Community Action Grant for Systems Change-Phase II

"Elegir-Conseguir-Retener" Modelo de Rehabilitación Vocacional para Latinos con Condiciones Psquiatricas"

(The Choose-Get-Keep Approach to Vocational Rehabilitation for Latinos with Psychiatric and Co-occurring Conditions)

FINAL REPORT

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The Choose-Get-Keep Approach to Vocational Rehabilitation for Latinos with Psychiatric and Co-occurring Conditions

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I. Introduction

The goal of this Phase II-Community Action Grant for Service Systems Change was to implement an exemplary practice, the model **Elegir-Conseguir-Retener" Modelo de Rehabilitación Vocacional para Latinos con Condiciones Psquiatricas (The Choose-Get-Keep Approach to Vocational Rehabilitation for Latinos with Psychiatric and Co-occurring Conditions)** in five sites across Massachusetts. The project was designed to ensure implementation of, and fidelity to, the Model using existing service dollars. Inherent in the exemplary practice is the ingredient of choice, and ownership of the goal. Consumers must have the opportunity to select work settings that are compatible with their interests, cultural values, abilities, and previous work experiences, empowering them to obtain productive roles in society. By the year 2025 the four major racial groups will account for 40% of the U.S. population (Surgeon General, DHHS, 1999). Key findings from this report conclude that most minority groups are less likely than whites to use services, and that they receive poorer quality mental health care, despite having similar rates of mental health disorders. Latinos/Hispanic Americans are the fastest growing minority group in the country. Their per capita income is among the lowest of the minority groups covered by the Surgeon General's Report: *Mental Health: Culture, Race, and Ethnicity (A supplement to Mental Health: A Report of the Surgeon General, 2001).*

In Massachusetts, this project was even more critical since Latinos have the highest poverty rate of Latinos in any state (Carballeira et al., 2000). Latinos have significantly less education, adversely affecting vocational alternatives, and are subjected to discrimination (Leal-Idrogo, 1993). Critical to Latinos is the cultural preference of Personalism, which refers to the tendency to place value in individuals, as opposed to institutions (Avila & Carballeira, 1996). The exemplary practice emphasizes partnership between the consumer and the practitioner, so both partners are working together to achieve the goal. It is a very individualized and respectful way to work with consumers and is reflective of the value of personalism. About 40 percent of Hispanic Americans in the 1990 census reported that they did not speak English very well. In addition, illiteracy and low literacy may accompany poverty among the Latino immigrant community (Flores, 1998; Medina, 1998). The result is that most Hispanic Americans have limited access to ethnically or linguistically similar providers (A supplement to Mental Health: A Report of the Surgeon General, 2001). Therefore, the impact of this project not only increases the community's capacity to serve Latinos, but provides a culturally and linguistically appropriate model for reaching consumers, family members, and practitioners who are monolingual, or for whom English is their second language.

II. Description of the Project

a) Project goals

The main purpose of the project was to implement the CGK Approach in five sites across Massachusetts by providing training, supervision and technical assistance, and evaluating the outcomes of this project. There were four major objectives for this project:

- ***Objective 1***: To develop a permanent, self-sustaining organizational structure that ensures implementation over time of the "Choose-Get- Keep" model for Vocational Rehabilitation of Latino Individuals with Psychiatric and Co-Occurring Conditions.

- ***Objective 2***: To Train Participants In The "Choose-Get-Keep" model for Vocational Rehabilitation Latino Individuals with Psychiatric and Co- Occurring Conditions.
- ***Objective 3***: To provide consultation to five sites to assure fidelity to the Model during the implementation of the "Choose-Get-Keep" model for Vocational Rehabilitation for Latino Individuals with Psychiatric and Co-Occurring Conditions.
- ***Objective 4***: To Evaluate the implementation of the "Choose-Get-Keep" model for Vocational Rehabilitation for Latino Individuals with Psychiatric and Co-Occurring Conditions in five sites.

Please refer to Appendix A for a detailed workplan of objectives and tasks.

b) Exemplary Practice

During Phase I of the Community Action Grant consensus was reached to modify the exemplary practice, the "Choose-Get –Keep" Approach for vocational rehabilitation, to meet the needs of Latinos with psychiatric and co-occurring conditions. The new adapted model is **"Elegir-Conseguir-Retener: Modelo de Rehabilitación Vocacional para Latinos con Condiciones Psquiatricas y/o Coexistentes",** and it was developed by three groups of stakeholders in areas around the state.

A description of the CGK approach was first published in 1984, and modified, extended, and refined over the years in numerous applications (e.g., Anthony, Cohen, & Danley, 1988; Anthony, Howell, & Danley, 1984; Danley and Anthony, 1987; Danley, Sciarappa, & MacDonald-Wilson, 1992; MacDonald-Wilson, Mancuso, Danley, & Anthony, 1989; Sullivan, Nicolellis, Danley, & MacDonald-Wilson, 1993; Unger, Danley, Kohn, & Hutchinson, 1987). The goal of the exemplary practice is to help people with psychiatric disabilities to obtain real jobs, in integrated work settings, with real wages (Danley et al., 1996).

The following were the adaptations made to the exemplary practice to better meet the needs of Latino consumers and their families:

- The original mission statement of Phase I was revised to include **Latino individuals with co-occurring conditions**. This is critical because Latinos experience major health problems at a rate disproportionate to their numbers in the general population (NCLR, 1997). For example, the rate of AIDS cases among Latinos was 46.2 per 100,000 population, as compared to 15.4 per 100,000 among non-Latino Whites (NCLR, 1997).

- In addition to the ten original values of psychiatric vocational rehabilitation, a new value called "Family Integration" was added. This value recognizes the importance of including the family in the vocational rehabilitation process, and the importance of educating the family about mental illness, vocational rehabilitation, and community resources. The importance that Latinos place on the family as the primary social unit and source of support for individuals has been discussed extensively in the literature (NCLR, 1998). Help and advice are usually sought from within the family system first, and important decisions are made as a group (Valdez, 1997).

- In order to attend to the urgency that Latino consumers may have to find immediate work, the practice recommends that the practitioner, during the Choosing Phase, help the individual

set both a short-term and a long-term goal. This is supported by the fact that the exemplary practice is based on the values of psychiatric rehabilitation, such as consumer choice, flexibility, individual planning, and consumer involvement in the rehabilitation process, allowing practitioners to tailor the process to the unique situation of the Latino consumer (Farkas & Anthony, 1989).

- The manual was adapted to acknowledge the fear associated with losing Social Security benefits if a consumer returns to work. This fear was consistently mentioned by consumers, practitioners, and participants as one of the biggest barriers to providing vocational rehabilitation services. Therefore, we added a new tool in the manual to help consumers assess their employment readiness and we are proposing to train staff in the implementation phase on Social Security work Incentives.

- In addition to the original principles of psychiatric vocational rehabilitation, a new principle called "Respect for Cultural Values" was added. The principle recognizes that there are unique cultural differences that the Latino individual with mental illness brings to the vocational rehabilitation process. It respects each individual as a unique human being. This new value acknowledges that every individual has an ethnicity, as well as gender, sexual orientation, level of ability/disability, age, and socio-economic status (Pernell-Arnold et al., 1998).

