approach is to incorporate the way family members understand the disorder into the psychoeducational enterprise.

Changes in joining The joining process is designed to make the family members feel like a part of the treatment team. As such, it builds on the good will created during the engagement process by continuing to display respect for the family's values, preferences and attitudes.

For instance, as the clinician gets to know the family member, he or she must be careful to maintain a nonjudgmental attitude toward the opinions expressed by the family member. The key is to form a bond, rather than criticize family members for beliefs they have (e.g., that the disorder may be the result of *brujería* or witchcraft).

Another important part of the joining process is to allow ample time for family members to describe their points of view. The key to joining is to develop a relationship rather than to race through an agenda. It is not unusual for family members to want to discuss issues that may not seem germane to the problems of their loved one. Nevertheless, the therapist is advised to spend as much time as is feasible to make the key relative feel that the clinician will be a long-term ally of the family as a whole.

Changes in family education workshop As mentioned, in the Latino MFG program the psychoeducational workshop for families is conducted in Spanish. The written materials, however, are best made available in both English and Spanish to accommodate all levels of acculturation among the generations. It is also helpful to have as much material as possible available in pictorial form to counter the high prevalence of illiteracy in either language.

The MFG trainers need to allow enough time to get through the formal agenda and to make sure family participants are heard. Family members will want to discuss their specific situations and problems during the educational workshop. Time must be allocated for them to adequately address their concerns and needs.

Changes in MultiFamily Group sessions Although it is important that families identify the issues that make up the bulk of MFG sessions, some problems may not be addressed spontaneously, thereby requiring the therapist to elicit them from family members. The reluctance to bring up certain issues may result from unwillingness to discuss sensitive subjects (e.g., sexuality), but also may stem from a lack of experience with the process of group discussion.

In addition, some families may be overly deferential to the therapists, believing that they (the therapists) are there to initiate the discussion and ask the necessary questions. Latino MFG clinicians need to work to encourage an increasing willingness to initiate discussion within and between family members. Eventually, clinicians can function as facilitators of dialogue and skills training for family members.

Facilitation by a Family Advocate

In many cases it also can be beneficial to identify a family advocate to help deliver the Latino MFG program. Family advocates can be identified by consultation with local community leaders or through groups such as the National Alliance for Mental Illness (NAMI). These need to be Spanish-speaking individuals who are willing to volunteer time to work with a mental health agency clinician in supporting a group, although in some cases they also can be compensated for this work.

The MFG process can then be co-facilitated by the mental health professional and the family advocate. In one of the recent pilot tests of the Latino MFG both co-facilitators are family advocates, with training and supervision provided by agency clinical staff.

The family advocate will first need to engage in a training process to become familiar with the MFG intervention, as is the case for agency clinical staff who serve as facilitators. During the training, the family advocate will receive information about the symptoms and causes of mental disorders, pharmacological and psychosocial treatments, self-care, communication and problem-solving skills, as well as the importance of long-term engagement in the treatment process.

The MFG training ideally involves about 12 hours of didactic and experiential activities, conducted by a team of mental health professionals with years of experience teaching these methods. After completion of the training, the family advocate can be paired with a trained mental health professional as an active collaborator in all aspects of the MFG program, from engagement to ongoing psychoeducational groups (and in some cases may work with another advocate as needed).

Given the success of both professionally run multi-family groups and family-conducted psycho-educational programs such as Family-to-Family,[55] it is expected that the co-facilitated MFG program can serve as an effective amalgamation of the two models.

An additional benefit of this approach is to increase the likelihood that community providers will be able to replicate the co-facilitated MFG program because the presence of the family advocate allows the community agency greater flexibility in the allocation of their most precious resource - trained mental health professionals. Further resource conservation may be possible if both facilitators are family advocates – initial results from the recent Latino MFG pilot test of this strategy indicates that it works well, but true research validation has yet to be done.

Costs of Implementing the Latino MFG Program

The costs associated with an implementation of the Latino MFG program in a mental health agency fall into three categories:

- Costs for the initial staff training
- Costs for the program's implementation, including the family psychoeducation workshop
- Costs for ongoing operation of the program

During planning for Latino MFG program implementation, these costs can be summarized, at least roughly. However, no rigorous data about cost experiences have been accumulated yet, so comparisons are not possible at the present time.

If one or more volunteers are identified to facilitate the initial staff training (as described above), the costs for this training session may be minimal, except for the staff time devoted to the training effort. However, in some cases an outside trainer may be brought in to provide special expertise to agency staff for this training process. Costs of outside trainers vary.

