

Implementing and Disseminating a Latino MFG Program

Valley Nonprofit Resources/Human Interaction Research Institute

PILOT IMPLEMENTATION EVALUATION REPORT

September 2009

Objective and Project Overview

The objective of this two-year project is to create and implement in two pilot settings in the San Fernando Valley region of Los Angeles a manualized Latino Multifamily Group (LMFG) program. LMFG involves Spanish-speaking Latino families in mental health services for their ill family members. The pilot work is focused on families of Latino adolescents, likely the first such language and cultural adaptation of the MFG program to this population anywhere in the United States.

Based on the MultiFamily Group program first developed by Dr. William McFarlane and widely validated, the Latino MFG program is presented in Spanish and is culturally-adapted, with learning materials for professionals in English. Following training for agency professional staff, two pilot groups were convened of families of adolescent clients at two mental health agencies in the San Fernando Valley region of Los Angeles. The *LMFG Manual*, published in October 2008, includes learning activities related to content, effective implementation and sustainability of this program.

Based upon the success of the pilot implementations, a refined *LMFG Manual* is being prepared for wider use in the Valley, and nationally. A consultative session hosted by the Annie E. Casey Foundation, funder of this project, will be convened in October 2009 to review lessons learned from and this program, how it might be disseminated further, and larger issues on how to implement evidence-based programs for youth mental health services rigorously but cost-effectively. A report based on the pilot study and the consultative session will be distributed along with the *Manual* to the mental health, evidence-based program/implementation, and philanthropic communities.

The Latino MFG Project is part of Valley Nonprofit Resources, a capacity-building center for the more than 4,000 nonprofits in the San Fernando Valley region of Los Angeles. LMFG also is a sister project to Raising the Bar (funded by UniHealth Foundation), which has been implementing the MFG program in Valley mental health agencies serving adult client populations and English-speaking families. The goal of both projects is to help mental health agencies and practitioners in the Valley learn about and implement research-based mental health practices (Raising the Bar also offered training on medication management for psychiatrists in a group of mental health agencies).

The projects address an increasingly urgent need in mental health today: *to build the capacity of service agencies to identify, rigorously implement, evaluate and sustain EBPs.* Throughout the health and human services field, these research-validated practices have increasingly become the “gold standard” – and in fields like 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 challenges of long-term sustainability for these practices once they're set in place.

Leadership for both projects is provided by Human Interaction Research Institute President Dr. Thomas Backer, who has studied EBPs and mental health services for many years; and San Fernando Mental Health Center Medical Director Dr. Alex Kopelowicz, who also is funded by the National Institute of Mental Health for research on adaptation of the MFG program to improve services for Spanish-speaking Latino consumers. They work in partnership with mental health agency staff throughout the Valley, under the umbrella of Valley Nonprofit Resources.

Activities and Results to Date

The Latino MFG project was initiated in early 2008. Agreements were made with San Fernando Mental Health Center and San Fernando Valley Community Mental Health Center, two large mental health agencies in the Valley, to participate in the project. A small amount of funding support was offered to both agencies to help them defray some of the costs of implementing the program, and a contract was written with each agency about what they in turn would provide in the way of institutional and staff support.

The *LMFG Manual*, intended to guide creating and sustaining a culturally-adapted, Spanish-language MFG program, was drafted in Spring 2008. It is designed not to stand alone, but to complement training materials and approaches for the MFG program developed by Dr. McFarlane, and it draws on approaches developed by Dr. Kopelowicz for his NIMH research project. The *Manual* also adapts information presented in a 2008 comprehensive learning notebook for family psychoeducation with Latino families, created by the New York State Research Foundation in Mental Hygiene, to which Dr. Kopelowicz was a contributor.

In August 2008 a planning meeting was conducted with staff at the two agencies assigned responsibility for coordinating the LMFG program. They reviewed a draft version of the *LMFG Manual*, which was then revised and published in a working version in October 2008. Then comprehensive staff training was provided to the two agencies in a day-long session, also in October. Dr. Alex Kopelowicz led all these sessions.