Please refer to Appendix B to see the Exemplary Practice.

c) Key Stakeholders

Both the commissioner of the Department of Mental Health (DMH) and the commissioner of Massachusetts Rehabilitation Commission (MRC) supported the key statewide stakeholders for the project. They each appointed a key representative to work with us consistently throughout the trainings and the implementation process at the five sites. They also facilitated the development of relationships at the local level with various providers; they hosted some of the trainings, and served as liaisons between local areas and the commissioners. In addition, we utilized the existent effort to fold the CAG into the DMH mental health system ensuring a permanent, self-sustained organizational structure that ensured the implementation of the exemplary practice. One of the biggest accomplishments of the project, particularly in the western part of the state, was to bring players from these two systems to the same table, facilitating collaboration between programs. Another major accomplishment was to facilitate new referrals from MRC, in part by assisting some of the sites to become a vendor for the state VR agency.

Another key state stakeholder was the Peer Educators Project (VINFEN). Moe Armstrong, from Vinfen, was the consumer advisor in the grant. We joined efforts to educate staff and to bring more consumers and family members to the project. An intended outcome of this collaboration is that the grant has been facilitating the implementation in two of our sites of the "**Recuperando La Esperanza**" an educational recovery group for the consumers. This was a critical step in the process of systems change so that empowerment of Latino consumers can facilitate later engagement in the vocational rehabilitation process.

d) Project Sites

We had five sites across the state committed to implement the **"Elegir-Conseguir-Retener: Modelo de Rehabilitación Vocacional para Latinos con Condiciones Psquiatricas y/o**

Those programs are located in the cities that according to the census have the largest percentage of Latinos in Massachusetts. These include the cities of Lawrence (42%), Holyoke (31%), Springfield (17%), and Boston (11%). All the sites were very different, and the implementation activities were tailored individually to provide supervision and technical assistance to meet the needs and readiness of each agency to implement.

Site 1- CEO – Goodwill Industries, Springfield, MA

CEO is a vocational rehabilitation program that serves people with disabilities in the Springfield area to maximize their employment opportunities, economic self-sufficiency, independence, and quality of life. They have a contract with MRC to provide these services to Latino individuals, some with psychiatric and co-occurring conditions. Activities in this program are often provided individually, and designed to assist individuals enter the work force for the first time or to return to work with newly acquired skills, some related to choosing, getting and/or keeping jobs. Some of the staff is Spanish-speaking (the case manager and job developer), and they were highly committed to implementation. The program materials (such as rehabilitation plans, brochures) were all in English.

Site 2- Arco Iris Social Club – Gándara Mental Health Center, Springfield, MA

Arco Iris Social Club is a social club type of service program serving Latinos with severe psychiatric disabilities in the Springfield area. The program is funded by DMH. Most service activities in this program are social, recreational or therapeutic. This program has been in transition from a Day Treatment program format to a social club/rehabilitation program format. Vocational or educational activities were limited to work units within the club (preparing lunches for members, providing some business or maintenance tasks related to operation of the club). All member materials were in Spanish (English versions are provided for DMH records) and all staff were Spanish-speaking.

Site 3- Community Career Links – North Charles Inc., Somerville, MA

Community Career Links is a vocational employment program that serves individuals with psychiatric disabilities in the Somerville/Cambridge area. The program is funded both by MRC and DMH. All service activities were vocational or educational in nature and were conducted both individually and in classroom formats. These activities reflect choosing, getting, and keeping a Job /School. One staff person was bilingual, and conducted individual meetings in Spanish if needed, but all program materials and forms were in English. Some forms were translated into Spanish.

Site 4- Career Initiatives – American Training, Inc., Lawrence, MA

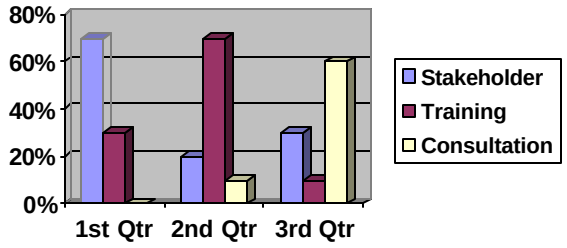
Career Initiatives believes that people with mental illness have the right to access support in pursuit of their career path. The program is funded by a "Services for Employment and Education" contract from DMH. All service activities were vocational or educational in nature, were conducted primarily individually, and were driven by an individual's values, preferences and potential competencies. These activities reflected Choosing, Getting and Keeping a Job/School.

Site 5 - Casa Primavera – Bay Cove Human Services, Roxbury, MA
Casa Primavera is a Fountain House model clubhouse designated to serve Latinos with mental illness in the Boston area. The program has social, as well as vocational activities. All the staff were bilingual, and activities were conducted in Spanish. The staff attended the trainings, but the supervisor did not participate due to the fact that she needed to provide staff coverage at the club.

Other site: As the project progressed, stakeholders joined efforts and become unofficial implementation sites, demonstrating once more the need and importance of this new model, and strengthening our collaboration. This was the case with *Saint Francis House*, a program that serves the homeless population in Boston. They also serve a lot of Latinos, and they wanted to implement a vocational component. One staff person attended the trainings, and collaborated with the other Boston sites.

e) Project Management Activities
There were three major activities occurring in the project to facilitate implementation of the model: engaging the stakeholder, providing training, and providing consultation. Figure 1 graphs the percent of project staff effort across the year of the project in the three major activity areas. In general, the first quarter involved engaging stakeholders and beginning training. The second quarter was characteristically training activities, with some effort in engaging stakeholders and beginning program consultation. By the third quarter, training decreased while consultation and stakeholder engagement increased as program implementation was underway.

Figure 1. Percent of Project Staff Effort Over Time



1. Engaging the stakeholders. We received the award after a long six months waiting period between Phase I & II, so energy during the first quarter was devoted to re-establishing the three regional workgroups and advisory committee. This outreach to key stakeholders was found to be a very time consuming activity for the project staff, and one that was critical in promoting a permanent, self-sustaining organizational structure. Activities included 12 regional advisory meetings to provide feedback on the project activities, and to facilitate implementation activities in the five sites. In addition, a lot of energy went to recruiting consumers and family members to participate in those groups.

2. Trainings. The goal of the training was to increase knowledge and awareness about the model **"Elegir-Conseguir-Retener: Modelo de Rehabilitación Vocacional para Latinos con Condiciones Psquiatricas y/o Coexistentes"**. We wanted to increase community awareness about the model to facilitate the implementation for the sites. We trained a total of 60 people that included program staff from participating agencies and collaborators in the networks connected with the participating programs. Three-quarters of the trainees were Spanish-speaking. Four full-day training sessions were delivered. The first session involved an overview

of the CGK approach for Latino individuals with psychiatric and co-occurring conditions, with 57 trainees in attendance. The second session involved cultural competency training and involved 36 trainees. These sessions were conducted in both English and Spanish. The third and fourth sessions were planned for those people who were implementing CGK in the participating agencies, so it was delivered in Spanish. The third session involved information about the Social Security Work Incentives and the details of the CGK approach and partnering skills, and involved 23 trainees. The fourth session focused on the CGK skills and partnering skills and involved 21 trainees. Refer to Appendix D.