As for program implementation costs, a recent study by Breitborde and colleagues[56] examined the costs of implementing an MFG (this study was not focused either on Latino families or adolescent clients, but rather on adults from all backgrounds with schizophrenia). In this study, the costs of implementing an MFG were extended to include (1) labor costs for three one-hour joining sessions provided by one clinician (assuming 6 families per group), (2) one eight-hour psychoeducation workshop provided by two clinicians, and (3) two additional hours of clinician time per patient for other activities (e.g., preparatory activities and paperwork). This totals 46 hours, times an estimated $19.44 per hour (the average 2008 salary for a "health counselor" in the US), or $894.00 in 2008 dollars. These costs may be modified if only one clinician conducts the workshop, or other adjustments are made.

In adapting these cost estimates, it should be noted that bilingual staff typically have higher salaries (up to $55,000 a year) and so do clinical staff with advanced graduate degrees. Also, there are important regional differences in salary level for these personnel.

Results from the study suggest that multifamily group psychoeducation may not only be a cost-effective intervention for first-episode psychosis, but may often be a cost-saving intervention, even under very conservative assumptions of benefit.

Costs of ongoing operation continue for one or two facilities (unless they are volunteers) for weekly sessions lasting from six months to one year. There may also be costs for family transportation, child care, food, transportation, etc.

SECTION 6
RESOURCES FOR FURTHER LEARNING

Professional and Scientific Publications

Acosta, F. (1987). *Hispanic perspective*. Rockville, MD: National Institute of Mental Health.

Alegria, M., Mulvaney-Day, N., Torres, M., Polo, A., Cao, Z., & Canino, G. (2007a). Prevalence of psychiatric disorders across Latino subgroups in the United States. *American Journal of Public Health, 97*(1), 68-75

Alegria, M., Mulvaney-Day, N., Woo, M., Torres, M., Gao, S., & Oddo, V. (2007b). Correlates of past-year mental health service use among Latinos: Results from the National Latino and Asian American Study. *American Journal of Public Health, 97* (1), 76-83.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR.* Washington, DC: Author.

Bean, R.A., Perry, B.J., & Bedell, T.M. (2001). Developing culturally competent marriage and family therapists: Guidelines for working with Hispanic families. *Journal of Marital & Family Therapy,* 27(1), 43-54.

Beels, C.C. (1975). Family and social management of schizophrenia. *Schizophrenia Bulletin,* 13, 97-118.

Bernal, G. & Rosello, J. (2008). Depression in Latino children and adolescents. In: J.M. Ramos & C.G. Magana (Eds.), *Depression in Latinos: Assessment, treatment and prevention*. New York: Springer.

Berry, J.W. (2003). Conceptual approaches to acculturation. In K.M. Chun, O.P. Balls & G. Marín (Eds.), *Acculturation: Advances in theory, measurement and applied research.* Washington, DC: American Psychological Association.

Blazer, D.G., Kessler, R.C., McGonagle, K.A., & Swartz, M.S. (1994). The prevalence and distribution of major depression in a national community sample: The National Comorbidity Survey. *American Journal of Psychiatry,* 151, 979-986.

Breitborde, N.J., Woods, S.W. & Srihari, V.H. (2009). Multifamily psychoeducation for first-episode psychosis: A cost-effectiveness analysis *Psychiatric Services,* 60(11), 1477-1483.

Campbell, J.A. (1999). *Health insurance coverage: 1998.* Washington, DC: US Department of Commerce.

Canino, I.A., & Canino, G. (1980). Impact of stress on the Puerto Rican family: Treatment considerations. *American Journal of Orthopsychiatry,* 50(3), 535-541.

Cañive, J.M., Sanz-Fuentenebro, J., Vazquez, C., Qualls, C., Fuentenebro, F., Perez, I.G., & Tuason, V.B. (1996) Family psychoeducational support groups in Spain: Parents' distress and burden at nine-month follow up. *Annals of Clinical Psychiatry*, 8, 71-79.

Carrasco, M. (2004). *Latino outreach resource manual.* Arlington, VA: National Alliance for Mental Illness.

Centers for Disease Control & Prevention. (1997). *Youth Risk Behavior Surveillance Survey Report*. Available at www.cdc.gov/yrbss.

Centers for Disease Control & Prevention. (2005). *Youth Risk Behavior Surveillance Survey Report*. Available at www.cdc.gov/yrbss.

Comas-Diaz, L. (2001). Culturally relevant issues and treatment implications for Hispanics. In: D.R. Koslow & E.P. Salett (Eds.), *Crossing cultures in mental health* (pp. 31-48). Washington D.C.: SIETAR International (pp. 31-45).

Council on Scientific Affairs. (1991). Hispanic health in the United States. *Journal of the American Medical Association*, 265, 248-252.

Detre, T., Sayer, J., Norton, A., & Lewis, H. (1961). An experimental approach to the treatment of the acutely ill psychiatric patient in the general hospital. *Connecticut Medicine*, 25, 613-619.

