EVALUATION OF THE IMPLEMENTATION OF THE MENTORING PROGRAM FOR BEHAVIORAL HEALTH SERVICE COORDINATORS IN ALLEGHENY COUNTY

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EVALUATION OF THE IMPLEMENTATION OF THE MENTORING PROGRAM FOR BEHAVIORAL HEALTH SERVICE COORDINATORS IN ALLEGHENY COUNTY

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Serious and persistent mental illnesses (SPMI) are the most costly diagnoses in the United States (Insel, 2003). There are significant financial costs associated with these psychiatric disabilities, including the costs associated with treatment and loss of wages, as well as significant social costs, including lack of social support, poverty, and inadequate available treatment services.

Case managers are the mental health staff members who spend the greatest amount of time in direct contact with people with SPMI in the community. There are widespread problems in the case management workforce. Case managers have inadequate education, work experience, and on-the-job training for the amount of responsibilities that are required in their jobs. It is a career that offers limited opportunities for advancement, low salaries, and low retention.

In Allegheny county, a major mental health system reform was implemented called SPA (Single Point of Accountability). One of its goals was the implementation of a Case Management Mentor Program, which was designed to provide consistent training for behavioral health case managers, develop a career ladder in case management, and help new case managers learn their jobs.

This dissertation was a mixed methods study using semi-structured interviews, focus groups, and survey data to understand the barriers and facilitators to implementation of the program from the perspectives of the case managers and how the type of mentoring they

received contributed to the mentee job satisfaction. The study sample consisted of 18 mentors who participated in the Service Coordination Mentor Certificate Course and 30 mentees that were trained in their new jobs at their respective agencies.

Overall, mentoring was associated with higher job satisfaction. Support from a mentor during crisis situations was most significantly associated with job satisfaction. All of the participants reported that mentoring is needed and beneficial in case management. Over the course of implementation, most mentees consistently participated in a variety of mentoring activities with their mentors and overall, reported that these were very helpful. The activity that that participants reported to be most helpful, but occurred the least frequently, was the mentor having the opportunity to observe the mentee in the field.

TABLE OF CONTENTS

LIST OF TABLES

PREFACE

This is a dissertation about mentoring. I have been blessed to be mentored by Dr. Katie Greeno—your encouragement, guidance, kindness, and wisdom have helped me to move forward and find myself again.

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1.0 INTRODUCTION

1.1 OVERVIEW OF THE PROBLEM

In the United States, 2.6% of the adult population meets the criteria for diagnosis of a serious and persistent mental illness (Kessler et al., 2001). A serious and persistent mental illness (SPMI) is an illness that results in a tremendous functional disability with significant impairment in social and occupational functioning. These illnesses are characterized by episodes of prolonged hospitalization and the need for ongoing outpatient treatment due to both active and chronic symptom manifestation. Some examples of diagnoses seen in this population include schizophrenia, bipolar disorder, schizoaffective disorder, severe depression, and obsessive-compulsive disorder (Torrey, 2001). Of these, schizophrenia is the most expensive, both in terms of treatment costs and losses associated with long term functional disability, which include unemployment, lack of social support, incarceration, and co-morbid medical and substance abuse problems (Rice, 1999). Cost estimates exceed over nineteen billion dollars per year in the United States for the treatment and indirect costs associated with schizophrenia (Kessler, et al., 2001). Medication adherence for people with schizophrenia is low; within one year of medication initiation, up to 50% of people no longer take their medicines and within two years, 74% stop completely (Tunner & Salzer, 2006). Additionally, people with SPMI are at a

significantly higher risk to complete suicide than the general population (Yoon & Bruckner, 2009).

For people who live with these disorders, the consequences of the illness can sometimes be more difficult than the illness itself. For example, seriously mentally ill people frequently have limited social support systems and decreased social skills, along with problems commonly associated with poverty, such as limited housing options, lack of education, and underemployment (Anthony & Blanch, 1987; Johnson & Rubin, 1983; Koegal, Burnam & Baumohl, 1996; Polak & Warner, 1996). Social support networks for seriously mentally ill people are smaller in comparison to the general population and are more likely to consist primarily of family members (Froland, Brodsky, Olsen & Steward, 2000; Perese & Wolf, 2005; Phillips, 1981). Beyond their immediate families, many lack natural supports, such as neighbors, friends, or co-workers, which can help them navigate through common daily stressors. Lacking these social supports, people with SPMI often turn to the public mental health system as their primary source of support. The professionals who staff this system include nurses, social workers, therapists, psychiatrists, and case managers.

The majority of direct care support services for mentally ill people in the community are provided by case managers who assure that they receive consistent and continued services for an unlimited amount of time (Torrey, 1986; Test, 1992; Hangan, 2006). Case managers are responsible for assessment, linking consumers with appropriate services, monitoring progress, providing counseling with the support of a therapeutic relationship, and assuring treatment adherence (Thornicroft, 1991; Rapp, 1998).

Despite being an integral component of mental health service delivery, there are ongoing problems with the case management workforce. The case management profession consists of a

cadre of people who frequently lack training in human services, have limited work experience, and receive little pay with limited opportunity for advancement. As a result, the people who provide the most intense level of community services, to the most seriously mentally ill people, are the least educated, trained, and compensated (Rapp, 1998).

To address these critical problems in its case management workforce, Allegheny County has created a series of mental health systems reforms, including the Single Point of Accountability (SPA) initiative. This initiative has several goals, one of which is the development and implementation of a Case Management Mentor Certificate Program.

1.2 PURPOSE OF THE STUDY

This study explored how the Case Management Mentor Certificate Program was implemented from the perspective of the case managers who completed the course and the newly hired case managers who were mentored as a result of this new program.

This study had three aims:

1. To understand, from the perspective of the case managers who participated in the mentoring program, how this experience changed the way they understand, learn and perform their jobs.
2. To explore the barriers and contributors to the implementation of the Case Management Mentor Certificate Program in the community.
3. To examine the impact of the mentoring experience on job satisfaction of case managers who were mentored in the program.

This study contributes to scholarship through the evaluation of an innovative training program that demonstrates how mentoring helps case managers to understand, learn, and perform their jobs. This information can be used for further study about the critical issues facing the case management workforce, including inadequate training, education, and work experience through the evaluation of a program that addresses these issues. This study examined these issues from the perspectives of case managers who are currently working in direct practice and explored their perceptions of how they learned to do the essential work of providing direct support to people with chronic mental illness and how this training program contributed to their understanding of and ability to do their jobs.

In conducting this research, I have had to carefully examine and reflect on my own experiences as a mental health professional and my beliefs about case management as a mental health professional. I have over seventeen years of social work practice experience and have worked with many of the provider agencies and interfaced with case management staff members included in the study. In order to address these issues, I have received ongoing research supervision to identify and control the influence of any perceptions and interpretations arising from this experience on the study.

1.3 IMPLICATIONS FOR SOCIAL WORK

This study is relevant to the field of social work because social work is the profession best suited for training case managers and fulfilling the occupational responsibilities of case management positions (Langer-Ellison, Rogers, Sciarappa, Cohen, & Forbes, 1995). Case management is an area where social workers can and do work in direct practice or supervisory roles. Case

management content is included in course curricula in schools of nursing and social work, but is rarely taught as a separate course (Scheyett & Blyler, 2002). Currently, case management content appears primarily in graduate level coursework, despite the fact that most case managers that are hired have bachelor's level credentials (Scheyett & Blyler, 2002). Nevertheless, social workers are trained in the classroom and the field to do many of the key functions of case management including brokering, advocacy, community work, rehabilitation, and clinical work (Johnson & Rubin, 1983). Case management requires all of the skills that are essential to social work training, including assessment, advocacy, and linking with services.

Despite these similarities, case management positions are filled by nurses, rehabilitation professionals, and people who have bachelor's degrees in a wide variety of disciplines (Johnson & Rubin, 2001). There is a perception that no single field can exclusively fill case management positions and that no specific professional skills are required to function as a case manager (Johnson & Rubin, 2001). Yet case managers are expected to fulfill a very specific role in the mental health service continuum.

Similar to social work, case management uses an ecological and systems framework. Social workers have specialized knowledge of systems theory, a willingness to work with people in their environments, and a core value of a person's right to self-determination, all of which are skills and values that are essential to effective case management. Despite being well suited for case management careers, there are few social workers who pursue case management employment (Avirum, 2002).

The Case Management Mentor Certificate Course was taught by School of Social Work faculty at the University of Pittsburgh. The information about the course implementation

obtained from this study can be used in planning future case management training and in curriculum development and courses for case managers and social work students.

More broadly, this study will increase knowledge about how people who provide direct services to the most chronically mentally ill people in the community learn, understand, and do their jobs. This understanding can be used in the development of future research about case management, the behavioral health work force, the role of social work in case management, and policy formulation about community mental health services and mental health recovery.

1.4 SINGLE POINT OF ACCOUNTABILITY

For a number of reasons, which will be described in depth later in this section, Allegheny County undertook a period of self-study of its mental health services in 2005, with case management identified as a target for reform. Allegheny County is located in southwestern Pennsylvania, and includes the city of Pittsburgh and its surrounding suburbs. It has a total population of 1,215,103 people (Allegheny County DHS, 2009). There are approximately 60,000 people who receive services in the public mental health system in the county and approximately 8,000 are diagnosed with a serious and persistent mental illness (Allegheny County DHS, 2009**).** Mental health services are monitored by the Office of Behavioral Health under the auspices of the Department of Human Services. The continuum of available mental health services in the county includes approximately 580 inpatient psychiatric beds, extended acute services, residential programs, case management, community treatment teams, enhanced clinical case management, psychiatric rehabilitation, crisis services, and outpatient treatment. There are twelve service coordination units (SCUs) in the county and eight of these agencies contract with the county to provide case

management services. These agencies are: Mon Yough Community Services, Mercy Behavioral Health, Staunton Clinic, Milestones, Inc., Western Psychiatric Institute and Clinic, Family Services of Western Pennsylvania, Turtle Creek Valley MH/MR (Mental Health/Mental Retardation), and Chartiers MH/MR. The number of case managers employed in these agencies ranges from between 3 and 77 (Allegheny County DHS, 2009). While all SCUs are regulated by the Pennsylvania Office of Mental Health and Substance Abuse Services and have the same standard requirements, each agency serves a different region of the county and has its own unique work culture and specific organizational practices.

In an effort to improve service delivery and to explore the vision for the future of county mental health services, a series of meetings were convened in 2005, which included county staff, consumers, advocacy groups, families, providers, and the managed care organization (MCO) for the county. As a result of these meetings, initial recommendations were made for transformation of the existing mental health system (Allegheny County DHS, 2009). The two most significant reforms that were identified were the need for macro-level changes of both the county mental health crisis response system and case management services (Allegheny County DHS, 2009).

In order to meet the goals of transforming the case management service delivery system and to address the changing needs of people with mental illness in the post-state hospital era, a best practice initiative called the Single Point of Accountability (SPA) was developed (Allegheny County DHS, 2009). The goals of SPA included changing the name of case managers to service coordinators, developing a career ladder and increasing salaries for case managers, improving education and training, revamping the billing structure, and developing a recovery orientation that would be used in documentation and in work with clients and families.

The role of case managers was expected to change to make them the identified single point of contact for clients on their caseload. They would assist clients in the identification of highly individualized goals and work collaboratively to develop a cross system plan to help them to achieve these goals on their recovery journeys. Further, they were expected to facilitate meetings, interface with other disciplines, and coordinate all aspects of service delivery to support recovery (Allegheny County DHS, 2009). It was anticipated that through these changes, case managers would increase their credibility as professionals among other mental health staff members, such as physicians, nurses, and social workers. Case managers would be facilitating interdisciplinary meetings, coordinating care, functioning autonomously, and have opportunities for career advancement in case management.

As part of this plan, the word "case management" was changed to "service coordination" and "case managers" became "service coordinators". This name change was selected because it better reflected the actual job responsibilities of a case manager. Rather than directing clients and "managing" their lives, the term "service coordinator" described the essential responsibilities of helping people to access services that support their individual recovery goals.

In addition to the case management name change, a myriad of other changes were planned for case management as part of SPA. Currently, projects are in various stages ranging from initial conceptualization to full implementation. Among them was a proposal that would increase base salaries for case managers incrementally. The salary increases would create a career ladder that would support people remaining in case management careers over an extended period of time. It was expected that with a potential career ladder and increased wages, case management retention would increase. Additional training opportunities for case managers were planned to provide "certification" in required knowledge and skills. The mentor certificate

course was offered and all newly hired case managers were to be assigned to a mentor. An undergraduate course was offered to introduce undergraduates to case management as a potential career option.

The urgency of the SPA initiative was underscored by the need to prepare case managers to meet the demand of an influx of high needs clients, as one method of managing mental illness, institutionalization, gave way to another, coordinated outpatient care. In December 2008, Mayview State Hospital, the last state hospital in the county completed a process of closure which had extended over the course of three years. This led to the simultaneous occurrence of a number of significant changes to the mental health provider and consumer communities including an influx of people being discharged from the state hospital into the community, the expansion of community mental health services and decreased state hospital and community inpatient psychiatric bed availability.

Case management is particularly important when people are initially discharged from a state hospital and they integrate into the community because they may be unfamiliar with how to access services that were previously readily accessible to them in the hospital (Crane-Ross, Roth & Lauber, 2006). The state hospital closure process is lengthy, and at the time of closure, the community experiences a sudden flood of patients with high needs and limited exposure to mainstream society (Yoon & Bruckner, 2009). Even when a person has not had a state hospital admission, people who are assigned to a case manager have a demonstrated need for a high level of service and usually have had multiple short term hospitalizations. In one study, results indicated that the average case management client had spent 337 days on inpatient units over the course of multiple hospitalizations prior to being assigned to a case manager (Pyke & Lancaster, 1997).