3. Consultation. The goal was to provide ongoing technical assistance on the integration of the model into the structure of each agency. We provided technical assistance and supervision to assist the five sites on the development of processes and procedures for the implementation of the model. Consultation activities began in the second quarter, and intensified during the third quarter. There were a total of 50 meetings that were conducted among the five sites, and each of the consultation activities was tailored to the implementation site. These activities involved: individual supervision, group supervision, direct skill teaching demonstration, skill coaching and/or meetings to help overcome implementation barriers. In addition, some consultation was provided to facilitate key collaborations with other programs in the community. The process of consultation was facilitated when program supervisors were involved.

f) Budget Expenditures

We received the award on 6/15/00 and it ended on 3/1/4/02. The expenditure of grant funds was as follows:

By the first quarter, we expended 25% of the budget. Efforts were devoted primarily to re-establish the three regional workgroups after a six-month waiting period between Phase I and II. The progress to the overall achievement of implementation was 20%-49%.

By the second quarter, we expended 53% of the budget. Efforts were devoted to train people on the model across the state. The progress to the overall achievement of implementation was 50%-69%.

By the third quarter, we expended 70% of the budget, leaving us to request a not cost extension that was approved to 3/14/02. The progress to the overall achievement of implementation was 70%-100%.

III. Project Evaluation

a) Evaluation Plan

A formative evaluation of the program implementation was conducted. The purpose of this evaluation was two-fold:

1) To provide an accurate description of the program implementation process at each site (environmental and organizational context; staffing and other resources; implementation activities, barriers and facilitators; program clientele; activities/characteristics of the program as actually conducted; and program outcomes); and

2) To monitor the implementation process and provide feedback to those involved in the effort so that corrective actions can be taken to improve the success of the program.

The evaluation plan for this project focused on individual, program, and systems level outcomes using a variety of research and analysis strategies. Individual level outcomes involved quantitative assessment of trainees' gains in knowledge, skill acquisition, and skill utilization, as well as exploration of satisfaction of consumers and their family members with the CGK Approach implementation in the project sites. Qualitative analysis of the trainees' evaluation of the training and recommendations for change in the future was also conducted. These outcomes are reported primarily under Objective 2.

Program level outcomes were assessed through the baseline and bimonthly updates including the CGK activities implemented in the programs, and information about the participants in those programs. In addition, technical assistance and supervision reports identified implementation barriers and strategies in each of the sites. These outcomes are reported primarily under Objectives 1 and 3, and somewhat under Objective 4. System level outcomes were assessed qualitatively through steering committee meetings involving systems level stakeholders and data gathered regarding stakeholders perspectives at the end of the project. These outcomes are reported primarily under Objectives 1 and 4. Please refer to Appendix C for evaluation tools. Results will be reported on by Objectives below.

b) Results by Objectives

1. Results of Objective 1 – To develop a permanent, self-sustaining organizational structure that ensures implementation over time of the CGK approach.

Program changes were evaluated by assessing each site at baseline, and continued with bimonthly updates. Changes were reported around the staff, the program structure and the outcomes for Latino consumers.

Site 1- CEO – Goodwill Industries, Springfield, MA

CEO is a vocational rehabilitation program that serves people with a variety of disabilities in the Springfield area. At baseline, CEO was rated as:

- **Moderately committed to implement** because the direct service staff was eager to learn about the model, and the agency's administration recognized the importance, but left it up to the supervisor, who is not Spanish speaking, to carry on the project.
- **Moderately accurate implementing** the model because services were individualized, provided support, did outreach, and developed plans involving the consumers.
- **Moderately relevant cultural practices**, it had Spanish-speaking staff, and some forms were in Spanish, but the majority of the activities were in English despite the fact that between 25-40% of the consumers spoke Spanish only. The program did not attend to the spiritual needs of the Latino consumers, and the families were involved only if needed or initiated by consumers.

The program staff was highly committed throughout the implementation process, despite changes in supervisors. They attended all trainings, and the regional committee was highly supportive of the implementation. Highly accurate implementation of the model was achieved

by the end of the project. They are now addressing the needs of families, and they are training consumers in Social Security Incentives. They have incorporated some of the Spanish versions of the forms into their vocational evaluation, and they incorporated some aspects of assessing readiness for rehabilitation in the program. In addition, the project facilitated the increase of referrals of people with major mental illnesses, and the collaboration with the local DMH office.

Site 2- Arco Iris Social Club – Gándara Mental Health Center, Springfield, MA

Arco Iris Social Club is a social club type of service program serving Latinos with severe psychiatric disabilities in the Springfield area. At baseline, Arco Iris was rated as:

- **Somewhat committed to implement** the model. The staff was interested in learning about the rehabilitation readiness activities, in the hope that it would support their transition from a social club into a more structured rehabilitation program. The program had multiple staffing changes throughout the course of the project, including two program directors who left during implementation.
- **Not implementing the model** because the program does nothing vocational. They provide peer-run activities, recreational and social activities.
- **Highly relevant cultural practices** since all the staff were bilingual/bicultural, and the club activities reflect Latino values and activities (food, music, art). The staff addressed the spiritual issues of their members but families were not involved in the program activities.

This program moved from not implementing the model to successfully integrating the rehabilitation readiness component into their program. Because of the nature of the program, and the multiple staff changes the implementation process was very slow. Only half of the current staff was trained, the new ones needed to be oriented to the process, including the supervisor. A class name NUEVOS HORIZONTES has been added to the club weekly schedule and the majority of activities are being introduced to club members. In addition, the program started to visit several job sites to help members to increase awareness of work in the community. The director has also hired a professional instructor to teach ESL classes to members. A staff from the other site in Springfield went to train the members on Social Security Work Incentives. Multiple relationships with other agencies in the community were facilitated by the project. A brochure announcing the new group was created.

Site 3- Community Career Links – North Charles Inc., Somerville, MA

Community Career Links is a vocational employment program that serves individuals with psychiatric disabilities in the Somerville/Cambridge area. At baseline, this program was rated as

- **Moderately committed to implementing.** The director was very committed to increase the program's capacity to serve Latino consumers, but there was only one Spanish-speaking staff (out of 7) whose job responsibility also includes a case load of English-speaking clients.
- **Moderately accurate implementing** the model since program activities look similar to the exemplary practice but it has very few Latino consumers to accurately judge.
- **Somewhat relevant cultural practices**. Very limited bilingual capacity, program materials were only in English. There was no family involvement, or discussion on addressing the spiritual needs of the consumers.

The program has made strides in implementing the project despite their struggle with bilingual staff retention and recruitment. The English-speaking staff committed themselves to weekly informal Spanish language lessons during lunch. In addition, they attended the overview training to help increase their cultural awareness and sensitivity. Posters on the walls and job board headings are now bilingual, and several Spanish language community newspapers have been purchased and are available for program participants. Even though it took longer than expected, and the program staff was disappointed, all program materials now have been translated into Spanish. These activities and outreach to community agencies serving Latinos resulted in an increase of Latino referrals.

Site 4- Career Initiatives – American Training, Inc., Lawrence, MA
Career Initiatives is a vocational employment program that serves individuals with psychiatric disabilities in the Lawrence area. At baseline, Career Initiatives was rated as:

- **Moderately committed to implement.** The staff and the supervisors were interested in learning and participating in the process. The direct staff had concerns about the supervision and how the changes would impact them, and the program since they already did the CGK for their English-speaking consumers.
- **Moderately accurate implementing** because this program uses the CGK approach but they did not address the rehabilitation readiness component of high importance for engaging Latino consumers in the process.
- **Somewhat relevant cultural practices**, the bilingual staff was very stable, but they were serving a relatively low percentage of Latino consumers considering the area in which they are located. The program brochure was in Spanish. The program did not involve the family, or address the spiritual needs of Latino consumers.