Dixon, L., McFarlane, W., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., Mueser, K., Miklowitz, D., Solomon, P. & Sondheimer, D. (2001) Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services,* 52, 903-910.

Dogra, N., Parkin, A., Gale, F. & Frake, C. (2009). *A multidisciplinary handbook of child and adolescent mental health for front-line professionals*. London: Jessica Kingsley Publishers.

Dyck, D.G., Short, R.A., Hendryx, M.S., Norell, D., Myers, M., Patterson, T., McDonell, M.G., Voss, W.D., & McFarlane, W.R. (2000). Management of negative symptoms among patients with schizophrenia attending multiple-family groups. *Psychiatric Services*, 51, 513-519.

Facundo, A. (1990). Social class issues in family therapy: A case-study of a Puerto Rican migrant
family. *Journal of Strategic & Systemic Therapies*, 9(3), 14-34.

Franklin, M.E., DeRubeis, R.J. & Westen, D.I. (2006). Are efficacious laboratory-validated treatments readily transportable to clinical practice? In J.C. Norcross, L.E. Beutler & R.F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 375-402). Washington, DC: American Psychological Association.

Franzini L., Ribble, J.C. & Keddie, A.M. (2001) Understanding the Hispanic paradox. *Ethnicity and Disease,* 11(3), 496-518.

Fristad M.A., Goldberg-Arnold, J.S. & Gavazzi, S.M.: (2002) Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder. *Bipolar Disorder,* 4, 254-262.

Garcia-Preto, N. (1996). Puerto Rican families. In M. McGoldrick, J. Giordano & J.K. Pearce (Eds.), *Ethnicity and family therapy.* New York: Guilford Press.

Gonzales, N., Knight, G., Morgan-Lopez, A., Saenz, D. & Sirolli, A. (2002) Acculturation and the mental health of Latino youths: An integration and critique of the literature. In: J.M. Contreras, Kerns, A. & Neal-Barnett, (Eds). *Latino children and families in the United States: Current research and future directions.* Westport, CT: Praeger. (pp. 45-74)

Grant, B.F., Stinson, F.S., Hasin, D.S., Dawson, D.A., Chou, S.P., & Anderson, K. (2004). Immigration and lifetime prevalence of DSM-IV psychiatric disorders among Mexican Americans and non-Hispanic whites in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry,* 61(12), 1226-1233.

Griner, D. & Smith, T. (2006) Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 531-548.

Hazel, N.A., McDonell, M.G., Short R.A., Berry, C.M., Voss, W.D., Rodgers, M.L. & Dyck, D.G. (2004) Impact of multiple-family groups for outpatients with schizophrenia on caregivers' distress and resources. *Psychiatric Services*, 55(1), 35-41.

Hough, R.L., Hazen, A.L., Soriano, F.I., Wood, P., McCabe, K., & Yeh, M. (2002). Mental health care for Latinos: Mental health service for Latino adolescents with psychiatric disorders. *Psychiatric Services,* 53, 1556-1562.

Huey, S.J., & Polo, A.J. (2008). Evidence-based psychosocial treatments for ethnic minority youth: A review and meta-analysis. *Journal of Clinical Child and Adolescent Psychology*, 37, 262-301.

Kopelowicz, A. (1998). Adapting social skills training for Latinos with schizophrenia. *International Review of Psychiatry*, 10(1), 47-50.

Kopelowicz, A., Wallace, C.J, Liberman, R.P, Aguirre, F., Zarate, R, Mintz, J. (2007) The use of the Theory of Planned Behavior to predict medication adherence in schizophrenia. *Clinical Schizophrenia and Related Psychoses,* 1, 227-242.

Kopelowicz, A., Zarate, R., Smith, V.G., Mintz, J., & Liberman, R.P. (2003). Disease management in Latinos with schizophrenia: A family-assisted, skills training approach. *Schizophrenia Bulletin,* 29(2), 211-228.

Kopelowicz, A., Zarate, R., Wallace, C.J, Liberman, R.P, Lopez, S.R., Mintz, J. (submitted for publication). The impact of multifamily groups to improve treatment adherence in Mexican Americans with schizophrenia.

Kreyenbuhl, J., Buchanan, R.W., Dickerson, F.B & Dixon, L.B. (2010). The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin,* 36(1), 94-103.

LaFromboise, T., Coleman, H. & Gerton J. (1993) Psychological impact of biculturalism: evidence and theory. *Psychological Bulletin*, 114, 395–412.

Laquer, H.P. (1968). General Systems Theory and multiple family therapy. In: J. Masserman (Ed.), *Current Psychiatric Therapies.* New York: Grune & Stratton.