The pilot implementations occurred in early 2009, starting with selection of families to participate. Two family psychoeducational workshops, launching the Latino MFG program at the pilot sites, were conducted by Dr. Kopelowicz and Dr. Roberto Zarate in February 2009.

At San Fernando Valley Mental Health Center, the LMFG program is embedded in the Child and Family Services division of the agency, and is offered to adolescents aged 13-16 who are diagnosed with depression. At San Fernando Valley Community Mental Health Center the LMFG program is embedded in Intensive In-Home Services (which in turn coordinates with the agency's Full Services Partnership and Children's System of Care projects). It is offered to adolescents aged 12-15 who are diagnosed with ADHD or other externalizing disorders.

The original program design called for the psychoeducational workshops to be co-facilitated by a family member, but this proved infeasible. Repeated efforts were made to recruit two Spanish-speaking Latino family members to participate, using Dr. Kopelowicz's regular interactions with the Valley chapter of the National Alliance for the Mentally Ill as a recruitment platform, but these approaches were not successful.

Evaluation Method

Pre- and post-surveys were administered to participants in the October 2008 staff training session. They assessed participants' level of knowledge and skill regarding the MFG program, their assessment of the likelihood of the program's implementation in their agencies, and their suggestions for improving the Manual and the training program. In March 2009, brief interviews using an interview schedule were conducted with the two pilot implementation coordinators by project coordinator Julaine Konselman. These gathered initial implementation data and additional suggestions for improvements. In August 2009, project consultant Dr. Roberto Zarate conducted interviews in Spanish with selected family members who participated in the two pilot groups.

Evaluation Results

When they began the October 2008 training session, mental health agency staff were asked to rate their current level of knowledge about the MFG approach. They then were asked to make the same rating at the end of the training on a separate questionnaire. Results are as follows:

	<i>Before</i>	<i>After</i>
Very low	27%	0%
Low	27%	0%
Medium	36%	56%
High	9%	44%
Very high	0%	0%

Clearly, according to these self-reports, participants felt that their level of knowledge about the MFG approach had increased substantially as a result of the training they received.

In the post-survey, the majority of agency staff also rated their knowledge about two specific components of the LMFG - the "Joining Session" and the "Getting to Know One Another Session" as either "High" or "Very High." Their knowledge about the overall LMFG problem-solving approach was not self-rated as highly - after the training session, 67% of the respondents still only rated their knowledge level as "Medium."

This finding is not surprising. In general, the problem-solving portion of MFG tends to be the most difficult for clinicians to learn. "Joining" and "Getting to Know One Another" are very similar activities to what almost all clinicians are taught to do in their general training, but problem-solving using the seven-step process is rigorous and challenging.

A total of 78% of respondents rated the likelihood of implementing the LMFG approach in their agency as either “High” or “Very High.” They also had some suggestions for improving the Latino MFG program approach, which are presented below.

Both program coordinators regarded the Latino MFG program to be initially successful in their agency, and for the clients and families they serve. As of March 2009, six families were part of the Latino MFG program at San Fernando Valley Community Mental Health Center, where the facilitators of the group are 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 are a staff licensed clinical social worker and a clinical psychologist. Both groups have since concluded.

Results from the interviews conducted with family members from each of four families who participated in the pilot implementation groups indicated that they found the groups to be very helpful. Being with other families and having the entire family together had particular impact (as compared to groups with just parents or just children). 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 very valuable, 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 communication specific to dealing with the mental illness, as well as in general.

During these interviews, family members gave several specific examples of impact from the groups:

* One family had a problem of regular fights with their ill relative about home chores, and refusal by the ill family member to provide any help at all. Through the group, the ill relative learned that other consumers do in fact help out with such chores; she was then able to accept this in her own home.