The program has successfully implemented changes around the choosing phase. They also modified the way they engage and do outreach to the Latino consumer and their families. They incorporated some of the Spanish forms, and we helped the bilingual staff to complete other Spanish translations. The program supervisors were very supportive; they attended the trainings, and felt that it helped them increase their cultural sensitivity. The bilingual staff of this program was very stable. We expended a lot of time and energy doing outreach to increase the number of Latino referrals. In this site we also encountered a lot of resistance from various key players in the community, but in the end, the project helped facilitate those working relationships by clarifying that the agency was a collaborator, not a competitor.

Site 5 - Casa Primavera – Bay Cove Human Services, Roxbury, MA
Casa Primavera is a Fountain House model clubhouse designated to serve Latinos with mental illness in the Boston area. It receives funds from DMH. At baseline, it was rated as:

- **Moderately committed to implement,** the director has been involved since the beginning of Phase I but program coverage needs to be planned for when staff attends the trainings.
- **Moderately accurate implementing** as a Clubhouse program they have been incorporating some vocational activities. There was a job developer on the staff, and they were moving toward formalizing the vocational process.

- **Highly cultural practices**, since all the staff was bilingual/bicultural, and the club activities reflected Latino values and activities (food, music, art). The staff addressed the spiritual issues of their members but families were not involved in the program activities.

The program has successfully implemented the activities of the choosing phase of the model. They now have weekly groups that help consumers identify their values.

In addition, we helped facilitate conversations with the Vocational Rehabilitation State agency to explore possibilities to become an MRC vendor. This will help the program financially, and it will ensure the implementation of the practice. Although the director of the program has been actively involved in the project, little programmatic change has occurred due to many of the organizational problems. Barriers included problems with the staff coverage, limiting staff participation, and limited capacity to organize and collect outcome data. We had to provide a research assistant to collect the data from this site.

2. Objective 2 – To train the participants in the 'Choose-Get-Keep' model for Vocational Rehabilitation for Latinos with Psychiatric and Co-Occurring Conditions

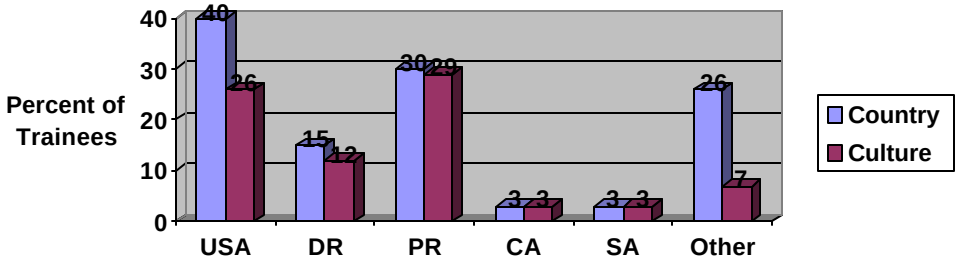
Trainees were recruited from the 5 participating programs and from agencies in the network of service providers in the mental health and vocational rehabilitation systems in one of 3 regions – Holyoke/Springfield, Lawrence, and Boston, MA. Assessments of trainee knowledge and skill were obtained immediately prior to training (Pre-Test), immediately after training (Immediate Post-Test), and 3 months after training ended (3 Month Post-Test). The Pre-Test contained items on knowledge, skill application, and trainee demographics. The Immediate Post-Test contained items on knowledge, skill application, skill utilization, and satisfaction with training. The 3 Month Post-Test contained items on skill application, skill utilization, and satisfaction with training.

Description of Trainees

A total of 60 individuals started training in the 3 regions of the state. Eighteen out of 60, or 30% were from the 5 participating programs. The remaining 70% of trainees were from collaborating agencies in the mental health and vocational rehabilitation systems in the 3 regions. Most trainees (90%) were employed full-time. Approximately half of the trainees worked in direct service positions, 17% in supervisor/manager positions, and 10% in administrator/executive positions, the remainder in other types of positions. Regarding education levels, 18% of trainees had high school or less, 25% had some college, 18% had a Bachelor's degree, and 35% had a Master's or Doctorate. Only 1 out of 60 trainees (2%) reported having a consumer relationship with the mental health system, 80% a service provider relationship, and 18% reported some other relationship.

Trainees were asked several questions regarding racial/ethnic backgrounds, including the country in which they were born, as well as the culture with which they identified. Figure 2 presents the results.

Figure 2 - Trainees' Country of Birth and Cultural Identity



USA – United States of America/North American
DR – Dominican Republic/Dominican
PR – Puerto Rico/Puerto Rican
CA – Central American/Central American
SA – South America/South American

Of note, no trainees identified themselves as Mexican or Cuban, nor were born in either Mexico or Cuba. The largest percentage of trainees was born in the United States (40%), altho ugh the majority of trainees were born outside of the U.S. The largest percentage of trainees identified with Puerto Rican culture (29%), although North American (26%) and Other (26%) were similar. In examining the other category for cultural identity, 2/3 identified themselves with more than one culture. Overall, 70% identified themselves as of Latino/Hispanic ethnic/racial background, 24% Caucasian, 2% African American, 3% other. However, in looking at Figure 1, only 47% specified a Hispanic Culture (Puerto Rican, Dominican, South American, Central American). Clearly, there are a number of ways to characterize racial/ethnic diversity, and the type of question yields different results. Generally, these trainees were largely Hispanic, Puerto Rican, and born outside of the United States. Seventy percent had lived in the United States more than 10 years, and were fluent in both English (90%) and Spanish (77%).

Attendance

A total of 60 trainees attended at least one day of training. Overall, 24 out of 60 individuals attended 1 day of training, 11 attended 2 days of training, 7 attended 3 days of training, and 17 attended a total of 4 days of training. Approximately one third attended the full training.

Impact of Training on Knowledge Gain

Knowledge was assessed before training and immediately after training using multiple-choice questions about the CGK approach. Knowledge was scored based on the number of correct responses out of a total of 14 questions. At Pre-Test, the average number of correct responses out of 14 was 7.90 (s.d.=1.98, n=60). At the Immediate Post-Test, the average number of correct responses was 9.23 (s.d.=2.03, n=43). Using a paired-samples t-test, there was a significant difference between Pre-test and Post-test scores (t=-5.15, df=40, p= .000), resulting an improvement in Knowledge gain from before training to after training. The conclusion is that Training resulted in a significant improvement in knowledge, although the gain was modest (x=1.34 points, s.d.=1.67).

In examining the individual knowledge items, the most frequently correct questions involved the Principles of the CGK approach for Latinos, the involvement of the family, the Social Security Work Incentives, and disclosure during the job application process. The most frequently incorrect questions involved Essential Values, Choosing a Job Activities, and Assessment items. Table 1 illustrates a comparison of the pre-test and post-test knowledge items.