Lau, A.S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice*, 13, 295-310.

Lopez, S. (2002). Mental health care for Latinos: A research agenda to improve the accessibility and quality of mental health care for Latinos. *Psychiatric Services,* 53 (12), 1569-1573.

Lopez, S., Kopelowicz, A. & Cañive, J.M. (2002). Strategies in developing culturally congruent family interventions for schizophrenia: The case of Hispanics. In: H. Lefley & D. Johnson (Eds.), *Family interventions in mental illness: International perspectives.* Westport, CT: Praeger.

Malgady, R.G., Rodriguez & R. Orlando (Eds). (1994). *Theoretical and conceptual issues in Hispanic mental health.* Malabar, Fla: Krieger. (pp. 156-180).

Malgady, R.G., Rogler, L.H., & Costantino, G. (1990). Culturally sensitive psychotherapy for Puerto Rican children and adolescents: A program of treatment outcome research. *Journal of Consulting and Clinical Psychology*, 58(6), 704-712.

Malone, N., Baluja, K.F., Constanzo, J.M., & Davis, C.J. (2003). The foreign-born population. In *Census 2000*. Washington, D.C.: U.S. Government Printing Office.

Massey, D.S., & Eggers, M.L. (1990). The ecology of inequality: Minorities and concentration of poverty. *American Journal of Sociology*, 95, 1153-1189.

McFarlane, W.R. (1997). Family psychoeducation: Basic concepts and innovative applications. In: S.W. Henggeler & A.B. Santos (Eds.), *Innovative approaches for difficult-to-treat populations.* Washington, DC: American Psychiatric Press, (pp. 211-237).

McFarlane, W.R. (2002). *Multifamily groups in the treatment of severe psychiatric disorders.* New York: Guilford Press.

McFarlane, W.R. (1994). Multiple-family groups and psychoeducation in the treatment of schizophrenia. In: A.B. Hatfield (Ed.), *Family interventions in mental illness: New directions for mental health services* (pp. 13-22). San Francisco, Jossey-Bass.

McFarlane, W.R., Dixon, L., Lukens, E., Lucksted, A. (2003) Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy,* 29(2), 223-245.

McFarlane, W.R., Dixon, L. Lukens, E. & Lucksted, A. (2003). Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy,* 29, 223-245.

McFarlane, W.R., Dushay, R.A., Statsny, P., Deakins, S.M., & Link, B. (1996). A comparison of two levels of family-aided assertive community treatment. *Psychiatric Services*, 47, 744-750.

McFarlane, W.R., Dushay, R.A., Deakins, S.M., Stastny, P., et al. (2000). Employment outcomes in family-aided assertive community treatment. *American Journal of Orthopsychiatry*, 70, 203-214.

McFarlane, W.R., Lukens, E., Link, B., Dushay, R., Deakins, S.A., Newmark, M., Dunne, E.J., Horen, B., & Toran, J. (1995). Multiple family group and psychoeducation in the treatment of schizophrenia. *Archives of General Psychiatry*, 52, 679-687.

Mezzich, J.E., Ruiz, P., & Munoz, R.A. (1999). Mental health care for Hispanic Americans: A current perspective. *Cultural Diversity & Ethnic Minority Psychology*, 5(2), 91-102.

Miklowitz, D.J. & Goldstein, M.J. (1990). Behavioral family treatment for patients with bipolar affective disorder. *Behavior Modification*, 14, 457-489.

Miranda J., Bernal G., Lau, A., Kohn, L., Hwang, W.C. & LaFromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology*, 1,113-42.

New York State Research Foundation in Mental Hygiene. (2008). *Family psychoeducation in Latino American communities: Implementation resource kit - final report.* Albany, New York: Author.

Padilla, A.M., Cervantes, R.C., Maldonado, M., & Garcia, R.E. (1988). Coping responses to psychosocial stressors among Mexican and Central American immigrants. *Journal of Community Psychology,* 16(4), 418-427.

Paniagua, F.A. (1994). *Assessing and treating culturally diverse clients: A practical guide*. Thousand Oaks, CA: Sage Publications, Inc.

Pickett-Schenk, S.A., Lippincott, R.C., Bennett, C., & Steigman, P.J. (2008). Improving knowledge about mental illness through family-led education: The Journey of Hope. *Psychiatric Services,* 59,49-56.

Potter, L.B., Rogler, L.H., & Moscicki, E.K., (1995). Depression among Puerto Ricans in New York City: The Hispanic Health and Nutrition Examination Survey. *Social Psychiatry and Psychiatric Epidemiology,* 30, 185-193.

Pumariega, A.J., Rogers, K., & Rothe, E. (2005). Culturally competent systems of care for children's mental health: Advances and challenges. *Community Mental Health Journal,* 41(5); 539-556.