1.5 CASE MANAGEMENT WORKFORCE

As previously stated, there is widespread recognition that case management is a workforce that is in crisis. Research suggests that the factors that contribute to job stress and dissatisfaction in mental health workers include high workloads, low salaries, lack of recognition for stellar performance, and lack of promotional opportunities (Gellis, Kim & Hwang, 2004). These are issues that are commonly associated with the case management workforce. Copious data exists about case managers' lack of specialized training in human services, mental health, and necessary skills for working with mentally ill people, their families and larger systems and organizations (Bromberg & Starr, 1991; Coursey et al., 2000; Hoge et al., 2005; Hoge, 2002).

The lack of skilled or competent case managers is a serious problem since the case manager is the person providing the most frequent and intense level of care (Ziguras, Stuart, & Jackson, 2002). This ill-prepared workforce is the result of low retention caused by low wages and limited opportunities for advancement (Gellis, Kim & Hwang, 2004). Low retention results in a perpetual shortage of case managers, which subsequently results in an ongoing need for training. In most agencies, there is not a consistent group of well trained staff with long tenure.

Ultimately, these workforce deficits impact the clients, many of whom rely on case managers to assist them to meet their daily needs in order to maintain their lives outside of an institutional setting (Baker et al., 1993). Each time a case manager resigns from a position, a caseload of people must establish new relationships with a new staff member, in addition to becoming familiar with the staff members who temporarily fill the responsibilities of the vacant position (Bliss, Gillespie & Gongaware, 2010). When there is frequent staff turnover, clients report higher levels of dissatisfaction with case management services and decreased trust in their providers (Barak, Nissly, & Levin, 2001). Increased staff continuity provides an ongoing

relationship for the consumer to develop trust, learn to function independently, and practice social skills, all which are necessary for success in the community (Thornicroft, 1991).

Case managers working in environments where there is high turnover are constantly extended beyond their normal caseloads to cover the additional work when a position is vacant. Over time, the burden and frustration associated with extra work contributes to burnout and reduced job satisfaction (Gellis, Kim & Hwang, 2004).

The SPA initiative was created to begin to address the barriers that contribute to job dissatisfaction, burnout, and high turnover. The implementation of the Case Management Mentor Certificate Program was expected to provide new job descriptions, increased pay, productivity adjustments, and additional training and education for the mentors. Mentors would receive new job descriptions and an accompanying pay increase to compensate them for their new mentoring responsibilities. Productivity, which refers to the number of expected billable hours spent working with clients, would be adjusted for mentors. This would permit mentors to have allocated time to spend with mentees which would not have to be accounted for through the normal billing process. For the mentees, it was designed to provide an established orientation and training regimen that applied to all agencies and an opportunity to learn how to do their job with the support and guidance of an experienced peer.

1.6 CASE MANAGEMENT MENTOR CERTIFICATE PROGRAM

To work toward the achievement of the goals of SPA, various workgroups were created and continue to meet to address workforce challenges, financial issues, and outcome measurement. The workgroup that was formed to address workforce issues was comprised of local mental

health providers, university faculty and staff, advocates, and county human services staff. It focused primarily on improving support and training for case managers and was responsible for the development and planning of the Case Management Mentor Certificate Program.

The Case Management Mentor Certificate Program signified a major change in the job training that case managers received in Allegheny County. The implementation of this program immediately addressed the issue of low pay and lack of incentives for existing case managers, while the mentorship that arose from the training insured that these issues would be lessened in the future. Prior to this, training was agency-specific and while some case managers completed on-line training modules, others went to a central orientation, and still others received very limited formal training.

This fifteen week course was first conducted at the University of Pittsburgh's School of Social Work in the spring semester in 2009. A select group of experienced case managers participating in the course had an opportunity to learn about methods of teaching and the role of a mentor in a mentorship relationship. Additionally, they received training about serious and persistent mental illness, medications, co-morbidity, treatment interventions, resources, and mental health recovery. Once mentors were enrolled in the course, all newly hired case managers could be assigned immediately to begin the training process with a mentor, rather than waiting for training until an orientation was scheduled. The mentees were trained by the mentors using the information that they learned in the course. This created a consistent system-wide process across county providers, and all new case managers were expected to be assigned to a mentor when they started in their new positions.

1.7 IMPLEMENTATION ISSUES

All of the service coordination units (SCUs) were required to participate in the mentor certificate program as a condition of their contract with Allegheny County to provide case management services. The SCU directors were oriented to the course, the expectations, and the plans for mentoring of new case managers. Despite the fact that each agency was required to participate, variations amongst SCUs could potentially impact implementation. There was a wide diversity in the populations and communities that were served by each agency. Each SCU had different numbers of case managers and salaries at different rates. There was variation in the way that incentive and bonus pay was calculated for exceeding productivity requirements. All agencies provided their own unique benefits package (e.g. health insurance, tuition reimbursement). There were different resources for providing services, such as access to company vehicles, contingency funds, and fuel cards. Finally, every agency had a unique orientation process in place for all newly hired staff members, as well as agency specific policies and procedures.

2.0 LITERATURE REVIEW

In this section, literature about the origins of case management and mental health recovery is reviewed. These sections explore the history of mental health service delivery in the United States and the events that led to the development of the profession of case management. The literature about the challenges and rewards of case management work and job satisfaction is reviewed, as well as literature about professional development. An overview of the case management course is provided. The conceptual frameworks for this study include key concepts about mentoring, implementation science, and transfer of learning.

2.1 ORIGINS OF CASE MANAGEMENT

Case management is grounded in the early principles and practice of social work casework, which held the belief that people had a right to self-determination and the ability to be self-reliant (Lee & Kenworthy, 1929). These early beliefs are similar to the current guiding principles of mental health recovery. Case management in the United States began in the 1860's and was used to provide poor immigrants with assistance navigating community problems, managing finances, and accessing services (Kersbergen, 1996). In 1863, the Massachusetts Board of Charities was created to coordinate these services and assist with the conservation of public funds that were used for the infirm and poor (Wiell, 1985). The Charitable Organization

Societies (COS) worked with families to assess needs and to resolve neighborhood issues and environmental problems. During this time, social workers were an important part of advocacy for vulnerable populations and community organizing (Kersbergen, 1996). They were leaders in the development of aftercare programs for mentally ill people who were discharged from mental hospitals into the community in the early 1900s (Starnino, 2009). Social workers have a long history of doing casework with vulnerable populations and these early days of social casework provided the foundation for modern case management.

Similar to the social workers who did early casework with the poor, modern case managers are charged with assessing and fulfilling the need for access to limited resources and the use of public funds for services for consumers. No longer working solely with immigrant populations, modern case managers work with people with another vulnerable population, people who are diagnosed with serious and persistent mental illness. By linking people with these supports and services, case managers help people with SPMI to be able to live meaningfully in the community, and whenever possible, avoid inpatient hospitalization, which is very costly.

The policy of deinstitutionalization gave rise to the modern profession of mental health case management (Drake, Green, Mueser & Goldman, 2003**).** Deinstitutionalization derives from the mental health policy of community reintegration for people with mental illnesses linked with the closure of state mental hospitals that began in the 1950's (Mechanic, Schlesinger, & McAlpine, 1995). Over the past sixty years, there have been ongoing efforts to transition people with mental illnesses from state mental hospitals into the community. From 1955-1980 the population in state hospitals declined from 558, 922 to 126, 359 (Scull, 1981). From the year 1970-2000, beds dropped from 201 to 21 beds per 100,000 people (Manderschied et al., 2004). By 2006, there were 46, 000 state hospital beds in the United States and the total national

expenditure for state hospitals was $7.7 billion dollars (Fisher, Geller & Pandiani, 2006). While many states and counties continue to operate state hospitals, Allegheny County has made a determination that its mental health consumers will no longer utilize state hospital beds, and that all services will be provided to people with SPMI at local inpatient hospitals, crisis services, and in the community.

There are several driving forces behind the policy of deinstitutionalization. The Mental Health Act of 1946 authorized federal funding for research on psychiatric illnesses and investigation into the operations of the state hospital system (Osborn, 2009). State hospitals were generally found to be understaffed and in poor condition, providing primarily custodial cares (Osborn, 2009). There was a growing body of research that suggested that mental illnesses were biologically-based, which led to new research about the neurobiological factors that contributed to illnesses (Drake, Mueser, & Goldman, 2003). The discovery of new pharmacological interventions (e.g. Thorazine) allowed people who previously could not live in the community, due to the severity of their symptoms, an opportunity to be discharged from state hospital settings (Osborn, 2009; Mellman et al., 2001; Scull, 1981). The advent of the Civil Rights Movement in the 1960's led to the growing recognition that people with mental illnesses had the ability and right to live in the least restrictive setting in the community of their choice (Benson, 1996). With the development of Medicare, Medicaid, and supplemental Social security income (SSI), it also became possible for states to shift the burden of the cost of care from the states to the federal government (Scull, 1981). In order to be eligible for SSI, people needed to be living in the community, so there was an incentive to move towards discharge from the hospital, particularly from the perspective of the state governments (Scull, 1981). Also, if a person was placed in a nursing home, reimbursement would be captured from Medicare and Medicaid,

which led to an increase in the number of people with SPMI who were discharged from state hospital and inappropriately admitted to nursing homes or transinstitutionalized (Scull, 1981).

In principle, deinstitutionalization affords people the opportunity to live in the least restrictive setting—the community, which promotes recovery by allowing people to make decisions in their lives and how they spend their time. In practice, while many people with serious mental illnesses live successfully in the community, there are also many people who live in extreme poverty, in unstable housing situations, and with limited social supports. Sometimes people have very limited and poor choices about where they can reside and their quality of life in the community. Without access to a state hospital, case managers in Allegheny County are charged with supporting a high needs population with scant resources. They must work creatively to access resources and programs and to advocate for their clients' needs and goals. In the Case Management Mentor Certificate Program, it is expected that new case managers will be mentored in these skills and learn how to navigate complex systems and how to interface with other disciplines to support their clients in the community.

The Community Mental Health Centers Construction Act of 1963 authorized funding for outpatient clinics so that mental health services would be consolidated into one central locale in the community. Theoretically similar to a state hospital, patients lived at home instead of in the hospitals and would go to the center to receive services, rather than have services immediately accessible (Drake et al., 2003). Instead of serving the people that they were designed to treat; those with serious and persistent mental illnesses who were recently discharged from the state hospitals, the community mental health centers (CMHCs) found a new population of people also in need of mental services, less seriously ill adults, children, and families, who previously had not been connected to mental health treatment (Mechanic, 1991). To some degree, staff in

community mental health centers found the populations of people with SPMI from the state hospital less attractive to work with, in comparison to the new clientele of less severely ill, more educated, and affluent people. Those who were discharged from the state hospital were less socially adept, more difficult to engage, had more psychosocial problems, and were less adherent to treatment recommendations (Johnson & Rubin, 1983). Interestingly, there is current research that suggests that case managers spend more time with people on their caseload who are doing well, perhaps because these people appear to be able to benefit more from the services and resources that the case manager is coordinating for them in the community (Rapp & Goncha, 2006).

Additionally, access to available housing was compromised by these struggles to interact and advocate for themselves within the community. With inadequate available housing, people who were discharged from the hospital often ended living in substandard conditions, in welfare hotels, nursing homes, jails, or with family members who were not prepared for the amount of assistance that they required (Scull, 1981). There was an increase in deaths, homelessness, incarceration, and families reporting that they were unable to meet the needs of their family members who had been discharged to their care (DHHS, 1999).

Deinstitutionalization was soon recognized as a movement that had progressed without sufficient preparation and the results had negative consequences for people with mental illness, their families, and society. The system of care in the community was fragmented by a lack of comprehensive and coordinated services. As a result, people were not appropriately involved in needed services (Mechanic & Aiken, 1987; Thornicroft & Bebbington, 1989; Johnson & Rubin, 1983). To address the problems and inadequacies of the failed Community Mental Health Centers Construction Act, the Mental Health Community Support Plan was developed in 1977

(Mechanic, 1991). The philosophy of this legislation was that people with SPMI require an array of supports in the community beyond the available outpatient services of the CMHC, including housing, leisure activities, education, employment, spirituality, and culturally competent care and that by connecting to these supports in the community, they would be able to better access treatment (Mechanic, 1991). Case management was identified as the occupation that could best achieve these goals and additional funding became available for the recruitment and training of case managers who were expected to help people to connect with the supports that existed in the community (Rapp, 1998; Mueser et al., 2002; Hromco, Moore & Nikkel, 2003; Fiorentine & Grusky, 1990). Case managers would have a "linchpin" function and would help people to access services through assessment, planning, linking, monitoring, and evaluating (Fiorentine & Grusky, 1990).

However, inconsistency in case management practice made this problematic. Some case managers provided a high degree of direct care and others primarily worked to connect people with entitlements, such as SSI, food stamps, and vouchers (Mechanic & Rochefort, 1990). This problem persists even now, with case managers varying both individually and between agencies and in the different approaches of case management that are used to work with clients, families, and providers. Variation in orientation and training adds to this dilemma. One of the goals of Allegheny County's Single Point of Accountability is a more consistent countywide practice of providing a unified training for case managers and the use of uniformly trained mentors with newly hired staff. The mentor program potentially provides a way for all newly hired case managers to have access to the same information and training.