Table 1 – Frequency of Correct Knowledge Items

Knowledge Item	Pre-Test	Post-Test
1. Essential values of the CGK approach include family integration.	40%	67%
2. Some essential principles of the CGK approach are flexibility, creativity, respect, and sensitivity to cultural values.	85%	91%
3. Factors that must be considered when working with Latino individuals are the role of spirituality in the person's life, how the values of family and work interact, and the diversity among Latino cultures.	67%	65%
4. The best time to involve family members (with permission) of Latino individuals in the CGK process is from the beginning of the process.	80%	98%
5. The words "readiness for rehabilitation" in the CGK approach mean helping someone decide if he/she is prepared to get involved in rehabilitation.	65%	65%
6. Clinical skills that are important to use in the CGK approach to connect with Latino individuals with psychiatric and co-occurring conditions are demonstrating understanding and inspiring.	75%	65%
7. "Choosing a Job" activities involve defining one's work values, interests, and competencies, researching what job opportunities are available, and exploring the opinions of family and friends about the goal.	30%	35%
8. Assessment of work skills in the CGK approach should occur after setting the job goal in order to prepare to get the job.	8%	30%
9. The essential areas assessed for all participants in the CGK approach include skills and supports.	20%	46%
10. "Getting a job" activities involve describing a person's strengths to an employer, planning the tasks of getting a job with the participant, and negotiating the terms of employment.	55%	65%
11. In order to get a job, the applicant has the choice to tell an employer about a psychiatric condition at any time in the job process, or not at all.	72%	81%
12. The main activities in "Keeping a Job" include developing the interpersonal and technical skills and supports needed for the job.	57%	60%
13. Reasonable accommodations are the supports provided by an employer to help someone perform the required job tasks.	52%	67%
14. For the most part, if someone has Supplemental Security Income (SSI) benefits and is going to work part time, the person may lose some of his/her SSI check but still have more spending money (earnings and SSI) as soon as he/she starts to work.	85%	86%

Analysis included examining whether education level, work role of the trainee, and number of days attending the training were variables influencing the results. Overall, knowledge gain (number of points of improvement) was significantly lower for those with higher educational levels ($F=5.032$, $p= .031$) and those in supervisory vs. direct service roles ($F=9.00$, $p= .003$). Number of training days attended and whether the trainee worked in a participating program was not significantly associated with knowledge gain scores ($p> .05$). Those with higher education

levels and those in supervisory roles tended to have higher average knowledge scores at pre-test, although this did not achieve significance. This suggests that those with less knowledge initially, especially direct service providers and those with less than college education level, learned more from training.

Impact of Training on Skill Acquisition and Application

Skill acquisition and application was assessed at Pre-Test, Immediate Post-Test, and 3 Month Post-Test using 2 scenarios describing individuals and asking trainees to describe their actions or words in response to the situation. Responses were rated on a 5 point scale by experts in the CGK approach for Latinos from a 1 (not acceptable) to a 5 (ideal), with a 3 rated as the minimum acceptable based on the items included that composed a skilled response. The Pablo scenario incorporated partnering skills, responding to cultural issues and responding to spirituality. The Margarita scenario incorporated readiness for rehabilitation, choosing activities, involving family, and responding to cultural issues.

Using paired samples t-tests on both skill application scenarios, there was a significant improvement from Pre-Test to Post-Test (Pablo, t=-2.060, p=.047; Margarita, t=-5.033, p=.000). On the Margarita scenario, there was also significant improvement from Pre-Test to the 3 Month Post-Test as well (t=-2.729, p=.015). Scores on both scenarios at Pre-Test improved from a median rating of 2 (less than acceptable) to a 3 (minimum acceptable) at Post-Test. Results indicate that training resulted in skill gain to the minimum acceptable level. Partnering skills and responding to spirituality appeared more difficult skills to sustain at the 3 Month Post-Test. In general, the 3 month Post-Test was administered before much ongoing training, technical assistance, and supervision was provided at the program sites participating in the project, which may explain some of the mixed results in sustaining improvement in skill gain over time. Additional analysis did not find any significant differences in skill application scores or gain based on number of days of training attended, education level, or by role (direct service vs. supervisor).

Impact of Training on Skill Use

Skill Use was evaluated at the Immediate Post-Test and at the 3 Month Post-Test by asking trainees to rate how often they used particular skills 3 months before training started, at the Immediate Post-Test time and at 3 Month Post-Test (never, sometimes, most of the time, always). In addition, trainees were asked to report on what caused them trouble in using the skills, what helped them use the skills, and recommendations for improving the effectiveness of training.

At the Immediate Post-Test, trainees reported a range of frequencies in the 3 months prior to training, in using the Choosing, Getting, Keeping, and Leaving skills. In general, trainees most often reported sometimes or most of the time using the skills, and least often reported never or always using the skills. However, by the end of training at the Immediate Post-Test, there was a trend toward increasing use of specific choosing and keeping activities (more trainees reporting using the skills most of the time or always), although these findings were not statistically significant using chi-square analyses, given the small numbers of trainees. The particular activities that appeared to increase in use were the choosing activities of *specifying the employment goal* and *selecting the preferred employer*, and the keeping activities of *assessing*

skills and resources, developing reasonable accommodations, and *coordinating services and supports*, while there was one leaving activity of *documenting professional gains*. While the frequency of most of the time and always increased between 3 months prior to training and at the immediate end of training, there also appeared to be an increase in trainees reporting that they never used the skill, and a decrease in the number reporting that they sometimes used the skill. These increases also appeared not to be sustained at 3 months after the training, but again, this difference was not statistically significant. Trainees reporting on these skills included people who were not implementing the CGK approach in their programs but were from collaborating agencies, and thus may not have had the opportunity or support to use these skills in their jobs. One other caveat in interpreting these findings is that for many of those trainees who were from participating agencies, ongoing training, technical assistance, and supervision was only getting started approximately 3-4 months after training, and supports may not have been in place for staff to use these skills. Finally, skill use was obtained through self-report of staff, not from actual use as observed by experts. Caution should be taken in interpreting that the impact of training on skill use is only as reported by staff.

Further analysis was conducted to determine if the number of days of training attended had an impact on the reported frequency of using these skills. In general, attending more days of training (3 or 4 days vs. 1 or 2 days) did not result in reported differences in the frequency of using CGK skills, with the exception of the skills of *selecting the preferred employer* ($x^2 = 4.97$, df = 1, p= .038) and *developing reasonable accommodations* ($x^2 = 4.968$, df=1, p= .047). This increase in frequency was noted from 3 months before training to immediately after training, but was not sustained at 3 months.

Additional analysis on the difference between trainees who were from the programs participating in the implementation of CGK or who were from collaborating agencies found that trainees from participating agencies more frequently *specified the employment goal* ($x^2 = 4.822$, df=1, p= .041), *profiled employment potential* ($x^2 = 6.217$, df=1, p= .018), and *located best fit employers* ($x^2 = 5.125$, df=1, p= .037) immediately after training compared to 3 months before training, but this difference was not significant 3 months after training. Program participant trainees also reported that they more frequently *negotiated terms of employment* compared to collaborating agencies trainees, 3 months after training was completed ($x^2 = 6.804$, df=1, p= .035). Overall, it appears that training increased the reported use of Choosing and Getting skills for participating program trainees compared to collaborating agency trainees who did not directly use the CGK approach in their agency.

Regarding the reported frequency of using five different clinical (partnering) skills, there were no statistical differences found from 3 months prior to training to immediately after training or 3 months after training, due in part to the small number of participants. However, there were trends toward an increase in frequency in using the clinical skills (orienting the person to the task, asking open-ended questions, demonstrating understanding, disclosing personal information, inspiring) from 3 months prior to training to immediately after training, and a drop 3 months after training. It was interesting to note that across time, there appeared to be an increase in the number of people reporting that they never used these clinical skills in their work. Again, these findings were not statistically significant using a chi square analysis.