Pumariega, A.J., Rothe, E., & Pumariega, J.B. (2005). Mental health of immigrants and refugees. *Community Mental Health Journal,* 41(5), 581-597.

Randolph, E.T., Eth, S., Glynn, S.M., Paz, G., Leong, G.B., Shaner, A.L., Strachan, A., Van Vort, W., Escobar, J.I., & Liberman, R.P. (1994). Behavioral family management in schizophrenia: Outcome of a clinic-based intervention. *British Journal of Psychiatry*, 164, 501-506.

Rogler, L.H., Malgady, R.G., & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research.* Malabar, Fla: Krieger.

Schooler, N.R., Keith, S.J., Severe, J.B., Matthews, S.M. et al. (1997). Relapse and rehospitalization during maintenance treatment of schizophrenia: The effects of dose reduction and family treatment. *Archives of General Psychiatry,* 54, 453-463.

Siedman, E., & Rapkin, B. (1983). Economics and psychosocial dysfunction: Towards a conceptual framework and prevention strategies. In: R. Felner, L. Jason, J. Moritsugu & S.S. Farber (Eds.), *Preventive psychology.* New York: Pergamon Press. (pp. 175-198).

Smokowski, P., Buchanan, R.L. & Bacallao, M.L. (2009). Acculturation and adjustment in Latino adolescents: How cultural risk factors and assets influence multiple domains of adolescent mental health. *The Journal of Primary Prevention,* 30 (3-4), 371-393.

Sue, D.W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). Hoboken, NJ: John Wiley & Sons Inc.

Szapocznik, J., & Kurtines, W. (1989). *Breakthroughs in family treatment*. New York: Springer.

Szapocznik, J., & Kurtines, W. (1980). Acculturation, biculturalism and adjustment among Cuban-Americans. In: A. Padilla (Ed.), *Recent advances in acculturation research: Theory, models, and some new findings.* Boulder, CO: Westview Press. (pp. 139-159).

Szapocznik, J., Kurtines, W., Hervis, O., & Spencer, F. (1984). One-person family therapy. In: W.A. O'Connor & B. Lubin (Eds.), *Ecological approaches to clinical and community psychology*. New York: Wiley. (pp. 335-355).

Szapocznik, J., Kurtines, W. & Santisteban, D.A. (1994). The interplay of advances among theory, research, and application in family interventions for Hispanic behavior-problem youth. In:
R.G. Malgady, R.G. Rodriguez & R. Orlando (Eds.), *Theoretical and conceptual issues in Hispanic mental health.* (pp. 156-180). Malabar, FL: Krieger.

Szapocznik, J., Rio, A., Perez-Vidal, A., Kurtines, W., & Santisteban, D. (1986). Family effectiveness training (FET) for Hispanic families. In: H. P. Lefley & P.B. Pedersen (Eds), *Cross-cultural training for mental health professionals.* New York: Charles C. Thomas.

Szapocznik, J., & Truss, C. (1978). Intergenerational sources of role conflict in Cuban mothers. In: M. Montiel (Ed.), *Hispanic families*. Washington, DC: COSSMHO.

Telles, C., Karno, M., Mintz, J., Paz, G., Arias, M., Tucker, D., & Lopez, S.R. (1995). Immigrant families coping with schizophrenia: Behavioral family intervention vs. case management with a low-income Spanish-speaking population. *British Journal of Psychiatry,* 167, 473-479.

Therrien, M., & Ramirez, R. (2001). *The Hispanic population of the United States: Population characteristics*. Washington, DC: US Department of Commerce.

Udry, J.R. (2003). *National Longitudinal Study of Adolescent Health.* Chapel Hill, NC: Carolina Population Center, University of North Carolina at Chapel Hill.

U.S. Census Bureau. (1999). *Current population reports: Money income in the U.S.*. Washington, D.C.: U.S. Government Printing Office.

U.S. Census Bureau. (2001a). *Census 2000 profiles of general demographic characteristics*. Washington, D.C.: U.S. Government Printing Office.

U.S. Census Bureau. (2001b). *The Hispanic population: Census 2000 brief*. Washington, D.C.: U.S. Government Printing Office.

U.S. Census Bureau. (2002). *Demographic trends in the 20th century: Census 2000 special reports*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the Surgeon General.* Rockville, MD: Author.

U.S. Dept. of Health and Human Services, National Institute of Mental Health (1992). *Epidemiologic catchment area study, 1980-1985*. Rockville, MD: Author.