Another change that occurred at the time of the Community Support Program implementation was that case management became a Medicaid reimbursable service. In 1981,

there was no Medicaid supported case management programs in United States, but within ten years, case management was 100% Medicaid funded (Thornicroft, 1991). As a billable service, there is a fiscal imperative within agencies to capture the reimbursement that can be garnered by case managers. Case managers meet these agency expectations through productivity requirements. Productivity accounts for direct service provision and this is a mechanism to capture the time spent interacting with consumers, which is the primary responsibility of the case manager. One of the challenges with the mentor program implementation in Allegheny County has been to find a way for case managers to maintain sufficient productivity, but still have time to accompany the mentees in the field and to spend time teaching and problem solving.

One of the important skills that mentors can provide teaching about is the role of the family in supporting a mentally ill person in the community. This was one of the other challenges in community mental health, which remains a problem even at the present time, was that when the seriously mentally ill were re-integrated into the community, their families were often the only other support that they had outside of the formal mental health system. Many families were not prepared for the responsibility and effort that was required to help support their family member. Some families had not maintained contact with their family member during the hospitalization and did not have an established relationship. Also, for many years there had been a belief that families contributed to or were responsible for their impaired family member's mental illness (Terkelson, 1983). Families continue to be an important contributing factor to a person's success or difficulty with community integration and family work is an essential skill for case managers.

During the 1970's, there was research about psycho-educational interventions that could be used to help families interact with each other in ways that were more supportive and

increased their ability to cope with the stresses associated with having a family member with a SPMI (Anderson, Reiss, & Hogerty, 1986; Falloon, Boyd, & McGill, 1984). These interventions helped the providers in the community work more effectively with families and continue to be widely used in clinical practice. Working with families is an important responsibility of case managers as family members are usually the major support person for a mentally ill person.

2.2 MENTAL HEALTH RECOVERY

This section includes a review of the genesis of mental health recovery, its definition, and how it impacts on behavioral health service provision. Mandated by the New Freedom Commission Report in 2003 as a guiding vision for mental health service systems transformation, mental health recovery is the philosophical underpinning of current mental health service delivery models in the United States. Recovery and psychiatric rehabilitation are used to support community integration and functioning by helping people to develop life skills, explore vocational opportunities, learn to complete activities of daily living (ADLs), like bathing, doing laundry, cooking, and cleaning, independently, and by assisting in locating safe and affordable housing, and increasing social interactions (Anthony, 2000; Lieberman, Glynn, Blair, Ross, & Mandler, 2002; Muesser, Drake, & Bond, 1997). The field of psychiatric rehabilitation is focused on individual strengths, the instillation of hope, improving vocational and social outcomes, and helping people to achieve goals in the environment of their choice (Lamb, 1994). Psychiatric rehabilitation draws many of its practices and techniques from the physical rehabilitation disciplines, where the standard goals for people recovering from physical disabilities includes work on the restoration of relationships, retraining in life skills, and identifying and establishing

goals (Anthony, 1993). Instead of the traditional models of mental health treatment, there is an effort to reverse the focus on illness and deficits, and instead focus on strengths and rehabilitation (Rapp, 1998).

There are ten key principles of recovery. Recovery is strengths-based, self-directed, individualized, non-linear, and holistic, uses peer support, promotes empowerment, responsibility, hope, and respect (Anthony, 1993). The New Freedom Commission Report mandates for the inclusion of mental health recovery in service planning, implementation, and provision (DHHS, 2003). The other essential component to mental health system transformation is the inclusion of evidence-based practices in service delivery (Drake et al., 2001; Torrey & Wyzik, 2000). Evidence-based practices are services that are demonstrated to be effective as a result of research (Torrey & Wyzik, 2000). However, mental health recovery is often understood to be inconsistent with the mandate to include evidence-based practices in service delivery. Some view these two strategies to be in direct conflict with each other (Anthony, 2003). Recovery is highly individualized. What works for one person, may not be effective for another. In evidence-based practices, research has demonstrated effectiveness across populations.

In the SPA initiative, the incorporation of recovery principles into practice is imperative for systems change and implementation. Case managers are to become supports for people in their recovery journeys, and to demonstrate a recovery orientation in their documentation and interaction with clients, families, and other providers. The mentor training increases knowledge and incorporation of recovery principles through the education received in the certificate course, through the manual as a reference tool, and through the experience of including recovery in practice.

The shift to a recovery orientation moves the mental health system away from a deficit orientation (Anthony, 2000). The mental health recovery movement began in the 1930s with the mental health consumer-survivor movement (Ralph, 2002). People who had experienced extended hospitalizations and had traumatic experiences in the mental health system joined together as a mutual support. One of the first examples of this is the group of former patients from Rockland State Hospital who met as a support group and later created Fountain House in New York City, the first psychiatric rehabilitation clubhouse model in the United States (Macias, Jackson, Schroeder, & Wang, 1999; Drake et al., 2003). Recovery has been closely identified with the discipline of psychiatric rehabilitation and both recently have moved to the forefront of mental health service delivery (Davidson, Drake, Schmutte, Dinzeo, Andres-Hyman, 2009; Bledsoe, Lukens, Onken, Cardillo-Geller, 2008). All behavioral health providers are now expected to include recovery principles in their mission and service provision (Starnino, 2009; DHHS, 2005). In addition to the individual experience of recovery, the larger recovery agenda seeks to decrease stigma and poverty, increase the use of natural supports and self-help, and promote wellness and social justice (Torrey & Wyzik, 2000).

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes recovery as a process that includes hope, dignity, empowerment, respect, consumer choice, social support, engagement in meaningful activities, and sense of purpose (DHHS, 2007). Mentally ill people often experience disempowering circumstances. Examples include housing arrangements that afford limited choices, involuntary hospitalization, or day to day activities dominated by problems associated with psychiatric illness (Torrey & Wyzik, 2000; Busch & Shore, 2000).

One way to empower a person is through the alliance of a relationship (Howgego, Yellowlees, Meldrum, & Dark, 2003). Case managers are an essential element to achieve the goals of the larger recovery agenda. Case managers work with people to achieve highly individualized goals in the community and help people to connect with natural supports and to find a meaningful life beyond their mental illness.

Other concepts of mental health recovery include ideas such as achievement of goals, enhanced feelings of hopefulness, increased responsibility, and re-establishment of identity (Anderson , Oades, & Caputi, 2003). It is person-centered, holistic, empowered, and is grounded in the belief that there are a number of supports available to people with SPMI outside of the traditional mental health system (Farkas, Anthony, & Cohen, 1989; Davidson & Roe, 2007).

Case management has traditionally worked to maximize independence and to encourage client choice (Intagliata, 1982; Kanter, 1989; Bachrach, 1989). Recovery oriented case management is person-centered, collaborative, strengths-based, and empowered (Davidson et al., 2009). Mental health consumers report feeling most empowered when their needs are met (Crane-Ross, Lutz, & Roth, 2006). Case managers can support people to meet their needs, so that they can move forward with their recovery and other things that are important to them in their lives. Case managers help people to connect with the resources and programs that best meet their individual needs, and often can help people to utilize natural supports, and as these things occur, life becomes less focused on managing the illness and more about living in a meaningful way.

Although there are consistent principles and themes of recovery as mentioned previously, recovery has different interpretations. One body of literature about recovery is derived from the

voices of people who have lived with mental illness (Deegan, 1998). The information obtained from this perspective is that of a person who is living with mental illness and who has navigated the mental health system and been able to survive and thrive (Deegan, 1998; Anthony, 1993). Longitudinal research has shown that between 25-65% of people diagnosed with a SPMI achieve some measure of recovery, meaning that they improve and/or overcome their mental illness (Harding, Brooks, Ashikaga, Strauss, & Brier, 1987; Anthony, 2003; Davidson et al., 2009; Jobe & Harrow, 2005). It is important for case managers to be aware of the evidence that people can and do recover from mental illness. This information can help them to remain hopeful for the client and for the work that they are doing.

Recovery can also describe how a person overcomes the disability caused by mental illness. In other cases, it refers to how a person overcomes the impact of stigma and social problems that include poverty and social isolation (Harding et al., 1987). Case managers are often the sole companions that people with SPMI have in the community. Case managers might be the only people who call them, check in on them, know how they are feeling, and are familiar with their living arrangements. Despite these important relationships, nearly one third of people with SPMI do not utilize the mental health treatment system (DHHS, 1999). There are people who live in the community with mental illnesses without the interventions available in the formal system.

The concept of mental health recovery presents challenges for the current mental service delivery system. Recovery is described as a process, not a finite end, or an outcome (Corrigan & Ralph, 2005). Recovery is a highly personal and individualized process, so it is difficult to quantify it as an outcome. Since most providers are expected to demonstrate outcomes of their interventions and to utilize evidence based research in practice, the mandated integration of

recovery presents a dilemma. Practitioners have an ethical imperative to deliver the best care and service and that is done through evidence-based practice (DHHS, 1999, 2003; IOM, 2001; NIMH National Advisory Mental Health Council Behavioral Science Workgroup, 1999). Being able to present and offer evidence-based practices gives the practitioner the best chance at meeting this expectation, since these are practices that research has demonstrated to be the most effective. Without best practices, practitioners lack the information to determine the best treatment options, so that people can be presented with all the necessary information to make an informed choice about their treatment. Evidence based practices for SPMI include family psycho-education, assertive community treatment teams, integrated treatment for co-occurring conditions, illness management and recovery, and supported employment. Case management is integral to recovery and implementation of evidence-based practices (DHHS, 2007).

Recovery is not evidenced in formal treatment research (Davidson et al., 2009 Anthony 2003; Deegan, 1998; Bellack, 2006). It can occur despite symptoms, and people can continue to be hopeful and live a meaningful life with a mental illness without engaging in structured treatment (Anthony, 2003). The recovery movement advocates for supporting a person's ability to actively participate in decision making and to engage with providers in shared decision making about medication and treatment (Deegan & Drake, 2006; Crane-Ross, Lutz & Roth, 2006; Davidson et al., 2009). By making informed choices about medication and illness management, a person is empowered to make decisions that might help to better control the symptoms of illness and increase the chances of staying out of the hospital. Being in the community, and outside of the hospital, affords people the opportunity to achieve recovery goals, such as finding a place to live, getting a job, or having friendships. When case managers support people to make informed decisions about medication adherence and treatment, they are helping

them in their recovery journey. In this process, the consumer and the provider explore the potential advantages and disadvantages of various options and with this information the client can choose what course of action to pursue that best meets his or her life needs and goals, which may or may not include utilizing scientifically proven interventions (Deegan & Drake, 2006).

Case management is a profession well able to support the recovery agenda. Case managers support the recovery of people in the community by utilizing natural supports, having a high degree of flexibility and creativity, and encouraging client choice in decision making (Rapp & Goscha, 2006). Case Managers refer their clients for supported housing and employment, empowering their clients to explore vocational opportunities (Bond et al. 2001; Tsemberis, Gulcer, & Wakal, 2004). Case managers must be familiar with these resources if they are to facilitate recovery and community integration.

Recovery-oriented services include having consumers actively involved with service planning (Crane-Ross, Lutz & Roth, 2006). When the mental health system defines a client's goals it is disempowering for the individual, and therefore is inconsistent with recovery principles (Torrey & Wyzik, 2000). One of the goals in the SPA initiative is that case managers will work with clients to develop a recovery plan that will be consumer-driven. This will be the guiding plan for a person's recovery journey and all service plans will reflect principles of recovery. The Case Management Mentor Course contained information about how to build relationships with consumers that promote recovery. These skills are modeled in the relationship that the mentor has with the mentee and then can be translated into the therapeutic alliance with the client.

2.3 CHALLENGES IN CASE MANAGEMENT WORKFORCE

Mental health workers face a number of challenges to meeting their occupational responsibilities, including frequent changes in their daily work processes, demand for increased documentation, new regulations, and hospital closures (Koeske & Koeske, 1993; Lu, Miller, & Chen, 2002; Hall & Kepfe, 2000). The mental health workforce in the United States is comprised of both professional and paraprofessional service providers who have a wide variation in education, training, and skills (Robiner, 2005).

Case managers are usually recent college graduates who lack previous experience working in mental health (Bliss, Gillespie, & Gongaware, 2010). They are often not prepared for the expectations of the work including providing direct care, crisis intervention, complex problem solving, and working with multiple disciplines, including physicians, nurses, and social workers. Typically, case management training occurs on the job (Oliva & Sterman, 2001). This is inadequate because on the job training does not provide new case managers with the knowledge base that they need to be successful (Garb & Grove, 2005; Aegisdottir et al., 2006). Lack of knowledge about interventions that help clients on their recovery journeys remains a significant problem in case management (Farkas, Anthony, & Cohen, 1989; Bromberg & Starr, 1991).

Most case managers have bachelor's degrees. However, many of these are not in human services (Gellis, Kim, & Hwang, 2004). In a study of case managers in Iowa, Illinois, and Indiana, it was reported that 80% of case managers have bachelor's degrees, and of that group, 50% do not have degrees in areas of mental health concentrations, such as psychology or social work (Gellis, Kim, & Hwang, 2004; Hromco, Lyons, & Nikkels, 1997). In some programs, case managers have high school diplomas, but have not completed their undergraduate degrees.

There are also case managers that have master's degrees, but this is not the norm, and often these individuals are in supervisory roles (Rapp, 1998). Since case managers are working with clients with serious mental illnesses, it is problematic when they lack sufficient training in mental health diagnoses, symptoms, and treatments. One of the goals of the SPA initiative is to provide uniform training for the current case management workforce in the county. The Case Management Mentor Certificate Program established a method for providing newly hired case managers with the practical and technical knowledge and skills that they need to do the fundamental aspects of their job.

In one training program for case managers in New York City, a curriculum was developed to train new case managers about their job tasks, psychiatric rehabilitation, mental illnesses, and medications (Robinson & Bergenman, 1989; Weill, 1985; Withridge, 1989; Anthony, 1993). At the end of the course, participants reported feeling increased optimism about their work and more confident about their knowledge and skills for practice (Bromberg & Starr, 1991).