Recommendations were made by trainees to have more training time in the future. Immediately after training, the trainees suggested that the training incorporate more practice exercises, more days of training, more time in the program to use the CGK skills, and more technical assistance. These recommendations were suggested by ¼ to ½ of the trainees participating. By 3 months after training, the recommendations continued to emphasize more training sessions and practice exercises, but also focused on more supervision after training and more support from agency administrators.

3. Objective 3 – To provide consultation to five sites to assure fidelity to the model during the implementation of the "Choose-Get-Keep' model for Vocational Rehabilitation for Latinos with Psychiatric and Co-Occurring Conditions

Consultation and technical assistance was tailored individually to each implementation site since each site has unique consultation and technical assistance needs. When asked what things helped in using the CGK approach immediately after training, training in cultural competence, practice exercises, training sessions in CGK, supportive trainers and the worksheets/forms provided were most frequently identified by trainees. Three months later, the most frequently identified items that were helpful included the training sessions, supportiveness of trainers, cultural competence training, and getting the right amount of support from the program.

We asked trainees to identify the major reasons that they had trouble using the CGK approach in their jobs both at the immediate after training and 3 months after training. Overall, immediately after training, the most frequently cited reasons for having trouble using the CGK approach involved needing to plan ahead, needing more time, needing more training in CGK skills, and other (primarily trainees were not working in a program using the approach). By 3 months after training, the most frequently cited reasons focused on needing more training on CGK skills, needing more time, and needing more support from the program to use the CGK approach. To address this concerns we provided individual and group supervision after the trainings in each site. In addition, we did demonstrations of the skills learned on the trainings, groups with consumers and family members and in some sites we did additional in-services. We helped each program incorporate the exercises and forms that fit their program needs. All five sites recommended that ongoing consultation be provided.

4. Objective 4 – To evaluate the implementation of the 'Choose-Get-Keep' model for Vocational Rehabilitation for Latinos with Psychiatric and Co-Occurring Conditions in five sites in Massachusetts

Satisfaction of Consumers and Families with the CGK Approach

The satisfaction survey consisted of 10 individual satisfaction questions in which individuals were asked to rate each item on a 4-point Likert scale. Structured response questions asked individuals to list 3 things they liked about the program, 3 things they did not like, and ways in which they had changed as a result of the program. General information about characteristics of the survey respondents was also obtained.

A total of 42 individuals completed the satisfaction with the CGK approach. Eighty-eight percent identified themselves as program participants, one person identified as a family member,

and 4 did not specify. Overall, the majority was not working for pay. Ninety-eight percent were fluent in Spanish, 43% were fluent in English, and 45% considered themselves bilingual. Out of 42 respondents, 40 considered themselves Latino, 1 considered themselves Latino and American, and 1 did not specify. The culture most often identified was Puerto Rican (72%), with Dominican Republic (9.5%). Cuban, Central American and North American accounted for 3 other individuals. Only 17% were born in the United States, and for those born outside the U.S., the most frequent country of birth was Puerto Rico (62%) and the Dominican Republic (14%), with two other individuals born in Cuba and Central America. Those not born in America had been living in the U.S. an average of 17 years. Over two thirds (69%) had a high school diploma or less in education, and only 8% had a bachelor's degree or higher.

This group of individuals was generally very satisfied with the program in which CGK was implemented. Overall, the program was rated Excellent (x=1.33, s.d.= .57). No one rated the program as poor, and very few rated it as fair. Examination of individual satisfaction items resulted in all items receiving an average rating of 1 to 2, indicating moderately to very satisfied. Although satisfaction levels were high, out of the 10 items, survey respondents were most satisfied with how well staff communicated with them, how respectful staff were toward them, and how well staff informed them about Social Security benefits and working. Survey respondents were least satisfied with staff helpfulness around choosing, getting, and keeping job or school, and staff sensitivity to their needs. Note that satisfaction even for these items was high (see Table 2).

Table 2 – Average Satisfaction with the CGK Approach

Satisfaction Item	N	Mean*	Standard Deviation
How well the staff communicated with you	42	1.19	.55
How sensitive the staff were to your needs	41	1.37	.73
How sensitive the staff were to cultural and spiritual needs	41	1.29	.56
How well the staff involved you in the process	41	1.27	.67
How respectful the staff were to you	42	1.21	.56
How helpful the program was in helping you to choose a job or school	40	1.38	.67
How helpful the program was in helping you to get a job or school	39	1.38	.75
How helpful the program was in helping you to keep a job or school	38	1.39	.72
How well the staff informed you about Social Security benefits and working	40	1.20	.61
Overall program rating**	42	1.33	.57

* Ratings for all items except the last one – 1=Very, 2=Moderately, 3=Somewhat, 4=Not at all
** Rating – 1=Excellent, 2=Good, 3=Fair, 4=Poor

Content analysis was conducted on the structured question responses on what they liked about the program, what they disliked about the program, and changes observed as a result of

participating in the program. Survey respondents most often mentioned that they liked the friendliness and communication with people, the work activities and job opportunities, and the supportiveness and helpfulness of the staff. Respect was also mentioned. These likes are reflective of the primary values of the CGK approach with Latinos: respect and friendliness. The three things most often mentioned that survey participants did not like about the program included food, lack of work opportunities, the short time of the program. Note that there were much fewer comments (only 2-3) about dislikes than likes about the program. Survey respondents identified a number of changes that they observed in themselves as a result of participating in the program: that the feel better or healthier, that they feel more useful, productive or motivated, and that they are less shy or more connected to other people.

c) Evaluation Tools and Products Developed (see Appendix C)

A variety of tools were developed to evaluate the project outcomes previously described under Objectives 2 and 4 of this project. These tools were developed to capture changes in the participating sites, in the trainees, and in consumers and family members.

Appendix C contains a brief description and the instruments and forms for use in the implementation and evaluation of this project. The Institutional Review Boards of Boston University and the Massachusetts Department of Mental Health approved all instruments and forms. All products are written in both English and Spanish unless otherwise indicated.

IV. Lessons Learned

a) Barriers and Strategies

Overall, there were several barriers to project implementation across sites. Knowledge of these barriers was used to design strategies and modify implementation activities to overcome barriers.

1. Lack of community awareness of the "Choose, Get, Keep" model.

Success in this project depended on increasing the awareness of the importance of referring Latinos for vocational rehabilitation within mental health and rehabilitation agencies in the community. While some implementation sites already had sufficient clients from whom to draw referrals, there were others who depended on outreach to agencies and individuals in the community.

The training effectively increased the community awareness of the model. Project staff met with executives and staff of all potential referral agencies to explain the Model as well as the vocational needs of people with mental illness. In addition, project staff worked with consumer and family groups in each implementation region to explain the Model and the vocational needs of people with mental illness.

2. Lack of information in Spanish.

The availability of materials in Spanish was essential to address the language barriers experienced by Latino consumers. Funds were budgeted for translating materials, and technical assistance was provided to some sites on translating agency information critical to Latino consumers and their families.