Valley Nonprofit Resources (2009). *Latino MFG Pilot Implementation Evaluation Report.* For a copy go to www.valleynonprofitresources.org

Valley Nonprofit Resources (2011). *Latino MFG Pilot Implementation Evaluation Report II.* For a copy go to www.valleynonprofitresources.org

Zastowny, T.R., Lehman, A.F., Cole, R.E., & Kane, C. (1992). Family management of schizophrenia: A comparison of behavioral and supportive family treatment. *Psychiatric Quarterly*, 63, 159-186.

Spanish Language Publications for Families

The following are available free of charge from the SAMHSA Store (www.samhsa.gov/store)

Conozca a Las Personas antes de Juzgarlas (Before You Label People, Look at Their Contents (SMA96-3118SP) - Pamphlet. SAMHSA's National Mental Health Information Center.

Guia para la familia sobre los sistemas de cuidado para niños necesidades de salud mental (SMA-4054S) - Booklet

Como estás? Que hubo? (CA-0036) - Brochure

Helplines and Websites

"Su Familia" National Hispanic Family Health Helpline (866-783-2645/866-SU-FAMILIA) helps Hispanic families obtain basic health information, and refers them to local health providers and federally-supported programs like the State Children's Health Insurance Program. *Su Familia* bilingual information specialists refer callers to one of more than 16,000 local health providers, including community and migrant health centers. Callers can also request basic health information, referrals to information sources, or receive consumer-friendly, bilingual *Su Familia* fact sheets.

Family Guide to Keeping Youth Mentally Healthy and Drug Free is a public education website developed to support the efforts of parents and other caring adults to promote mental health and prevent the use of alcohol, tobacco, and illegal drugs among 7- to 18-year-olds. The site also includes a mental health dictionary, drug facts, links for children and adolescents, and other resources. It is available at http://www.family.samhsa.gov.

National Alliance for Mental Illness is the nation's largest grassroots organization for people with mental illnesses and their families. Its Multicultural Action Center has a number of publications and other resources for Latino families. Go to www.nami.org.

Spanish Language Latino MFG Materials

The following four items are presented both in English and Spanish. All are adapted from the New York State Research Foundation in Mental Hygiene report (2008):

- *Family Guidelines for Latinos (specific to depression)*
- *Six Important Messages for Latino Families*
- *Problem Solving Steps*
- *Family Education Workshop Agenda*

FAMILY GUIDELINES FOR LATINOS

Offer support: Let depressed teenagers know that you're there for them, fully and unconditionally. Hold back from asking a lot of question (teenagers don't like to feel patronized or crowded) but make it clear that you're ready and willing to provide whatever support they need.

Be gentle but persistent: Don't give up if your adolescent shuts you out at first. Talking about depression can be very tough for teens. Be respectful of your child's comfort level while still emphasizing your concern and willingness to listen.

Keep it warm: Family bonds are important. Family members' love and support for one another can be a big help.

Validate feelings: Don't try to talk teens out of their depression, even if their feelings or concerns appear silly or irrational to you. Simply acknowledge the pain and sadness they are feeling. If you don't they will feel like you don't take their emotions seriously.

Give each other space: Time out is important for everyone. It's okay to reach out, and it's also okay to say no. People need emotional space as well as physical space.

Set limits: Everyone needs to know what the rules are. A few rules keep things calmer.

Listen without lecturing: Resist any urge to criticize or pass judgment once your teenager begins to talk. The important thing is that your child is communicating. Avoid offering unsolicited advice or ultimatums as well.

Keep it simple: Say what is needed – clearly, calmly and positively.

Get the most out of medication: Medication needs be taken as prescribed, and never shared. Ask the doctor about side effects and interactions with other medications as well as herbal remedies.

Carry on business as usual: Re-establish family routines as quickly as possible. Stay in touch with family and friends.

Take care of yourself: Families need to take care of themselves, too. Take care of yourself. Otherwise, it's hard to care for a loved one.

No street drugs or alcohol: They make symptoms worse, can cause relapse, and prevent recovery.

Pick up on early signs: Note changes. Consult the family member's counselor.

Solve problems step by step: Make changes gradually. Work on things one at a time.

Lower expectations temporarily: Compare this month with last month, rather than with last year or next year. Comparing other families' progress with one's own isn't helpful or educational.

GUÍA PARA FAMILIAS LATINAS

Ofrezca apoyo: Hagale saber a su famíliar adolecente deprimido que puede contar con usted totalmente y sin condiciones. No haga muchas preguntas (los jovencitos no admiten sentirse encerrados) y asegure se de que esta preparado para proveer todo el apoyo que necesitan

Sea gentil pero persistente: No desista si al principio su familiar adolecente trata de hacerlo callar. Hablar acerca de su depression es muy dificil para adolecentes. Su familiar debe sentirse comodo hablando y esson entender su preocupacion y deseo de escuchar.

Mantenga la calidez: Los lazos familiares son importantes. El amor y apoyo mutuo en la familia es una gran ayuda.