* Another family’s problem centered around issues of low self-esteem and irritability on the part of the ill relative, which they were able to overcome with the use of “encouraging” statements and support (for low self-esteem) and improved communication skills (for irritability) learned during the group.

* A third problem involved violent behavior by the ill relative towards another family member. The family learned that medications and medication adherence is critical in the consumer's treatment. Once the consumer was on medication, the violence stopped.

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

Overall, the family members interviewed said that the communication skills they've learned in these groups have reduced stress considerably, and sometimes improved the ill family member's mood state too. They 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.

Families also emphasized how much they learned in the groups about symptoms, and the need for professional treatment, specifically, the benefits of medication and medication adherence. Several also emphasized the value of learning about the cognitive symptoms of schizophrenia, for instance, problems with concentration.

Finally, family members reported they have learned to be better listeners, and to replace arguing with problem solving. This has resulted in a more collaborative attitude in the family. An important part of listening has been to pay attention to the ill relative's legitimate complaints. One family member said: "No es malcriado... esta enfermo" (He is not spoiled/lazy... he is ill).

All of those interviewed were very pleased with the Latino MFG program, and wanted their groups to continue. They hoped that there would be more efforts to motivate other families to attend, since the groups were small, and that help with transportation and alternative times for group meetings might make a difference. Publicity (e.g., in the schools) about these groups, as is done with NAMI programs, might also make a difference in recruiting families for future groups.

In both the post-training questionnaires and the evaluation interviews, staff at the two agencies consistently identified several challenges to the implementation and long-term success of the Latino MFG program:

1 - Transportation Attendance is a problem for family members in the Latino MFGs, often due to a lack of transportation. One solution is to provide vouchers so that participants without cars can take a taxi to the meetings (this was done at one of the two implementing sites, though at the time of the evaluation interviews it was not yet known whether vouchers will solve the transportation problem).

2 - Cultural Attitudes Interviewees said that Latino families are often reluctant to "accept the fact of mental illness," and thus are less likely to get the services they need - this affects their willingness to participate in the MFG program as well. As one of the interviewees put it, "Some don't believe their children have a mental illness - they're just being very bad kids." Some also have an attitude that it is "someone else's job to fix the client."

3 - Child Care Attendance also can be affected by the lack of child care. One solution is to provide child care on site where the meetings occur, though this is expensive and somewhat difficult to implement.

4 - Follow-Through One of the main challenges in implementing the MFG approach over time is

getting consistent follow-through from the families. Time management and scheduling for families is needed in order to get them to show up regularly. Several of the participating clinicians said that getting family members to come to the group meetings over time will probably always be a challenge, and that plans need to be made in advance to address this challenge.

Attitudes towards the *LMFG Manual* were very positive. One interviewee said the *Manual* is so good that she is “going to make a copy for each manager and told them to use it for any cross-cultural training they do.” Neither program coordinator had changes to suggest in the content or format of the manual, nor did participants in the October 2008 staff training session.

Recommendations

The following recommendations are made for the improvement of the Latino MFG approach in future implementations with Spanish-speaking Latino families:

1 - *Providing transportation and child care alternatives can significantly increase the rate of participation for the Latino MFG group meetings.* Such options should be explored during the planning phase of each new MFG program, along with other needed supports, such as the availability of food at the family meetings (which pilot program participants regarded as desirable).

2 - *While it was not possible to have a parent facilitator for these two pilot implementations, those interviewed suggested that adding an experienced parent to the group as a facilitator would increase the chances for success.* People are more receptive to hearing about problem-solving mechanisms that come from someone else who’s faced the same problems in their lives. The parent facilitator actually could be added in the future to the two groups reported here, which could make them more resilient in the face of anything that emerges in the future. Or, a facilitator could be selected from among the family members who are already part of the group.