3. Lack of cultural competence of agency staff and employers regarding Latino populations.

Some agency staff and employers were not aware of cultural differences for Latino consumers. The training on cultural competence was a critical component for this project. It provided an overview of issues related to cultural competence to the entire staff at each implementation site to increase their awareness of the cultural beliefs held by Latinos. Training on an ongoing basis was recommended.

4. Lack of knowledge of Social Security Work Incentives.

The fear of losing Social Security benefits was reported by consumers and workgroup participants as one of the most significant barriers when considering returning to work. The project incorporated specific training on Social Security Work Incentives. However, training must continue in order to support staff and consumers to access and use the work incentives.

5. Urgent need of Latino consumers to get jobs.

We learned in Phase I that language barriers, varying acculturation levels, immigration status, and the erroneous belief in the community that people with psychiatric disabilities cannot lead productive lives, prevent Latino consumers from working on a job of their choice. Poverty is a reality for this target population; the urgency to work is very high. Consumers need to get a job and earn some income rapidly. Project provided technical assistance to staff in how to work simultaneously on both short-term employment needs and long-term career goals.

b) Systems

Funding

Systems change efforts generally take much longer than two years. More funds are needed to continue with this effort, and to evaluate the effectiveness of the model. A phase III is necessary to continue with this work.

Sustaining key stakeholders involvement

A lot of effort went into reconnecting with people in the community. This is a critical component in this process, but it took lots of time, and personal connections. Systematic plans must be developed to sustain the involvement of key stakeholders beyond this project, especially when there are competing priorities for time and resources.

Collaboration not competition

Human service systems such as the ones that we were working with, the Department of Mental Health, and The Massachusetts Rehabilitation Commission let competition get in the way of collaboration, and impacted the numbers of referrals to the program. Creating an atmosphere of collaboration required a lot of networking and clarification, and the trainings were a great tool. Regional meetings also facilitated this collaboration. Systems change efforts should recognize competition as a potential barrier and develop strategies to address them. Coming from an academic setting presented a barrier in itself for being perceived as an outsider, and took additional effort to overcome resistance to change.

Ongoing short term training

Ongoing training strategies are a MUST for all systems, especially considering the difficulties with the bilingual staff retention. Additional training in cultural competence and in the model will be necessary, including more practice exercises, ongoing onsite technical assistance and supervision, as well as programmatic and administrative changes and supports are needed for successful implementation of the model. Time must be built into the programs and systems for staff to participate in training, learn the skills, and attempt to use the skills in their programs. Both supervisors and administrators should participate in training to be knowledgeable about the skills staff will be implementing, to prepare for conducting supervision with staff and modifying program activities and structure to support the use of the CGK skills by staff.

c) Programs

Bilingual Staff Retention – a critical issue for all the sites. We underestimated how difficult it is to retain the Latino staff, and the impact that it had on the programs. It clearly impacted our project because as pointed out before in this report**,** all five participating programs experienced changes in direct service staff during the period in which training occurred, and 2 of the 5 programs experienced a change in the program supervisor (one program changed supervisors twice during the training period). So by the time we finished our training new staff came on board and needed to be trained in the model. Financial Incentives must be built in this program to help retain their staff, and mechanisms for ongoing training and orientation are needed.

Referrals

The project spent a lot of time and energy helping the sites get new referrals. The trainings increased the awareness, but the collaboration happened when the providers sat down at the same table. This was a very successful outcome of this process, it facilitated agencies that had never worked together, or did not know what each did, to learn about each other and referrals. Further education for consumers and their families via radio and local newspapers are recommended.

Lack of research infrastructure

We learned that the agencies do not have the capacity to do research tasks, and need additional resources and consultation to expand their capacity to evaluate their program outcomes. For one of the sites, we provided support from the university to collect some of the data. For the other sites, they provided staff but it was time consuming and impacted the rest of the personnel.

Ongoing Consultation to Promote Skill Use

Formal ongoing consultation strategies are a MUST for all programs, especially for those where implementation was slower, and those with the bilingual staff retention problem. Additional consultation is necessary to continue facilitating the integration of the model within the agency, and to overcome barriers. The principal investigator will continue an informal consultation with the five sites, but further funds are necessary to formalize the technical assistance.

d) Individuals

Family and consumer outreach

Engaging the families to participate continues to be a struggle for all sites. The training increased the awareness in all sites on the importance of the involving the family members, and they made

some changes. However, more needs to be done, and further collaboration with NAMI-MA needs to be in place in order to actively outreach families.

Role of the supervisor

Service staff recommended more involvement of the supervisor and administrator, with the training and implementation of the model. When supervisors were involved and knowledgeable, programs made greater strides in implementing and sustaining changes.

Facilitating empowerment and hope

We work very closely with the peer educator program facilitating in the process the establishment of new recovery workshops in two of the sites. This peer support led activities are critical to empower Latino consumers and their families. We recommend that this collaboration

Language Barriers

We learned that this is not only an issue for the consumers but for some the staff. Assessing the level of fluency in both English and Spanish is critical to the success of implementing cultural appropriate practices.

V. Summary

Phase II of the CAG accomplished successfully its major project goals of establishing supportive organizational structures, providing training and consultation, and evaluating the outcomes of the project. Trainees learned knowledge and used skills more frequently after training than before. Strategies for implementation in each program were developed to address individual, program, and system barriers. Ongoing training, technical assistance, and consultation is necessary in order for sustained change to occur, especially as staff, supervisors, and administrators change and system priorities move away from culturally competent programming to other hot topics. Systems change generally requires 7-10 years for planned implementation to take full effect. This project initiated that change in the hope that other efforts and resources can be marshaled to contrive this successful initiative in the future.

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Appendix A

CAG II Project Workplan

Objective 1: To develop a permanent, self-sustaining organizational structure that ensures implementation over time of the "Choose-Get- Keep" model for Vocational Rehabilitation of Latino Individuals with Psychiatric and Co-Occurring Conditions.

Task#	Action	Timeline	Outcome
1.1	Meet with executive staff of each site to review and revise their agency's implementation plan.	Month 1	• Reconfirm the implementation plan and forward to regional workgroup.
1.2	Re-establish statewide advisory committee	Month 1 – 2; Quarterly	• Provide guidance and feedback on project activities.
1.3	Reconvene and expand the three regional workgroups.	Month 1 – 2; Quarterly	• Provide guidance and support to local implementation effort.
1.4	Identify representative from each regional work group to participate on statewide advisory committee.	Month 1 – 2	• Provide feedback on the implementation activities.
1.5	Recruit consumers/family members to participate on regional workgroups.	Month 1 – 3	• Provide feedback on the implementation activities.
1.6	Conduct information sessions for employers on the project and the Model.	Month 1-4	• Network of employers that will hire Latino consumers.
1.7	Provide ongoing support to the statewide advisory committee and regional workgroups.	Ongoing	• Permanent, self-sustaining organizational structure.

Objective 2: To Train Participants In The "Choose-Get-Keep" model for Vocational Rehabilitation Latino Individuals with Psychiatric and Co- Occurring Conditions.