When there is high turnover in agencies that provide case management services, the additional workload contributes to the stress of the people who remain with the agency. When there are always vacant positions and virtually never full staffing and other staff members have to assume additional work to make up for the vacant positions, which increases their job stress. This is an ongoing problem in most agencies. Fifty percent of case managers work in the field for three years or less (Hromco, Lyons & Nikkel, 1995). This is consistent with information about job turnover in the human service workforce, which is between thirty to sixty percent per year (Barak, Nissly & Levin, 2001). The process of recruiting, hiring, and training new staff is a significant organizational burden that impacts an agency's primary goal of providing services to

mentally ill people. Ultimately, the client is the one most impacted by the high turnover in case management (Albizu-Garcia, Rios, Juarbe, & Alegria, 2005). When a case manager vacates a position, the client must establish a relationship with the person who is filling in and again, when a new person is hired. In addition to being stressful, this discontinuity can result in a disruption in services.

People who provide direct care in the mental health fields report increased levels of depression, anxiety, and stress (Deary, Algious, & Saler, 1996; Looney, Harding, Blotchy, & Barnhard, 1980). People who work in the community with people with mental illness report higher stress levels than those mental health staff who work in inpatient units in hospitals (Carson, Brown, Fagin, & Bartlett, 1996).

Case management is a job that inherently subjects people to a high level of stress and exposes them to continuous contact with seriously mentally ill people. Workers are frequently exposed to complex problems, challenging behaviors, and traumatic circumstances (Gellis, Kim, & Hwang, 2004). When people are acutely ill or highly symptomatic, they may require a high level of contact with the case manager, which can increase stress and require more direct practice skills on the part of the case manager.

Burnout increases for case managers when there is a high demand for limited community resources, caseloads are too high, or there is an excessive level of acuity in the caseload (Maslasch & Pines, 1982; McCleod, 1997; Savicki & Cooley, 1987; Carson, Brown, Fagin, & Bartlett, 1996; Moore, Ball, & Kuipers, 1992). Burnout is described as subjective stress and a self-reported feeling of being tired and feeling burdened by work (Koekse & Koeske, 1983; Acker & Lawrence, 2003; Arches, 1997). Burnout increases when people do not feel that they can do their jobs well (Harrison, 1980; Bandura, 1989; Cherniss, 1993). Having a caseload that is

overwhelming, either because of its size or acuity can lead case workers to lose confidence in their ability to effectively manage their work responsibilities. Caseload size for case managers ranges from 5-50 people (Kanter, 1989). Caseload size is important because when people have a higher caseload they report increased levels of stress (Hromco, Lyons, & Nikkels, 1991). Burnout decreases when people feel more confident in their ability to do their jobs (Acker, 2009). Training for the mentors and the mentees may increase the knowledge and skills that are needed to work with the more acutely ill and to prioritize caseload tasks, which may ultimately help case managers to be more confident in their ability to perform their jobs and increase job satisfaction.

In a study of case managers in Oregon, more experienced older case managers were more likely to effectively manage higher caseloads and the associated stress (Hromco, Moore, & Nikkel, 2003). This may be explained by the fact that the workers had more skills and experience and felt more confident about their ability to manage the challenges of this type of work. Methods for increasing confidence of case managers and improving retention are increasing their skills and knowledge, monitoring their caseloads, and helping them to manage stress effectively. When people have improved education and training, they are less likely to separate from an agency (Barak, Nissly, & Levin, 2001). Increased learning opportunities are associated with better coping and functioning of staff members (Mikkelsen, Saksvik, Eriksen, & Ursin, 1999). A potential benefit of educating case managers and providing mentors for new staff members is decreased job turnover, burnout, and job dissatisfaction. People may feel more satisfied in their jobs, may have better skills for coping with the more stressful aspects of work, and may be less likely to leave case management positions.

Increased retention has potential benefits for the clients as well as the case managers. The longer that case managers work with the SPMI population, the higher their reported job satisfaction (Jinnett & Alexander, 1999). This could be because those who remain in mental health careers for extended periods of time genuinely like working with people with mental illness and find the work rewarding. If case managers are supported to stay in their jobs for an extended amount of time, they may also have the experience of being more satisfied.

Other challenges for people seeking careers in case management are low salaries and lack of opportunities for advancement. In a survey in Allegheny County of case managers, starting salaries ranged from $23,000-$39,000 (Allegheny County DHS, 2009). The SPA initiative was designed to address the issue of low starting salaries by increasing the base salary for case managers incrementally over the next four years and creating a career ladder for case managers through the mentor program. This process has been initiated and is expected to continue for several years.

2.4 REWARDS OF CAREERS IN CASE MANAGEMENT

In some agencies, case managers can be rewarded for their efforts in the current system by exceeding their productivity requirements. If case managers exceed their productivity requirement, they become eligible for bonuses, overtime pay, or other compensation. Many case managers find this to be a benefit of their job and are highly motivated to exceed their productivity as a way to make extra money consistently.

Case managers have a high level of flexibility in how they structure their workday. They work fairly autonomously and spend most of their time in the field. It is common for people to

work as case managers while they pursue advanced degrees, in large part because of the flexibility that the schedule affords them.

Many case managers find case management to be a rewarding occupation. Even when case managers report high levels of burnout, the sense of personal accomplishment may act as a buffer for some and prevent them from leaving the field (Kirk, Koeske & Koeske, 1993). Case managers report that relationships they have with clients are one of the most rewarding aspects of their work (Angell & Mahoney, 2006). Additionally, they report that working with mentally ill people has offered them unique opportunities for personal growth and that they find the work to be satisfying because they are making a difference in the life of another person by helping them make positive changes (Stein & Craft, 2007). There are clear benefits for successfully addressing challenges such as high turnover, lack of professional advancement opportunities, and insufficient training and education within case management, since there are positive rewards associated with the work.

2.5 PROFESSIONALIZATION

In the mental health field, case management is not considered to be paraprofessional work. Case managers typically have completed a four year degree program. However, compared to other mental health disciplines, including social work, nursing, and medicine, case management is not typically recognized as a "profession", even though they have many professional responsibilities. One of the challenges of the SPA initiative is that is seeks to make case management a recognized profession within the mental health service delivery arena.

Historically, a profession was recognized as being distinct from other occupations (Etzioni, 1969). Professions are unique in the occupational hierarchy because they have specific characteristics that separate them from other work including specialized education, self-regulation, and autonomy (Etzioni, 1969). Examples of professions include careers in medicine, education, social work, engineering, and law.

The commonly accepted criteria for the professionalization of an occupation includes responsibility for the well being of the people that they serve and for the institutional arrangement where work occurs, shared collegiality with peers to promote decision making about clients, and ongoing professional development (Torstendahl, 2005). Professionals are perceived as being worthy of trust, committed to putting the needs of clients first, and vigilant about respecting confidentiality (Torstendahl, 2005). These characteristics are all part of the role and responsibilities of a mental health case manager.

Professional socialization is the process by which people selectively acquire the values and attitudes, interests, skills, and knowledge of the group in which they seek to become a member (Clouder, 2003). There is often a period of internalization or indoctrination that occurs during this process (Clouder, 2003). There are a number of ways in which this occurs, including teaching collegial interactions, career structuring, scholarship, community service, and professional development (Ballard, Klein, & Dean, 2007). The experience of professional socialization can be disempowering and requires a self-transformation that requires time and energy beyond that which is expected in other educational and occupational endeavors. During this transformative experience, a person learns new roles, meets the expectations of others, learns to fit in with a new group, and to follow the unwritten rules of the profession, as well as those that are explicit (Howkins & Ewins, 1999).

In order to be recognized as a profession, the education that people receive must move beyond "training" and focus on education and broad knowledge. Professional socialization is different from an apprenticeship. In an apprentice relationship, informal relationships with peers and informal learning occur in addition to a lesser amount of formal learning and training (Beck & Carper, 1956). In an apprenticeship model, an expert and novice work side-by-side and dialogue while practicing and developing new skills (Hargreaves & Dawe, 1990). This transformation has been occurring over time in the field of nursing, where there is a shift away from diploma training to university-based preparation for nurses (Apesoa-Varano, 2007). While a person can be trained to complete a specific task, for example, nurses, can be trained to insert a catheter, a person must be educated to understand why they are completing the task and its potential implications, such as recognizing that a low grade fever in the patient with the catheter could be the result of an infection at the catheter site.

The best way to foster professional development in people who are new to a profession is to integrate hands on learning with daily life and the classroom (Apesoa-Varano, 2007). As part of the SPA initiative, it was anticipated that the system wide transformation in case management would result in changes in the career paths of case managers. Through the mentoring program, case managers would have opportunities for pay increases and a career ladder that would support people staying in case management careers for long periods of time. Additionally, case managers would be trained to facilitate meetings and coordinate care across disciplines.

Despite the system changes, it is not likely that there are enough components in place for professional socialization or the professionalization of case management at this time.

2.6 JOB SATISFACTION

Job satisfaction describes a person's attitudes associated with their job and includes factors such as financial incentives, control of decision-making processes, and challenging work (Jayartne & Chess, 1991). Satisfying jobs are those that provide people with autonomy, supportive co-workers and supervisors, and inclusion in decision-making (Jacob, Bond, Galinsky, & Hill, 2008). There are aspects of case management that could be associated with increased job satisfaction. Case management is a career that provides a person with a significant amount of autonomy. A case manager can schedule his day in a way that is flexible and for the most part works in the community, not in the confines of an office. There are opportunities to receive bonuses and incentives in pay.

Even though the majority of work takes place in the field, there are opportunities to interact with co-workers in the office and at meetings. For case managers, having social support at work has been shown to increase coping skills and competence (Acker, 2009). Having positive relationships with co-workers can impact job satisfaction. Each day is different and the daily workload is not monotonous. Perhaps the most satisfying part of a case manager's job is the experience of sharing part of another person's life with them. Even though case managers report high stress levels, they also report being satisfied with their jobs (Kirk, Koeske, & Koeske, 1993).

Mentoring has the potential to provide social support and to help new case managers adjust to their new positions. They might feel more confident in their abilities, and have a person who they can seek out for advice and with questions. One of the objectives of this study was to explore whether mentoring had an impact on the reported job satisfaction of the mentees.

2.7 CASE MANAGEMENT MENTOR CERTIFICATE COURSE

The Case Management Mentor Certificate Course was developed after preliminary research determined areas that case managers indicated they had deficits including lack of knowledge about major mental illnesses, medications, health issues, and resources (Eack, Christian-Michaels, Denis, & Anderson, 2009). Case managers reported that while they had received required new-hire training in their agencies, it was inadequate to prepare them for what they encountered in the field (Eack et al., 2009). Informal mentoring occurred in agencies and usually consisted of asking questions or seeking information when the need arose, but not in a structured program (Eack et al., 2009). In one article, the case manager was compared to a medic on a battlefield, who learns many skills in the field during a crisis (Kanter, 1989). This is indicative of the experience that new case managers describe: they learn on the job, as they go. Regardless of the experience that case managers get "on the job," they still need and can benefit from formal training and structured education (Stanard, 1999). Thorough orientation, ongoing training, and support are essential in order to be successful in case management (Sullivan & Rapp, 1991; Bond, 1991).

The Case Management Mentor Certificate Course was a fifteen week course that was taught in spring semester of 2009 at the University of Pittsburgh in the School of Social Work for adult case managers. The Allegheny County Office of Behavioral Health paid for half of the cost of the training for each student and SCUs paid additional costs for their agency employees. After the first year the course was expected to be offered again. Agencies would then be expected to pay the full cost of tuition. Each class was three hours in length and held in the morning once a week. Classes were taught by a social work faculty member. There was student representation from the eight Service Coordination Units (SCUs) that provide case management

services in the county. The number of mentors that participated in the program varied by agency. Some agencies sent over five people, and others sent only one person to participate in the course. There were nineteen students enrolled, with eighteen completed the course. The students that were chosen to participate were role models in their agencies and identified as skilled case managers who had a positive attitude, could manage the extra responsibilities of being a mentor, and had the ability to teach and train co-workers. It was not required that participants be senior staff members, but rather people who were identified to have excellent practice and documentation skills. They were expected to provide 3 to 6 months of mentoring for all newly hired case managers beginning with their initial hiring. They would utilize curriculum from the course so that all newly hired staff in every agency would be learning consistent material. Mentors met weekly with the mentees and were expected to accompany them into the field. In class, mentors had an opportunity to discuss their experiences and the challenges that they faced in their new roles. Mentors were expected to return yearly for a meeting at the University of Pittsburgh to review progress, address systems issues, and get updated mentoring curriculum information. Mentors attended a post-course meeting in November 2009, six months after the class ended.

A training manual, "Mentored Case Management for Individuals with Severe Mental Illness" was developed for the course and contained information about mental illness including symptoms, medications, and issues of co-morbidity, as well as content about case management job tasks, including how to engage with clients, work with a multidisciplinary team, and access resources (Eack, Anderson & Greeno, 2007). This manual was commonly referred to in the course as "the Gray Manual."

The course content included information about mentoring methods, challenges the mentor might experience, the role of case managers in working in mental health, facilitating strengths, understanding psychiatric diagnoses and treatment, ethics, working with families, and resource brokering. Class assignments included tests, class participation, presentations about various community resources, and a weekly journal for the student to record his/her experiences with being a mentor. It was expected that the mentors would have a 10 to 15 % decrease in their productivity requirement when they enrolled in the course to allow for time spent in class, completing assignments, and working with mentees. Upon completion of the course, each of the participants received a certificate and was expected to continue in their new roles as mentors in their respective agencies.