Dé validez a sus sentimientos: No piense que simplemente hablando la depression juvenil se pasa, aun cuando los signos y comportamientos parezcan tontos o irracionales. Simplemente reconozca el dolor y tristeza que ellos sienten. No hacerlo, les hara sentir que sus emociones no son seriamente consideradas.

Dénse espacio: Crear momentos de espacio personal es importante para todos. Está bien que uno busque al otro, pero también está bien la privadad. La gente necesita “espacio emocional” así como “espacio físico.”

Establezca límites: Todos necesitan saber cuáles son la reglas. Unas pocas reglas es suficiente para mantene las cosas en calma.

Escuche sin dar sermons: Resista el deseo de criticar o juzgar una vez que su jovencito comienza a hablar. Lo importante es que se esta abriendo y comunicando. Evite dar consejos no sinque se epiola. No amenace.

Mantenga las comunicaciones sencillas: Diga lo que tiene que decir con claridad, calma y positivismo.

Obtenga los máximos beneficios de la medicación: Los medicamentos deben ser tomados tal y como son prescritos. No comparta los medicamentos. Pregúntele a su doctor sobre efectos secundarios e interacciones con otros medicamentos y hierbas medicinales.

Lleve adelante sus asuntos como siempre: Restablezca las rutinas familiares lo antes posible. Manténgase en contacto con familiares y amigos.

Cuídese: Las familias necesitan cuidarse también. Si no se cuida, es difícil que pueda cuidar a su familliar

No a las drogas ilegales o al alcohol: Estas substancias empeoran los síntomas, pueden causar recaídas, e impedir la recuperación.

Préstele atención a las señales de aviso de una recaioa: Observe los posibles cambios de conducta o estado de animo Consulte con el consejero de su familiar.

Resuelva los problemas paso a paso: Haga cambios gradualmente. Encárguese de una cosa cada vez.

Reduzca las expectativas temporalmente: Compare este mes con el mes anterior, en vez de pensar en el año pasado o el que viene. Evite compararse con los progresos de otras familias en recuperación.

SIX IMPORTANT MESSAGES FOR LATINO FAMILIES

There is hope for the return of health.

There are multiple pathways to mental health, including medical, psychiatric, and alternative remedies.

Families are not to blame for mental disorders.

Multiple family members can work as partners with clinicians to help their loved ones, since families are experts on living with the disorder.

Relatives can help their loved one because they possess great knowledge due to living with the disorder.

The disorder can be understood in terms of mind, body and spirit.

Families need to let their doctors know about their perceptions and usage of medication.

SEIS MENSAJES IMPORTANTES PARA LAS FAMILIAS LATINAS

Hay esperanza de recuperación.

Hay multiples caminos hacia la salud mental, incluyendo abordajes medicos, psiquiátricos, y otras alternativas.

Las familias no son las culpables del trastorno mental.

Los familiares pueden trabajar conjuntamente con los clínicos para ayudar a su ser querido, ya que las familias poseen mucho conocimiento, producto de vivir con el trastorno.

Para ayudar a su ser querido, ya que las familias poseen mucho conocimiento, producto de vivir con el transtorno.

El trastorno puede ser entendid en terminos de mente, cuerpo, y espíritu.

Las familias deben hacer saber a su doctor sus percepciónes y uso de la medicación.

PROBLEM-SOLVING STEPS

- *Define the problem.*
- *List all possible solutions.*
- *Discuss advantages and disadvantages.*
- *Choose the solution that best fits.*
- *Plan how to carry out the solution.*
- *Review the implementation (next meeting).*

PASOS EN LA RESOLUCIÓN DE PROBLEMAS

- *Defina el problema.*
- *Haga una lista de todas las soluciónes posibles.*
- *Debata ventajas y desventajas.*
- *Elija la solución más apropriada.*
- *Planee como llevar adelante la solución.*
- *Repase la implementación (próxima sesión).*

Family Education Workshop for Latinos: Suggested Schedule

9:00-9:15	Socializing
9:15-9:30	Introductions and explanation of format of the day
9:30-10:30	Overview of mental disorders Causes, course, and outcome of mental disorders The private experience of mental disorders The public experience of mental disorders
10:30-10:45	Break
10:45-12:00	Getting help for mental health problems Medication: how it works, why it is needed, impact on outcomes and side effects, the importance of follow-up with psychiatrist Treatment options Wellness management: health care, diet, stress Alternate resources and alternative remedies; spiritualism
12:00-1:00	Lunch
1:00-3:30	Latinos' experiences with mental disorders Families and mental disorders Family members' responses to mental disorders: thoughts, emotional reactions, and social effects What families can do to help loved ones The Family Guidelines for supporting recovery
3:30-4:00	Questions about specific problems Having patience with the slow pace of improvement Keeping hope alive Wrap-up, scheduling