Task #	Action	Timeline	Outcome
2.1	Conduct an overview of the model at each agency site.	Month 2	• Increased awareness and readiness for model implementation at each site.
2.2	Teach the CGK Model to staff and consumers at each site including: Partnership Skills, "Choose-Get-Keep" Model, Rehabilitation Readiness, Social Security Work Incentives, Cultural Competence, and other topics.	Month 2 –8 (6 days per site)	• Increased knowledge of Choose-Get-Keep Model for Latino individuals with Psychiatric and Co-Occurring Conditions.
2.3	Supervise individual staff practice in the Model.	Month 2 – 12	• Increased skills in using the Choose-Get-Keep Model for

Task #	Action	Timeline	Outcome
			Latino individuals with Psychiatric and Co-Occurring Conditions.
2.4	Provide supervision to supervisors and staff on the Model.	Month 2 - 12	• Increased practitioner use of the Choose-Get-Keep Model for Latino individuals with Psychiatric and Co-Occurring Conditions.

Objective 3: To provide consultation to five sites to assure fidelity to the Model during the implementation of the "Choose-Get-Keep" model for Vocational Rehabilitation for Latino Individuals with Psychiatric and Co-Occurring Conditions.

Task #	Action	Timeline	Outcome
3.1	Provide technical assistance on the development of processes and procedures for implementation of the Model.	Month 1 – 12 (32 hours/site)	• Established agency guidelines for implementation of the Model (e.g., who, when, where, duration)
3.2	Provide technical assistance on the development of documentation of the Model activities with consumers.	Ongoing	• Established client record consistent with the Model.
3.3.	Provide technical assistance in the development of supervisory structures and quality assurance measures for the Model.	Ongoing	• Identify supervisory criteria for use of the Model. • Identify set of program evaluation measures feasible for use on an ongoing basis.
3.4	Provide ongoing consultation on the integration of the Model into the structure of each agency.	Ongoing	• Identification of implementation barriers as well as resolution and follow-up for each. • Inclusion of the Model in agency brochures, staff job descriptions, and record keeping.

Objective 4: To Evaluate the implementation of the "Choose-Get-Keep" model for Vocational Rehabilitation for Latino Individuals with Psychiatric and Co-Occurring Conditions in five sites.

Task #	Action	Timeline	Outcome
4.1	Onsite visit to each site to observe program facilities and environmental context, to meet staff, to identify possible existing data sources, to negotiate access to agency-based data, to negotiate initial plan for ongoing data collection, and to collect baseline data.	Month 1	• Obtain baseline data; have agency-specific data collection procedures.
4.2	Interview Phase I project staff, review Phase I reports, and survey local area participants to obtain information about consensus on the implementation plan, and anticipated barriers to implementation.	Month 1	• Have information on consensus about implementation, and list of anticipated barriers.
4.3	Design data collection forms and develop interview guidelines.	Month 1	• Have data collection forms and protocols.
4.4	Develop instruments to measure knowledge, self-reported use, and satisfaction with CGK approach.	Month 1	• Have instruments to measure CGK knowledge, self-reported use, and satisfaction.
4.5	Collect pre- and post-data on level of Model knowledge for staff attending raining sessions.	Ongoing	• Assessment of CGK knowledge.
4.6	Collect from project staff reports on each training session documenting attendance, length of session, location, and topics covered	Ongoing	• Documentation of training attendance rates, duration of sessions, list of topics discussed, geographical locations.
4.7	Collect from project staff reports on supervision provided (when, to whom, topics covered, and amount of time).	Ongoing	• Documentation of supervision provided (when, to whom, topics covered, and amount of time).
4.8	Collect from project staff reports n technical assistance provided 9when, to whom, topics covered, and amount of time).	Ongoing	• Documentation of Technical assistance provided.

Task #	Action	Timeline	Outcome
4.9	Obtain reports from project staff as they make onsite observations and informally obtain information regarding program implementation, critical events, etc.	Ongoing	• Observational data on program implementation process and critical events.
4.10	Collect onsite data from agency records and documents, onsite observations, and interviews with program staff, agency administrators, and community stakeholders,	Months 2, 4, 6, 8, 10	• Documentation of implementation process.
4.11	Administer satisfaction survey to consumers and families.	Months 6, 11	• Assessment of consumers' and families' satisfaction.
4.12	Analyze data collected to date and provide feedback, which can be used to inform the program implementation effort.	Months 3, 5, 7, 9	• Report of program implementation process.
4.13	Summarize findings and prepare a report that details the implementation process and outcomes at each program site.	Month 12	• Final report on implementation and outcomes.

Appendix B

Exemplary Practice

Appendix C

Project Evaluation Tools and Forms

CAG Evaluation Tools and Forms

1. **Training Recruitment Flyer** – This flyer describes the training content and schedule, eligibility for participation in the training, location, and dates as well as instructions to register for training.
2. **Informed Consent Form (Consumer/Families Form)** – This form describes the project for consumers and family members who are willing to participate in a Satisfaction with the Project Survey.
3. **Informed Consent Form (Trainees Form)** – This form describes the project for people participating in the training. These trainees will be asked to complete knowledge and skill surveys before and after training to evaluate the effectiveness of the training.
4. **Baseline Program Datasheet** – This form is used to document information about each of the agencies participating in the implementation of the CGK approach before the start of training. It is completed by Project Staff based upon a site visit and collection of agency forms and documentation. Information is written in English only.
5. **Bimonthly Program Data Update** – This form is used to update information about each of the participating agencies every other month to evaluate changes during project implementation. It is completed by Project Staff based upon follow up contact/reporting arranged with each site. Information is written in English only.
6. **Program Update Participant Activity Chart -** to facilitate organizing information for the bimonthly update of the sites.
7. **Program Update Demographics Chart** - to facilitate organizing information for the update of the sites.
8. **Supervision Activity Form** - to document supervision activities conducted by project staff in each of the program sites.
9. **Technical Assistance Form** – to document technical assistance activities provided by project staff in each of the program sites.
10. **Training Activity Form** – to document training activities in each of the 3 regions of the state.
11. **Survey on Knowledge and Use of the CGK Approach to Vocational Rehabilitation for Latino Individuals with Psychiatric and Co-occurring Conditions (the CGK Approach) – Pre-Training Survey.** This survey is administered to all trainees participating in either the 2 days of overview training or the 4 days of full training. It is administered at the beginning of the first day of training. The purpose is to evaluate the baseline knowledge and application of the CGK approach in trainees before the start of training.
12. **Survey on Knowledge and Use of the CGK Approach to Vocational Rehabilitation for Latino Individuals with Psychiatric and Co-occurring Conditions (the CGK Approach) – Immediate Post-Training Survey**. This survey is administered to all trainees participating in the training either at the end of the second day of training (for those in the 2 days of overview training) or at the end of the fourth day of training (for those in the 4 full days of training). The purpose is to evaluate any change in knowledge and application of the CGK Approach as a result of participation in training.
13. **Survey on Knowledge and Use of the CGK Approach to Vocational Rehabilitation for Latino Individuals with Psychiatric and Co-occurring Conditions (the CGK Approach) – 3 Month Post-Training Survey.** This survey is administered by mail to

all trainees in the 4 full days of training 3 months after the completion of training. The purpose is to evaluate the application and use of the CGK approach as well as some of the barriers and facilitators to using this approach in each of the agencies participating in the project.

14. **Satisfaction Survey with the CGK Approach to Vocational Rehabilitation for Latino Individuals with Psychiatric and Co-occurring Conditions (CGK Approach)**. This survey is administered to consumers and their family members involved in programs implementing the CGK approach. The purpose is to evaluate their satisfaction with the program.

Appendix D

Sample of Training Agendas, Overheads, and Materials