2.8 MENTORING

The origins of mentoring are derived from the Homer's epic, the Odyssey. When Odysseus left to fight the Trojan War, Mentor was assigned to look out for his young son Telemachus; to guide, teach, and help him to grow into manhood. When Mentor was inadequate for the task, the goddess Athena would disguise herself as him to provide direction for Telemachus (Anderson & Shannon, 1988). Mentor required the oversight of "wisdom" or Athena. This early tale of the character of Mentor provides a vision of the modern practice of mentoring.

In the 1970's mentoring became increasingly popular in human resources in the United States and by 1989, one third of all major US companies had formal mentoring programs (Bragg, 1989). In behavioral health, agencies are not major US companies, and in fact, many agencies are barely able to make a profit or survive as not for profit entities. Formal mentoring is not

common, although informal mentoring occurs almost universally. The Case Management Certificate Course was created to provide a formalized mentoring program that all the agencies in the county could follow. This would help case managers as they were hired to be able to immediately connect with a more experienced co-worker and begin learning, rather than having to wait for a scheduled training.

A mentor is a person who nurtures, counsels, encourages, sponsors, and befriends the mentee (Anderson & Shannon, 1988; Bond & Holland, 1998). This person is accepting, non-judgmental, committed to the mentoring process, and a continuous learner (Anderson & Shannon, 1988). Colleagues, friends, family, and community members mentor people at different stages in their lives (Kram, 1985). In a mentoring relationship, both parties experience change and growth. The mentee develops professionally and the mentor has an opportunity to share knowledge and wisdom.

In the Case Management Mentor Certificate Program, the mentors were chosen because they demonstrated the qualities noted above. They were had an interest in teaching, understood their jobs, and were open to working with new people in an accepting stance. They received specific training about mentoring and the various roles of a mentor.

There are three main aspects of mentoring. These include the acquisition of learning, the management of transitions, and the opportunity to maximize potential (Samburijak & Marusic, 2003). Methods for mentoring include demonstration, coaching, teaching, debriefing, co-planning, and journaling (Harrison, Lyons, Baguley, & Fisher, 2009). In the certificate course, the mentors were trained from a manual that contained information about mental illness, physical health, medications, and case management job tasks. The mentor was expected to pass on this knowledge with the mentees through observation, conversation, and review of the manual. The

mentors helped the new case managers to transition into a position in a new agency and would introduce them as co-workers. Mentees were able to more quickly understand the work culture and the larger mental health system. Some case managers spend a significant amount of time at work in the field, working autonomously. They can be very isolated from co-workers unless they make an effort to stay connected. A mentor can help a new staff member to develop skills and social networks to support them when they are feeling isolated.

Mentoring also helps people to socialize into a profession (Shea, 2002; Morton-Cooper & Palmer, 2002). This is especially important for case managers, who have to interface with the public welfare system, hospitals, and other community services. Through mentoring, they can learn what their roles and responsibilities are during these interactions and become more cognizant of behavioral expectations.

The challenges to successful mentoring relationships include time limitations, competing commitments, and low staffing (Harrison et al., 2009). To mentor successfully, it is essential that mentors have time allocated apart from their other work responsibilities to spend time with mentees (Harrison et al., 2009). In the mentoring course, mentors were expected to have scheduled time to work individually with mentees on the curriculum in the manual and to discuss any issues or to answer any questions that the mentee might have about work. There would also be time for the mentor and the mentee to be in the field together to work with clients. Mentees would shadow the mentor and the mentor would spend time observing the mentee in practice. This would provide the opportunity for coaching and modeling "in vivo". Modeling and coaching helped the mentees learn about organizational structure, larger systems, and interfacing with other disciplines, such as doctors, nurses, social workers, lawyers, and law enforcement.

2.9 IMPLEMENTATION SCIENCE

Implementation science is the study of methods that are used to take research data and incorporate it into policy and practice (Eccles & Mittman, 2006; Kimberly & Cook, 2008; Proctor et al., 2009; Titler, Everett & Adams, 2007). While there is anecdotal research about implementation, there is not a large volume of more formalized research about it (Glasgow, 2008). Implementation research and implementation science is a relatively new field of research and is commonly associated with medicine, public health, and policy development (Lang, Wyer, & Haynes, 2007; Glasgow, 2008).

Processes of implementation take 2 to 4 years to complete in most organizations (Prochaska & DiClemente, 1982). In comparison to other fields, mental health implementation takes significantly longer. In human services, unlike in industry, the practitioner is the principal intervention (Fixsen, Blasé, Naoom, & Wallace, 2009). Human beings are highly variable and there is no prescribed formula that will result in an end product. In industry, the integration of research and innovation into product application delivery moves at a significantly different pace. This occurs because research leads to product development and the product is the intervention (Fixsen et al, 2009). Examples of this type of intervention are cars, computers, or pharmaceutical medications. A plan is developed and implemented which results in a uniform final product. When working with people, the final product is always variable because of the unpredictability of human beings.

Science does not always view implementation as part of the research agenda (Maden, Kupfer, Hofman, & Glass 2007). Historically, research was communicated to people in practice through dissemination, the distribution of research results to the practitioners. Once this was

done, there was little follow up about how the information was utilized in practice (Armstrong, Water, Grockett, & Keleher, 2007; Proctor et al, 2009; Grimshaw & Russell, 1994).

Implementation is the initiation of behavior and involves an exchange of knowledge between the researchers and requires the use of specific strategies to move the research into practice (Proctor et al., 2009; Dearing, 2009). For some researchers, this is a new way of conducting research. In the past, the ideal research came from randomized controlled trials (RCT), which provide the highest standard for scientific control with populations that are carefully identified, environments that are highly controlled, and protocols that are strict (Tunis, Stryer & Clancy, 2003). Frequently, though, the RCT results are difficult to implement in practice (Tunis, Stryer & Clancy, 2003). ‘

While all fields can benefit from science, the challenges discussed above make implementing research findings and science into health care and human services difficult. There is evidence that people often receive unproven treatments and interventions, and in one study of healthcare that included a sample of 6,700 people, it was found that forty-five percent were not receiving recommended treatments (McGlynn, Asch, & Adams, 2003). The widespread problem of research not being adequately translated into practice has been described as a “quality chasm” in the nation’s healthcare system (Chassin & Galvin, 1998).

Despite these potential obstacles, implementation research is essential to improved mental health services delivery. There is a wide gap between clinical research in mental health and how services actually are provided (DHHS, 2003). A huge volume of money is spent on mental health research in the United States and the direct and indirect costs associated with all serious mental illnesses exceeds $317 billion dollars per year (Insel, 2003). Even with these cost estimates, less than 10% of people with a given diagnosis receive evidence-based treatments

(Torrey, 2001). Evidence-based mental health practices have been proven to help decrease homelessness, substance abuse, symptoms, and the need for hospitalization (Drake et al., 2001; Mueser, Torrey, Lynde, Singer, & Drake, 2003). Even with these recognized costs and societal implications, it takes as many as fifteen to twenty years for research about treatments, medications, interventions, to be implemented into practice (Proctor & Rosen, 2008). These extensive delays are problematic because in addition to the fiscal and societal implications, people with SPMI are not getting the best treatment that is available, which can result in inconsistent, ineffective, and sometimes unsafe treatments (IOM, 2001; DHHS, 2003).

Implementation research is increasingly being identified as a way to explore the barriers to getting research into practice and to overcome them. Implementation science acknowledges that treatment innovations can develop in the organizations and in the clinical world (Chorpita, 2002; Daleiden, Chorpita, Donkervoet, Arensdorf, & Brogan 2006). New funding has become available in recent years at the NIMH for implementation research that is a collaborative effort between researchers and providers (Brekke, Ell, & Palinkas, 2007). The Case Management Mentor Certificate Course is the result of collaboration between researchers and service providers. The initial conceptualization of the program, its development, and implementation were a collaborative process.

Implementation of innovation is important because mental health workers generally work alone and often rely on intuition, or things they believe will be effective with the person that they are working with, rather than knowing for certain that it is a proven technique, skill, or treatment. Every time that a client has contact with a case manager, doctor, therapist, or social worker, the encounter involves some type of exchange, but often what actually occurs during the session is not entirely clear. In this study, new case managers may not have education and knowledge

about mental health diagnoses and treatments, so they are practicing based on what they think might be correct, but they do not know for certain. One area of concern is that despite having information to the contrary, clinicians continue to use non-rational considerations to make decisions rather than basing their choices on evidence (Dawes, 2001; Lilienfeld, 2002; Reber, 1993; Rosen, 2003; Shafir & LeBoeuf, 2002). There are a number of possible explanations for why this occurs. One is that professional education does not assure that a person will develop rational thinking skills, which are an important component of critical thinking and decision making (Lilienfeld, 2002; Gibbs & Gambrill, 1999). Another is that direct care staff are often inadequately trained and prepared through their education in the methods that are used in research (Kirk & Oenka, 1992). Also, they may lack familiarity and an awareness of current published research literature (Mullen & Bacon, 2003). Finally, they may have a negative attitude toward research based on their experience or lack of knowledge (Rosen & Mutschler, 1982).

2.9.1 Barriers to Implementation

Examples of common barriers identified to successful implementation include poor quality of guidelines for implementation, an unclear or inadequately articulated purpose, insufficient stakeholder involvement, a lack of perceived applicability by the practitioner, and a lack of clarity in the presentation of the intervention to be implemented in practice (Bhattacharyya, Reeves, & Zwarenstein, 2009).

Implementation science pays close attention to the socio-cultural environment into which the implementations need to fit (Stetler, Ritchie, Rycroft-Malione, Schultz, & Charns, 2009). This is important because careful examination could point to a number of factors that could be

potential barriers including: cost, organizational issues, staff issues, time constraints, lack of confidence in the benefits of implementation.

2.9.2 Successful Implementation Strategies

There are pre-implementation strategies that can be helpful to increase the potential for successful long-term implementation. One example is the completion of a needs assessment prior to implementation. This can be done through surveys, ethnography, and interviews (Kochevar & Yano, 2006). When preliminary information is gathered, potential barriers can be identified in advance. With knowledge about the system and potential conflicts, the researcher and clinical leadership can address issues such as stakeholder alienation and help people to understand the reason for the implementation prior to getting started (Proctor et al., 2009). Implementation planners need to consider how training will be offered to providers, how the providers prefer to practice, and how receptive the providers are to the idea of new practices, and the providers' patterns of decision making (Proctor & Rosen, 2008). The researcher needs to consider areas where she is amenable to changes, since there may be areas that need to be changed or adapted in order to increase the likelihood that they will be implemented (Proctor et al., 2009). Other things that need to be considered early in the process are whether or not the changes made in implementation will be sustainable and how they will be measured over time (Proctor, 2003). When researchers convey the results in a way that involves stakeholders, they can see the potential benefits and applicability to their work. This helps to foster a partnership and improves the chance of commitment from the clinician to make use of the data (Bhattacharyya, Reeves, & Zwarstein, 2009).

In the case of SPA and the case management initiatives, there was stakeholder involvement from the earliest meetings. Stakeholders were involved with all of the planning committees and there has been ongoing communication with case management mentors, supervisors, SCU directors, and agency administrators about the implementation process. All SCUs were required to train their staff about SPA and the changes that would be occurring over time as a result of its implementation.

Successful implementation involves staff selection, which includes identifying people who will be committed to using the intervention and working through challenges (Klinger, Ahwee, Pilonieta, & Menedez , 2003; Bernfield, 2001). In the case of the mentor program, the mentors were chosen because they were identified as "change agents" and people who could work through the process of starting a new program. Training is an integral part of implementation because people need to understand what they are doing and why they are doing it (Bernfield, 2001). Traditional training workshops are not always successful at changing practice (Jensen-Doss, Cusack, & deArellano, 2008). Interactive training has been demonstrated to be the most effective for change (Fixsen et al., 2005). The use of peer networks to help with training and coaching has also been shown to be beneficial for increasing implementation (Chorpita, 2003).

In the development of the course for the case manager mentor certificate program adult learning strategies were considered. The class included a wide variety of teaching methods and students were able to reflect on what they were doing in practice in their weekly classes. Successful implementation requires behavioral change at all levels, including at the organizational level and with administration, supervisors, and line staff (Klinger et al., 2003; Bernfield, 2001). In this study, the case managers were asked to talk about how they were

supported by their supervisors and the organization, since these are areas that can facilitate or inhibit implementation.

There are various stages of successful implementation. These include exploration, installation, initial implementation, full implementation, innovation, and sustainability (Fixsen et al., 2009). There are also organizational structures such as internal and external communication, technical knowledge, and professionalism which impact implementation (Damonpour, 1991). Prior to the implementation of the mentor program, there were many planning and informational meetings. The SPA initiative was introduced to all case managers, and the introduction of the mentor program was a part of that process.

Other things that impact implementation include the readiness of the system for change, organizational culture, incentives for change, and the behavior of leaders (Brekke, Ell, & Palinkas, 2007). Readiness for implementation in an organization is influenced by the attitudes of employees, the training and approach of leaders, the level of motivation, and the available support for the implementation (Kimberly & Cook, 2008; Kligner et al, 2003; Bernfield, 2001). There needs to be a comprehensive plan to communicate with the people who will be implementing the intervention in order to help them to fully understand their roles (Titer, Everett, & Adams, 2001). Changes are more likely to be implemented if there is perceived organizational benefit and it fits in with organizational norms (Buchanan et al., 2005; Pettigrew, Ferlie & McKee, 2001; Lozeau, Langley & Denis, 2002).