In retrospect, it does appear that the groups' organizers underestimated the difficulty of recruiting family co-facilitators. Part of the challenge is that the co-facilitators needed to be Latino and Spanish-speaking, which does restricts the number of available candidates. They may also have been harder to reach despite Dr. Kopelowicz’s close relationships with the Latino communities in the San Fernando Valley, since there is not a separate local NAMI organization for Latinos. In a July 2009 interview, the president of the San Fernando Valley NAMI affiliate reported that her organization was having difficulty recruiting Spanish-speaker members as well.

Moreover, for family members (Latino or non-Latino) who are interested in taking on a volunteer working role with other families, in addition to what they may be involved with for their own family member, there are other options already in place through their NAMI affiliate. They can become unofficial leaders of the “Caring and Sharing” sessions that occur at NAMI meetings. If they are even more highly motivated, they can receive training to become NAMI “Family to Family” program provides, which includes a full training curriculum as well as mentoring from a more experienced family member. One option might be to pay family members to co-facilitate the LMFG groups.

More structured recruitment efforts (e.g., circulation of a flyer about the groups and the need for a co-facilitator) undertaken a longer time before the groups were scheduled to begin might have been successful. The Valley NAMI chapter was quite cooperative, so a more intensive effort would likely have been feasible. Provision for training and mentoring as done with the Family to Family program might also be desirable, and inquiries could be made of current family members of the two pilot implementation groups to determine whether any of them would be interested in such a role.

3 - Hearing from other clinicians about the value of the Latino MFG approach can help motivate clinicians to participate. In particular, this is likely if the clinicians who advocate participation have already run or contributed family members to groups. They can speak persuasively about how much the groups have to offer, especially in a resource-poor environment where clinicians may have limited time to work individually with families.

4 - Hearing from family members about the impact of the Latino MFG groups for them and for their family members can motivate both clinicians and family members to participate. The interviews done for this evaluation with family participants in the pilot groups provide useful examples of the groups' impact, as well as anecdotal evidence of what overall value family members place on the groups. Such reports may be used to "market" the Latino MFG groups to potential family participants, as well as to motivate clinicians to obtain the needed training and implement a group.

5 - There is a need to convey more background information to participating clinicians about the problem-solving approach that is built into the MFG process. Learning about the solid science behind structuring problem solving may help them understand better this important aspect of the MFG model.

Engaging families in a routine of healthy, well-communicated problem solving is a fundamental aspect of what makes the MFG approach work, and also what helps to sustain it over time. Better conceptual understanding by clinicians will in turn help them convey more articulately to family members how problem-solving works.

6 - There is a need to gather data about the actual impact of the Latino MFG approach on both the functioning of families and outcomes for adolescent clients. So far, aside from the interviews done with a small number of family members, the only evaluative data are "one step removed" from actual service impact - they focus on the input of clinicians and program developers or funders only. More in-depth interviews with family members and with consumers can provide evidence of direct program impact.

Overall, the reactions of the participating clinicians in the Latino MFG program was very positive. As one clinician put it, "I think there is great benefit to MultiFamily Groups, as families who are going through similar issues will be a great support system for each other. Families also will find out they are not alone with their current struggles and issues." Similarly, the family members interviewed spoke very positively of their experiences with the LMFG groups, and were able to offer specific examples of their impact.

In the view of both participating clinicians and of the family participants interviewed, the MFG approach can and does improve communication between family members (including the consumer), lessens the isolation and stigma they feel, teaches them problem-solving skills, and increases awareness of treatment alternatives and access to services. Such positive assessments will, however, carry more weight when coupled with more substantial data showing how family members have improved their coping skills and relationships with their family members, and how consumers have actually improved in their life functioning as a result (including such concrete indicators as reduced hospitalizations, increased medication compliance, etc.). Along with more opportunities to implement the Latino MFG program, collecting such data can be an important next step in the development of this helpful technology for improving services to families of both people with mental health problems (children, adolescents and adults).

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