Taller de Educación para la Familia Latina: Programa Sugerido

9:00-9:15 Conversación casual

9:15-9:30 Presentaciones y explicación de la agenda del día

9:30-10:30 Descripción de los trastornos mentales
Causas, curso, y resultado de los trastornos mentales
La experiencia privada de los trastornos mentales
La experiencia pública de los trastornos mentales

10:30-10:45 Descanso

10:45-12:00 Obteniendo ayuda para problemas de salud mental, la importancia de seguir el tratamiento con su psiquiatra
Medicación: como funciona, por qué es necesaria, impacto y resultados, y efectos secundarios
Opciones del tratamiento
Manejo del bienestar: cuidado de la salud, dieta y estrés
Recursos alternativos y remedios alternativos

12:00-1:00 Almuerzo

1:00-3:30 Experiencias de Latinos con los trastornos mentales

Familias y trastornos mentales
Respuestas de los miembros de la familia a los trastornos mentales: pensamientos, reacción emocional, y efectos sociales
Que puede hacer la familia para ayudar a sus seres queridos
Pautas de la Familia para apoyar la recuperación

3:30-4:00 Preguntas a problemas específicos

Paciencia si las mejorías vou poco a poco

Manteniendo las esperanzas vivas

Conclusión, programación

End Notes

[1] Kreyenbuhl et al 2010
[2] McFarlane, et al 2003; additional background on family psychoeducation approaches is provided in Dixon et al 2001, McFarlane 1997, McFarlane 2002, McFarlane 1994, McFarlane et al 1996, McFarlane, W. R. et al 2000, McFarlane et al 1995, Beels 1975, Cañive et al 1996, Detre et al 1961, Dyck et al (2000, Hazel 2004, Laquer 1968, Miklowitz et al 1990, Randolph et al 1994, Schooler et al 1997, Telles et al 1995, Zastowny et al 1992
[3] U.S. Census Bureau, 2001a, p. 99
[4] Fristad et al 2002
[5] Miranda et al 2005
[6] Griner & Smith 2006, Huey & Polo 2008
[7] Miranda et al 2005, Huey & Polo 2008, Franklin et al 2006, Lau 2006
[8] www.valleynonprofitresources.org, Resources section
[9] Kopelowicz et al 2003, 2007, Submitted for publication
[10] Lopez et al 2002
[11] Kopelowicz et al. 2003
[12] Lopez, Kopelowicz and Canive 2002
[13] Valley Nonprofit Resources 2009, 2011
[14] U.S. Census Bureau 2001a
[15] U.S. Department of Health and Human Services 2001
[16] U.S. Census Bureau 2001b
[17] U.S. Census Bureau 2001b
[18] Malone, Baluja, Constanzo & Davis 2003
[19] Sue & Sue 2003
[20] Comas-Diaz 2001
[21] Mezzich, Ruiz & Muñoz 1999
[22] Mezzrich, et al 1999
[23] Garcia-Preto 1996
[24] Massey & Eggers 1990
[25] U.S. Census Bureau 1999
[26] Council on Scientific Affairs 1991
[27] Therrien & Ramirez 2001
[28] Campbell 1999
[29] Lopez 2002; U.S. Department of Health and Human Services 2001
[30] Seidman & Rapkin 1983
[31] Facundo 1990
[32] Canino & Canino 1980
[33] Acosta 1987; Rogler, Malgady & Rodriguez 1989
[34] Alegria et al 2007a,b
[35] Grant et al 2004
[36] U.S. Department of Health and Human Services 2001
[37] Kopelowicz 1998
[38] Bean, Perry & Bedell 2001
[39] Padilla, Cervantes, Maldonado & Garcia 1988; Paniagua 1994; Sue & Sue 2003
[40] Berry, 2003, Gonzales et al 2002, LaFramboise et al 1993
[41] Dogra et al 2009
[42] U.S. Department of Health and Human Services 2001
[43] Blazer et al 1994
[44] Potter, Rogler & Moscicki 1995
[45] Centers for Disease Control & Prevention, Youth Risk Behavior Surveillance Survey 1997
[46] Centers for Disease Control & Prevention, Youth Risk Behavior Survey 2005
[47] Udry 2003
[48] Szapocznik & Kurtines, 1980

[49] Smokowski & Buchanan 2009
[50] Szapocznik et al 1989
[51] Malgady, Rogler and Constantino 1990
[52] Bernal & Rosello 2008
[53] U.S. DHHS, 2001
[54] McFarlane 2002
[55] Pickett-Schenk et al 2008, further information also available at www.nami.org
[56] Breitborde et al 2009

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