In this study, all of the mentors received the same training and learning materials. Nevertheless, there were individual differences in how each mentor understood, modified, applied, and retained the information. Additionally, the mentees' individual experiences and learning styles and the agencies' adaptation of mentoring were also factors in how mentoring

was implemented. Despite all of the efforts, there ultimately may be some agencies that fail to fully implement or maintain the mentoring program over an extended period of time.

2.10 TRANSFER OF LEARNING

Transfer of learning refers to how prior learning affects new learning or performance (Marini and Generexu, 1995). It is of interest to a wide variety of disciplines including nursing, education, law, medicine, engineering, and social work (Curry, McCarragher, & Dellman-Jenkins, 2004). In all of these disciplines, the ability to transfer information from the classroom and translate it into practice and decision-making is essential.

In the United States, workplace training for staff members is often problematic and it is estimated that only ten to thirteen percent of cumulative learning from training actually transfers into practice. Once the training is completed and the knowledge does not transfer, the skill dollar loss is .87-.90 cents of each dollar spent on training (Gill & Murray, 2009). Overall, organizations in the United States spend $110 billion dollars per year on training and approximately fifteen billion work hours (Gregoire, Propp, & Poertner, 1998).

The concept of transfer of learning has its roots in the work of E.L. Thorndike at the beginning of the 20th century (Detterman, 1993). Thorndike was interested in studying whether students who learned Latin were able to use that knowledge to excel in other academic areas. He did several studies and was unable to find any indication that Latin skills made a difference in other areas of study (Detterman, 1993). As a result, Thorndike determined that people are more likely to be successful at what is referred to as "near transfer." This refers to situations where learning can easily be applied in similar contexts (Macauley & Cree, 1999). In human services

work, individual and situational variability make it unlikely for transfer of learning to occur in this way. When learning is adapted to highly variable situations and requires that the learner have a capacity for higher-level critical thinking and abstraction it is referred to as "far transfer" (Macaulay & Cree, 1999). Mastery of far transfer is the learning skill that is important for people who work case management.

One way to promote far transfer to is to teach and practice in the field. Education that takes place in contexts that resemble the situations where the knowledge and skills will be implemented is more likely to yield spontaneous use of information when the need arises (Johnson, 1995).

Another type of transfer of learning is "positive transfer", which describes how learning from one context improves performance in another (Macaulay & Cree, 1999). It is beneficial to understand what type of transfer needs to occur in a given situation and to develop strategies to achieve that type of transfer of learning.

Transfer of learning has been used recently in another area of human services, the field of child welfare. Training for child welfare caseworkers is essential for orienting new caseworkers, introducing changes, and teaching them how to work with challenging cases (Wehrmann, Shin & Poertner, 2002). These goals for training are similar to the types of skills that new case managers need when they are in the field. Unlike the case management mentor program, there is federal funding identified for training in child welfare (Curry, McCarragher & Dellman-Jenkins, 2004). In the case of the mentoring program, the county negotiated a rate increase from the state and expected agencies to use these funds to support pay increases and some of the training costs associated with the mentoring program. The county paid half of the cost the tuition and the university offered the course at a discounted rate.

There are a number of variables which impact transfer of learning. Examples include individual attributes, instructional design, organizational environment, and supervisory support (Lobato, 2006). The three major factors are trainer characteristics, training design, and trainer environment (Baldwin & Ford 1988). Individual attributes include locus of control, expectancy, and self-efficacy (Lobato, 2006). Locus of control refers to the idea that people who feel in control of their environment and can influence it are more likely to put effort into training (Wehrman, Shin, & Poertner, 2002). Expectancy is defined as the idea that if learners understand the goals and outcomes of what they are being trained, they will be more motivated to complete the transfer of learning. The motivation of the trainees is important not only to acquire skills but to use them on the job (Gregoire, Propp, & Poertner, 1998). Self-efficacy refers to the belief that a person can succeed in a task and is essential for behavioral change and ongoing maintenance (Bandura, 1986). Self-efficacy is critical to people who are being trained. The greater a person's sense of self-efficacy, the more effort they are willing to put in to handling the increasingly difficult demands of their job (Noe, 1986). Instructional design describes the effectiveness of the content of curriculum including clear objectives, positive trainer characteristics. Relevance to work and performance feedback increases the credibility of the transfer (Curry, McCarragher, Dellman-Jenkins, 2005).

Supervisory support is the most important factor in transfer of learning (Tannenbaum & Yukl, 1992; Baldwin & Ford, 1988; Olivero, Bane, & Kopelman, 1997). Supervisors who are overloaded with work or frequently have unplanned work will not have time to support transfer of learning efforts in their program (Garavaglia, 1993). A supervisor who is not receptive to change will not support a work culture conducive to learning and development. Staff members

who see supervisors as apathetic or negative are less likely to recognize the relevance of training and transfer of learning to the work that they perform (Garavaglia, 1993).

Transfer of learning is most likely to succeed in environments that are supportive and promote modeling and mentoring (Tannenbaum & Yukl, 1992; Noe, 1986). In a workplace where the organization and the supervisors create a culture of learning, staff members can observe the transfer of learning in practice. A new staff member can observe a supervisor or more senior staff member applying the concepts of transfer in actual practice. Through mentoring, the employee can work on transfer and be coached on ways to effectively use learning and training in diverse and changing situations.

3.0 METHODOLOGY

3.1 OVERVIEW

This was a mixed methods dissertation that had two parts. Study I was a qualitative study that used semi-structured interviews to examine the facilitators and barriers to the implementation of the Case Management Mentor Certificate Program from the perspectives of eighteen mentors. Study II included focus groups with thirty mentees to obtain qualitative data about their perceptions of the barriers and facilitators to implementation of mentoring and quantitative measures about the elements of mentoring that they used with their mentors and job satisfaction.

The choice of methods was determined by the questions to be answered by the research study. Qualitative methods are well suited for research that seeks to capture a person's lived experience, or to examine the unforeseen effects of a new program or service, and to explore a topic about which little is known (Padgett, 2008). This study sought to do all of these things. It was an inductive exploratory study that examined the experiences of front line case managers who were working in direct practice with people who were diagnosed with serious and persistent mental illnesses. It was designed to hear their perceptions about how the Case Management Mentor Certificate Program impacted how they learned, understood, and performed their jobs.

This study also sought to understand, from the perspectives of the case managers, what the barriers and facilitators were in the implementation process of the mentoring program. While

there is a considerable amount of research about case management, there is very little qualitative research about the topic of mentoring case managers and new training programs.

3.2 STUDY SAMPLE

Participants represented all of the eight service coordination units (SCUs) in Allegheny County that provide case management services. Participants varied in age, gender, work experience, and educational backgrounds. This study used purposive sampling, which is a deliberate process of choosing participants for a study based on their capability to provide the needed information for the research project (Padgett, 2008). Qualitative sampling was done for conceptual and theoretical purposes since the goal was not primarily to be representative of the larger world (Miles & Huberman, 1994).

3.2.1 Study I Sample

The sample for the study contained eighteen service coordinators who completed the Case Management Mentor Certificate Course. During the study, one of the mentors resigned, and only participated in the first set of mentor interviews. From the remaining seventeen participants, sixteen are currently employed as mentors. There was one agency which had not hired any new staff members and therefore the mentor did not have the opportunity to use mentoring. In the first set of interviews, mentors represented the eight SCUs in Allegheny County that provide case management services. In the second set of interviews, two SCUs did not participate and there was representation from six agencies.

3.2.2 Study II Sample

To obtain contact information for the mentees, the mentors were requested to provide email addresses and phone numbers. Several mentors indicated that people who had been mentored since the program's inception had already left their agencies, but all of the mentors provided information about the mentees who were still employed. Thirty-seven mentees were still employed as case managers. Two people were on extended leaves and unavailable. The remaining thirty-five people were invited, and thirty attended the groups.

3.3 STUDY DESIGN

3.3.1 Study I Design

Mentors were asked to participate in semi-structured interviews on two occasions. The first was in April 2009, upon completion of the course, and the second was six months after completion of the course, in November 2009.

3.3.2 Study II Design

Mentees were invited to participate in focus groups. There were three focus groups held at local restaurants. Mentees were emailed the dates of the groups and could select the one that best suited their schedules.

These methods for data collection were chosen because they best answered the research questions in the study:

- How did this innovation contribute to the way that case managers learn, understand, and do their jobs?
- What were the barriers and facilitators of the implementation of the Case Management Mentor Certificate Program?
- How was mentoring associated with the job satisfaction of the mentees?

Mentees were asked to complete the Job Satisfaction Survey (JSS) measure and to complete the Mentoring Frequency Measure, which is a brief questionnaire that was developed for this study to measure the frequency and helpfulness of various mentoring activities. Mentees were also asked to provide basic demographic information.

3.4 PROCEDURES

3.4.1 Study I Procedures: Qualitative Interviews with Mentors

Data was gathered from the mentors in semi-structured interviews because this format allowed for flexibility in execution and direct interaction between the researcher and the participants (Silverman, 2004). Interview questions allow the researcher to address facts, the participant's beliefs about facts, feelings and motives, standards of action, and past or present behavior (Silverman, 2004). Guidelines for interviewing include avoiding long explanations of the study at the start of the interview, refraining from deviating from questions or wording, avoiding

suggesting answers and interpreting meaning, and not allowing interruptions during the interview (Silverman, 2004). The purpose of the qualitative interviews was to describe and understand the perception of the mentors about the barriers and facilitators to implementation of the mentoring program and how the way that they understood and performed their job differently as a result of the program. In addition to hand-written notes, interviews were recorded and transcribed.

An interview guide was developed to provide a format for guiding the conversation with the mentors. It was designed by social work faculty at the University of Pittsburgh. Interview guides should be developed to address key topics in a way that makes sense to the participant (Padgett, 2004). In the mentor interview guide, there were leading questions and a number of potential probes for each question. Examples of questions in the mentor interview guide include:

- How do you see mentoring?
- How have things changed for you?
- How has your job changed?
- What adjustments have been made by your agency?
- How does it impact clients?
- What could be done differently?
- Is it a needed service for new case managers?

Interviewing is the most widely applied technique for social inquiry (Kvale, 1996). Charmaz describes interviews as directed conversations and a social encounter where knowledge is constructed between the interviewer and the participant (Charmaz, 2006). Interviews allow both the participant and the interviewer to be active participants in the process of constructing and "making meaning" of what the participant shares. The interview experience is not a conduit

to merely obtain knowledge, but an occasion for both the interviewer and interviewee to produce it together (Holstein & Gubrium, 1995). Given the exploratory nature of this study, the semi-structured interviews provided a method that allowed the mentors to share their perceptions in exactly this way.

3.4.2 Study II Procedures: Quantitative Data Collection

Mentees were asked to complete the Job Satisfaction Scale (JSS) and the Frequency of Mentoring Measure prior to the beginning of the focus group. These measures were used to rate the job satisfaction of mentees and to obtain information about what core elements of mentoring they engaged in with their mentors, how often they participated in these activities, and whether or not they found them to be helpful.

3.4.2.1 Job Satisfaction

Job satisfaction of the mentees was measured using the Job Satisfaction Survey (JSS). This scale was developed to measure job satisfaction of people who are employed in human services. It is now used widely for all professions (Spector, 1985). It consists of a thirty-six item scale that measures nine components of job satisfaction including: pay, promotion, supervision, co-workers, nature of work, communication, fringe benefits, contingent rewards, and operating procedures (Spector, 1985). Example of items include: " I feel I am being paid a fair amount for the work that I do", " I like doing the things I do at work", "work assignments are not fully explained, " and "many of our rules and procedures make doing a good job difficult" (Spector, 1985). Each item is rated on scale that ranges from one to six, where "1" is "strongly disagree" and "6" is "strongly agree". Items are written in both directions, with some of the responses

requiring reverse coding for analysis. Agreement with a positively worded item and disagreement with a negatively worded item represents satisfaction. For each of the four item subscales and the thirty-six item total scales, a mean item response of four or more represents satisfaction and three or less represents dissatisfaction. Mean scores between three and four represent ambivalence (Spector, 1985)

Reliability data for the JSS demonstrates that the total scale and subscales are internally consistent and the limited test-retest data demonstrates reliability (Spector, 1985). The coefficient alpha for the total score was .91 (Spector, 1985). Test re-test reliability was .37 to .74 for the subscales and .71 for the complete scale (Spector, 1985). The psychometrics for this measure indicated that it would be acceptable to use to measure job satisfaction. Dr. Spector gave permission for the scale to be used in this study.

3.4.2.2 Frequency of Mentoring Measure

The Frequency of Mentoring Measure was developed for this study and consisted of three sections. The first part was a demographic section which asked mentees to provide their age (in years), gender, education, mentor and agency, date of hire, and amount of case management experience prior to being hired in their present position. The names and agencies were coded and the mentees were provided with a list to identify their mentors and agencies by a letter and number, so that they would not be identifiable to the researcher in the analysis. The list of codes was created by another student and given to the mentees in sealed envelopes.

In the coding of this section, males were coded as "0" and females as "1." Mentees were asked to identify their level of education. High school was coded as "1", undergraduate degrees as "2", master's degrees as "3", and "other" as "4".

The second section of the measure asked the question, "On average, how frequently so you and your mentor meet?" The responses range from "none" to "daily". There was a response for "as needed", which was dropped from the analysis due to numerical ambiguity. These responses were coded as "1" for "none, "2" for "monthly, "3" for weekly", "4" for "daily", and "5" for as needed.

In the third section, mentees were asked to identify which of the core elements of mentoring they participated in with their mentors. These included "use of the gray manual", "shadowing by mentor", "observing mentor", "contacting mentor in crisis" and "meeting to review cases." If they answer "yes", they were asked to report the frequency that they engaged in these activities. These response choices were "daily," "monthly," "weekly," and "as needed**."** Lastly, the mentees were asked to rate the helpfulness of the activities that they engage in with their mentors. The ratings were "extremely helpful," "very helpful," "somewhat helpful," "neither helpful nor not helpful," and "not at all helpful." These responses were coded 5 to 1 respectively.

3.4.3 Study II: Focus Groups with Mentees

Focus groups first began in the 1940's at Columbia University, where research being conducted by Paul Lazarfeld and Robert Merton about television viewing patterns in the United States (Stewart & Shamasani, 1990). Since then, focus groups have continued to grow in popularity and are widely used as a research method.

Focus groups are comprised of people with similar backgrounds who do not know each other well (Stewart & Shamasani, 1990). They consist of 8 to 12 people, but can be as small as three and as large as fifteen (Silverman, 2004). There are a number of benefits to focus groups.

They allow the researcher to interact with the participants and to obtain information quickly. Focus groups are facilitated by a moderator who guides question and needs to be skilled in group work and interviewing skills, so that no one is able to dominate and to monitor so the group does not go off course (Stewart & Shamasani, 1990).

One of the main benefits of focus groups is that it is a forum to gather general information that can be used for later further research (Kvale, 1996). Focus groups also help to diagnose problems in new programs, products, or services, and to allow the researcher to understand how professionals talk about the topic of research interest (Silverman, 2004). Additionally, they are flexible in nature and allow participants to build on the responses of one another (Kvale, 1996). Since this was an exploratory study, focus groups were chosen because they help to diagnose problems in new programs, obtain information quickly, and gather information that can be used in ongoing follow-up of the implementation process.

Focus groups were taped and in addition to the moderator, there was another graduate student in the room who observed and took notes during the group. The moderator used a large tablet to jot responses briefly with a marker, taped the pages to the wall for the group to review during the process, and checked with the group to ensure that the notes reflect what was being said about the topic.

Examples of the questions for the focus group included questions about how the mentee was introduced to or found a mentor, which activities they engaged in with the mentor, whether these activities were helpful, and to what level they perceived that mentoring received organizational and supervisory support. There were probes built into each question to elicit additional responses when necessary.

3.5 ANALYSIS

3.5.1 Study I: Mentor Interview Qualitative Analysis

There are steps that occur during interpretation in a qualitative inquiry (Denzin, 2001). The first step is framing the questions to be analyzed and then deconstructing and doing analysis of prior conceptions about the phenomenon. This includes reviewing the existing literature. The third step is capturing the phenomenon and bracketing the data. This refers to reduction of the data it to its most basic elements, and the deconstruction of the phenomenon and the rebuilding. The final step is the interpretation process, which illuminates the phenomena as a real and lived experience and brings it to life for the reader (Denzin, 2001).

For this study, qualitative analysis, an inductive process, was used to analyze the mentor interviews using elements of grounded theory. Grounded theory is a method that is utilized to develop theories that emerge from qualitative data (Strauss & Corbin, 1988). In grounded theory, a researcher does not begin with a preconceived theory in mind, but rather allows the theory to emerge from the data to illustrate a reality that helps to develop understanding and can be used as a guide for future action and further study (Strauss & Corbin, 1988). Rather than the preconceived ideas of the researcher, the data drives the creation of theory (Charmaz, 2006). While the researcher may have some ideas about the topic under study, the nature of the inquiry allows the data to give meaning to the experience of the person and help to increase understanding of phenomena. Phenomena are essential ideas which emerge from the data that help to explain what is going on and help the researcher to determined how to illustrate the problems, issues, or concerns that are important to those being studied (Strauss & Corbin, 1988).

The sample size in grounded theory analysis is usually small, ranging from 20-30 people, but can be smaller (Padgett, 2004). In this study, the sample size of both the mentor and the mentee groups was within this range.

In grounded theory, the researcher is immersed in the data so that he can become familiar with the common themes and patterns of it (Charmaz, 2006). This starts at the very beginning and continues throughout the data collection and analysis process. The researcher is constantly connecting with the data and this process continues on through the duration of the study. Through the process known as immersion/crystallization, the researcher is deeply connected to the data. There are repeated cycles where the researcher immerses herself into the data and experiences the text and after extensive and thoughtful reflection with intuitive crystallization interpretations are reached (Crabtree & Miller, 1999). The researcher must be self-aware and able to be open to the uncertainty of reflection, she must be patient and able to listen, and have an understanding of reflexivity (Crabtree & Miller, 1999).

The primary method of analysis in grounded theory is coding. Through repeated readings of the texts, the researcher is able to move from general to more detailed descriptions (Charmaz, 2006). The purpose of coding is to remain open to all of the potential theories that may develop and emerge through the data (Charmaz, 2006). The process of coding is used to break the data apart and to reflect on what the data tells you about the categories and meanings. During the coding process, the researcher repeatedly considers how each category relates to others and to construct theories, to gather all the information and to refine categories (Richards, 2005).

As the researcher is immersed in the data, the coding process is ongoing. One of the ways that the researcher can begin to identify codes is through the use of sensitizing concepts. These

are ideas that the researcher has an awareness of and realizes might be relevant to the study or may surface in the content (Glaser, 1978).

There are three common levels of coding identified for grounded theory. These are open, focused and theoretical (Charmaz, 2006). Open coding refers to how the data is identified, categorized, and described based on the texts (Charmaz, 2006). During the process of code identification, Charmaz (2006) recommends the use of gerunds for coding, which are words ending in "–ing". Another way that Charmaz suggests to code is through the use of "in-vivo" coding, which uses the words of the participant as the code identifier. This helps the researcher to stay closely connected to the data and in the voice and words of the participant (Charmaz, 2006).

In open coding, text can be analyzed by words, lines, or longer segments (Charmaz, 2006). Segments are a series of lines that are about the same ideas in the text. As things are coded into categories, there will be concepts that emerge repeatedly. When a researcher sees the same topic repeating, saturation has been reached and the researcher can begin to build the next category (Glaser & Strauss, 1967). After the text has been read and re-read multiple times, the constant comparison method is used to look for themes and patterns in the text (Glaser & Strauss, 1967).

Focused coding is that which is grouped into categories (Charmaz, 2006). Codes that most accurately describe the experience and process from the data are grouped into categories, which are used to explain the experience. This is done by careful examination of what phenomena each group of codes describes (Strauss & Corbin, 1988).

Once the codes are finalized, a codebook is created. One way to increase construct validity for coding is to pick the sample text and to see if the other reader finds the same codes

pertaining to a theme because it should demonstrate a pattern that is not a random decision by the researcher (Padgett, 2004). Inter-coder agreement was obtained for this study by having a second reader review the texts, code them, and then compare results. The reviews were similar, which demonstrated that the codes were actually reflective of the interview data.

The last level of coding that was used in this analysis is theoretical coding, which synthesizes all of the coding into a cogent whole (Charmaz, 2006). Themes are identified from all of the codes that have reached saturation and these themes can be used in the interpretation.

One of the goals is to have "fit". Fit describes the extent that codes reflect the experiences of participants, and relevance is the extent to which the theory provides insight to the relationship between actions and processes (Charmaz, 2006).

In addition to coding, another important qualitative analysis technique is memo writing. Memo writing is the process of the researcher reflecting in her own words on the categories and emerging themes found in the data, so codes can be organized into themes (Charmaz, 2006). The memo is an informal note that the researcher writes for personal use and is used to analyze ideas about coding. This helps the researcher to think about the data as it emerges. Memo writing is a critical step between coding and writing a draft of the results (Charmaz, 2006). Writing memos throughout the process keeps the researcher connected to the data, helps to organize thoughts, and consider questions and alternatives (Charmaz, 2006). Early in the process, memos record the researcher thinking about what is happening in the data: What are people doing? What are people saying? What things do you need to check on? What do you think is going on? (Charmaz, 2006). Later in the process, more advanced memos help to categorize and describe how themes emerge and then help to identify beliefs and make comparisons (Charmaz, 2006).

Trustworthiness is another issue that is important to address in qualitative analysis. Trustworthiness is the extent to which the findings from the data are believable and most closely as possible represent the experiences of the respondent accurately (Glaser & Strauss, 1967). Having multiple coders or additional readers helps the researcher to evaluate whether or not the analysis accurately reflects what the data is telling.

Auditing and independent coding improve reliability (Kvale, 1996). Auditing requires the researcher to explore findings and process with others. In this study, other scholars who were knowledgeable about qualitative methods and familiar with the study provided an audit.

Another way to analyze to understand meaning and improve validity is by using thick description (Richards, 2005). Thick description asks: What is the importance and meaning? It requires the researcher to understand and connect with the participant. Thick description contains detailed imagery and recall and interpretive comments, connecting actual knowledge (Richards, 2005).

Reflexivity considers the way that the researcher is a part of the study (Richards, 2005). To address this, the researcher needs to accurately record what was discussed and write himself into the content of the analysis using the first person, and consider how he was a part of the construction of the knowledge and meaning that was created.

In this study, all text was coded and a second reader checked for inter-rater coding reliability. Memos were used during the coding process and thematic development. Thick description, auditing, and reflexivity were utilized throughout the data collection and analysis process.

3.5.2 Study II Quantitative Analysis of Mentee Data

The focus of the quantitative section was to examine the association between the experience of being mentored and job satisfaction of the mentees. SPSS was used to complete the analysis. Total scores were calculated for each instrument and all values were coded. Frequencies were run on these data to examine the values and descriptive statistics were used to check means and distributions. The beta coefficient of the relationship between variables and associated *p* values of the correlational relationships were evaluated in the analysis.

The structure of these data was such that different mentees could not be considered statistically independent. Since some of the mentees had the same mentors, they were dependent and could be more likely to report similarly because of the shared mentors. The problem of a nested data structure is best addressed through hierarchical linear modeling. This is a multi-level technique that addresses nesting and this approach specifically models both individual and group residuals recognizing interdependence of individuals within the same group (Raudenbush & Bryk, 2002). The advantage of this model is that it allows for the investigation of relationships at a particular hierarchical level and between or across hierarchical levels (e.g., mentor effects on mentee relationships) (Raudenbush & Bryk, 2002). Variables are measured at both levels and this technique estimates the variance and covariance components with nested data. Each level in the structure is represented in its own sub-model, which expresses a relationship among variables within a given level and specifies how a variable at one level influences relations occurring at another (Raudenbush & Bryk, 2002).

There were two sub-analyses in quantitative analysis of Study II:

1. The association between job satisfaction of the mentees and the frequency of mentoring.

2. The association between job satisfaction and the comprehensiveness of mentoring.

To predict job satisfaction from frequency and comprehensiveness, a model is needed that can account for the possibility of a shared mentor, which is the nesting factor. Such a model is presented in eq. 1-3. In this model, Y_{im} represents the outcome measure, job satisfaction, for each mentee *i* in mentor group *m*. The intercept, $\beta_{0m,}$ is a random variable representing average job satisfaction for the sample; β_{1m} is a non-random variable representing average relationship between job satisfaction and frequency across individual mentees within mentors, and r_{im} represents random error. The Level 2 equations then represent job satisfaction as a function of average job satisfaction for the sample, $\gamma_{00,}$ plus individual variation between mentor groups, μ_{0m}; and the association between frequency of mentoring and job satisfaction among mentees within each mentor group, $\beta_{1m,}$ as a function of the average magnitude of this relationship across all mentor groups.

Level 1:

$$Y_{im} = \beta_{0m} + \beta_{1m}(FREQ)_{im} + r_{im} \quad (1)$$

Level 2:

$$\beta_{0m} = \gamma_{00} + \mu_{0m} \quad (2)$$

$$\beta_{1m} = \gamma_{10} \quad (3)$$

The same model was tested for comprehensiveness of mentoring by replacing the covariate FREQ (frequency) with COMP (comprehensiveness) in eq. 1-3. It should be noted that

This study contains a modest sample size for using hierarchical linear modeling. Adequate statistical power may not be feasible. However, given the nested nature of these data, this remains the most appropriate analytic technique.

3.5.3 Study II Qualitative Analysis of Mentee Focus Groups

The mentee focus groups were recorded, transcribed, and analyzed. A second reader was used for code development and thematic analysis. Memo writing was used to help organize ideas about themes and to make meaning out of the stories of the mentors and mentees. The passage below is an example of a memo written about an early potential code called, "knowing the mentor's business." Mentees frequently talked about issues that the mentors were having regarding lack of changes in productivity requirements and their salaries. These parts of the mentees discussions were called, 'knowing the mentor's business". This code was ultimately refined through the analysis. The memo provides insight into this process.

> How do the mentees know so much about the mentors? Like how do they know that they did not get a pay increase? How do they know that their productivity did not change? Is it something that they talk about amongst themselves? Or is it something that the mentors talk to them about? It makes me wonder if the mentors are really not as empowered as they say that they feel, because an empowered person would address these things with people who have the power to change them—not share it with someone who has no control over it at all. I wonder if they are telling them so that they can explain why they can't spend as

> much time mentoring as they would like or think they should. I have always thought that case managers have jobs that make boundaries difficult—so maybe this is another example of too much information? If they want to be seen as more professional, then this is a behavior to consider and anyway sends a mixed message to the new case manager—that your new agency doesn't give people what it tells them it will—that mentoring is not as important as we would like you to think—

This example of memo writing reflects a realization that these were common themes shared across agencies and mentors and explores how to conceptualize the data.

4.0 RESULTS

This was a two part study. Study I included semi-structured interviews with the mentors. It explored the experiences of the mentors from the classroom to the field during the initial implementation process. Study II contained qualitative data from the mentee focus groups as well quantitative data about job satisfaction and frequency and types of mentoring activities. Results regarding job satisfaction and frequency of mentoring data from Study II are presented first, followed by the results from Study I on the qualitative interviews with the mentors. Lastly the focus groups' themes are presented in the final section.

4.1 STUDY II-QUANTITATIVE RESULTS

The total number of mentees employed at the time of the study was 37. Of that group, two people were on vacation or extended leave and unavailable for interview. There were 35 remaining mentees who were eligible to participate and thirty participated in the data collection. No information was obtained from the mentees who did not participate. Mentees were asked to complete the surveys at the beginning of the study, prior to conducting the focus groups. All quantitative data were completed and there were no missing data. Data were coded and entered into SPSS for statistical analysis.

4.1.1 Sample Characteristics

Demographic characteristics of the case management mentees, including age and amount of case management experience prior to beginning employment in their present positions, are presented in Table 1. From the total sample of mentees, there were 12 males and 18 females (Table 1). As shown in Table 1, one mentee had a high school diploma, twenty-one mentees had bachelor's degrees, and eight mentees had master's degrees.

Table 1. Mentee Mean, Standard Deviation, Minimum and Maximum and Percent of Total Sample Scores

Variable	Mean	SD	Min.	Max.	N (N=30)	% Total Sample
Age	30.53	8.86	23	58		
Months of experience in case management prior to hire	9.53	22.34	0	84		
Gender (female)					18	60%
Education (High school)					1	3%
Education (BS/BA)					21	70%
Education (Masters)					8	27%

This was a fairly young sample, and the majority had no prior work experience as a case manager (Table 2). There was one mentee who reported that he had eight years of case management experience prior to accepting his current position.

Table 2. Mentee MH Experience Prior to Position

Variable	N (N=30)	% Total Sample
No prior experience	21	70%
Less than 1 year	3	10%
1 to 2 years	2	7%
More than 2 years	4	13%

The case management mentees represented 6 of the 8 Base Service Units (BSUs) in Allegheny County that provide case management services including: Family Services of Western Pennsylvania, Mon Yough Community Services, Turtle Creek Valley MH/MR, Western Psychiatric Institute and Clinic, Chartiers MH/MR, and Mercy Behavioral Health. Two agencies were not represented in the sample. One agency did not have any mentees and another agency did not participate in the focus groups or complete the survey. Although six agencies were represented, 17 mentees (56.7%) of the mentee respondents came from one agency and 6 mentees (20%) from another. Approximately 77% of the sample came from 2 of the 6 participating agencies. This can be attributed to the fact that one agency employs 88 case managers (Table 3). Larger agencies provide services to a larger catchment area and serve more clients and consequently employ and hire more case managers. There were three mentors who had 4 to 6 mentees participate in the focus groups, but the majority had 1 or 2 per mentor. Most agencies had 1or 2 mentees. The 30 mentees who participated had worked with 14 of the 17 certified mentors who were in the workforce at the time of the study.

Table 3. Number of Adult MH Case Managers in Allegheny County by Agency

Agency	Total # of Adult MH Case Managers
Staunton Clinic	8
Milestones, Inc.	9
Chartiers MH/MR	15
Family Services of Western Pennsylvania	18
Turtle Creek MH/MR	20
Mon Yough Community Services	32
Mercy Behavioral Health	64
Western Psychiatric Institute and Clinic	88

4.1.2 Frequency of Mentoring

Mentees were asked how often they met with their mentors to determine how frequently mentoring was occurring. Response choices included "none", "monthly", "weekly", "daily", or "as needed". As shown in Table 4, there was one mentee who was newly hired and had not had regularly scheduled individual meetings with the mentor yet and responded with "none". This individual reported having spoken with the mentor and having received a copy of the gray manual. There were 19 mentees (63.3%) that reported meeting weekly with their mentors, and 9 (30%) said that they met on a daily basis**.** There was one mentee who responded that he met with his mentor "as needed". While illustrated in Table 4, because of the numerical ambiguity, since it was unclear how often they met in the "as needed" category, this participant was dropped from further quantitative analysis. In total, the vast majority (93%) of mentees reported that they

met with their mentors on a weekly or daily basis (Table 4). The frequency of mentoring reported by the mentees indicates that mentoring was occurring on a regular basis in the agencies that were represented.

Table 4. Mentee Frequency of Meeting with Mentors

Variable	N (N=30)	% Total Sample
None	1	3.3 %
Monthly	0	0.00%
Daily	9	30 %
Weekly	19	63.3 %
As needed	1	3.3%

4.1.3 Core Elements of Mentoring

In the Case Management Mentoring Program, mentors were encouraged to incorporate various activities into mentoring practice. These are referred to as the "core elements of mentoring" and include didactic training, which is achieved through the study of the Gray Manual, case reviews, crisis support, mentor shadowing, and observation in practice by the mentor. It was expected that these activities captured many of the activities that would be associated with mentoring.

When assessing the frequency with which mentees met with their mentors, mentees were also asked to report on whether or not they engaged in any of the core elements of mentoring with their mentors and whether they found these activities helpful.

The most frequently occurring mentoring activities that were reported by the mentees were shadowing the mentor in the field and reviewing cases with the mentor (Table 6). The least

frequent activity was being observed by the mentor in the field. Closely following that as the activity that was used with the least frequency was use of the Gray Manual. Interestingly, in the qualitative results, the mentors reported that they would have preferred to have more opportunities to spend time in the field observing the mentees and the mentees reported this was the activity that they wanted to engage in with more frequency.

The mentees shadowed the mentors more frequently (96.7%) than the mentors observed the mentees in the field (73.3%). This corresponds with qualitative data that will be discussed in another section that indicates that mentees reported that they would have liked more opportunities to have the mentors observe them in practice.

It was anticipated that mentoring would include all core elements of mentoring in varying degrees and analyses were conducted to determine how many of the mentees engaged in all five of the elements of mentoring, (i.e., review of the gray manual, being observed by their mentors, shadowing their mentors, and meeting to review cases). This new variable, "comprehensiveness of mentoring", was created by combining the mentoring frequencies of all of the core elements of mentoring (Table 5).

Table 5. Total Mentoring Activities

Mentoring Activities	N	% Total Sample (N=30)
One	1	3.3%
Two	1	3.3%
Three	3	10.0%
Four	10	30.0%
Five	15	50.0 %
Total		100%

As illustrated in Table 6, only 15 (50%) mentees were participating in all 5 of the activities that were considered core elements of mentoring in their work with their mentors. It should be noted, however, that 80% of the mentees engaged in at least 4 of the 5 mentoring activities with their mentors.

Table 6. Mentee Percentages of Engagement in Mentoring Activities

Variable	N (N=30)	% Total Sample
Used gray manual	23	76.7%
Observed by mentor	22	73.3%
Shadowed mentor	29	96.7%
Contacted mentor in a crisis	25	83.3%
Reviewed cases with mentor	29	96.7%

4.1.4 Perceived Helpfulness of Mentoring

Mentees were asked to rate the perceived helpfulness of each of the core elements of mentoring they engaged in with their mentors from 1 ("not at all helpful") to 5 ("extremely helpful"). The majority of the mentoring activities were rated as "very helpful" or "extremely helpful" by the mentees (Table 6).

Of all the activities, the Gray Manual was the activity with the lowest helpfulness rating, suggesting that it was not perceived as helpful as some of the other mentoring activities. Those activities, including "shadowing the mentor", "being observed by the mentor", "having case conferences", and "using the mentor for crisis support", were all rated, on average, as "very helpful" or "extremely helpful".

The activity that the mentees reported was most helpful was being observed by the mentor. This was also the activity that they reported occurred with the lowest frequency. Of the five perceived helpfulness variables, the following had unacceptable levels of skewness, "helpfulness of observing mentor" and "helpfulness of crisis support". Since these were negatively skewed, square transformations were applied. Despite the transformation, the variables remained somewhat skewed (Table 7).

Table 7. Mean, Standard Deviation, Minimum and Maximum and Skewness for Ratings of Helpfulness of Mentoring Tasks

Variable	N	Mean	S.D.	Min.	Max.	Pre Skewness	Post Skewness
Helpfulness of gray manual	23	3.87	.968	2	5	-.378	
Helpfulness of being observed by mentor	22	4.69	.510	4	5	-.196	
Helpfulness of shadowing mentor	29	4.56	.660	2	5	-2.768	-2.132
Helpfulness of crisis support	25	4.56	.712	2	5	-2.120	-1.450
Helpfulness of case review	29	4.52	.574	3	5	-.678	

4.1.5 Associations Between Frequency and Core Elements of Mentoring Activities

When frequency of mentoring was correlated with the core elements of mentoring there were no significant associations between the frequency of mentoring and of the core elements of mentoring (Table 8). Shadowing the mentor, however, was significantly correlated with being observed by the mentor, and review of cases was significantly correlated with using the gray manual, shadowing the mentor, being observed by the mentor, or getting support from the mentor in a crisis.

Table 8. Correlation of Frequencies of Mentoring Measure

Variables	1	2	3	4	5	6	7
1. Frequency of mentoring	-						
2. Use of gray manual	-.291	-					
3. Observation by mentor	-.187	.311	-				
4. Shadowing of mentor	-.153	.291	.594**	-			
5. Crisis support from mentor	.354	.294	.304	.319	-		
6. Case reviews with mentor	.025	.505*	.450*	.726**	.637**	-	

Note: * $p \leq .05$; ** $p \leq .01$

There were a few notable trends. The use of the gray manual was associated with decreased frequency of mentoring. In contrast, case reviews with the mentor were related to each of the core elements of mentoring. The more that the mentees engage in case reviews with the mentor, the more likely they are to do the other core elements of mentoring. There is a strong association between the likelihood of shadowing the mentor and being observed in the field by

the mentor. Overall, these results suggest that case reviews are incorporated into many aspects of mentoring, which is consistent with the reports of the mentees that case reviews are one of the most frequently occurring activities.

4.1.6 Job Satisfaction Results

When examining job satisfaction among the case manager mentees, the Job Satisfaction Scale (JSS) demonstrated excellent reliability with a Cronbach's alpha of .892. The JSS has nine subscales including pay, promotion, supervision, benefits, rewards, operations, co-workers, job tasks, and communication. Mean scores ranging from 4 to 12 represent job dissatisfaction, 12 to 16 are ambivalent and 12 to 24 representing satisfaction. The mentees reported being most satisfied with their supervisors and their coworkers and least satisfied with their pay (see Table 9).

Table 9. Mean, Standard Deviation, Minimum and Maximum, Skewness of Job Satisfaction Subscales and Total Score

Item	Mean	SD	Min.	Max.	Pre Skewness	Post Skewness
Coworkers	19.66	3.89	12	24	-.45	
Supervision	18.96	6.00	4	24	-.85	-.52
Tasks	18.13	3.17	10	24	-.31	
Communication	15.36	5.20	4	23	-.56	
Benefits	14.90	3.87	4	21	-.79	
Rewards	14.53	4.45	4	22	-.51	
Promotion	13.16	3.68	4	19	-.75	
Operations	11.36	4.15	4	19	.03	
Pay	9.73	4.16	4	16	.14	
Total Job Satisfaction Subscale	135.83	23.50	68	170	-.81	-.33

This quantitative data mirrors the qualitative data that the mentees provided in the focus groups. Mentees reported that they especially liked the people that they worked with and many indicated that they had good relationships with their supervisors (see Section 4.3). Two variables, supervision and overall job satisfaction, were unacceptably negatively skewed and were transformed using the square transformation. Once transformed, both variables were within acceptable ranges.

4.1.7 Associations Between Mentoring Frequency, Comprehensiveness, and Job Satisfaction

Having described the job satisfaction and core elements of mentoring that had been used by mentees and their mentors, a series of analyses were conducted using mixed effect models to examine the association between the frequency of mentoring, mentoring comprehensiveness, and job satisfaction. Mixed-effect models, in part, were used due to the dependency of mentee ratings of job satisfaction and mentoring qualities among those who shared the same mentor. Overall there were few significant associations between the engagement in the core elements of mentoring and frequency and comprehensiveness of mentoring and job satisfaction (see Table 10). However, contact with mentors during a crisis situation was significantly associated with job satisfaction. In particular, case managers who had increased contact with the mentors during crisis situations tended to have increased overall job satisfaction.

Additionally, while not statistically significant, an interesting pattern of association emerged regarding time spent in the field with the mentor. While shadowing the mentors was modestly associated with increased job satisfaction, having a mentor observe the mentee in the field had nearly twice the size of association as shadowing the mentor. These are consistent with qualitative findings reported by the mentors and the mentees that they most preferred spending time in the field and wanted more opportunities for the mentors to observe the mentees in practice.

When examining the comprehensiveness of mentoring, quite surprisingly, a non-significant trend was found suggesting that those mentees who engaged in all the core elements of mentoring with their mentors tended to be slightly less satisfied with their jobs.

This was a counterintuitive finding, especially given the possible association between crisis contact with the mentor and overall job satisfaction (Table 10).

Table 10. Associations Between Mentoring Frequency, Comprehensiveness, and Job Satisfaction

Variable	B	S.E.	*t*	*p*
Gray manual	4.76	5.29	.90	.383
Observation by mentor	10.39	9.61	1.08	.298
Shadowing mentor	.06	.15	.40	.491
Crisis contact with mentor	.28	.13	2.20	.045
Case review	1.64	8.05	.20	.841
Comprehensiveness	-1.00	.53	-1.95	.065
Frequency	- 1.32	6.29	-.209	.837

[a] Mentoring variables were entered separately in mixed effects modes.

As such, an exploratory analysis was conducted of the association between comprehensiveness of mentoring activities and individual job satisfaction subscales to investigate if comprehensiveness of mentoring activities was associated with particular components of job satisfaction.

It was observed that comprehensiveness of mentoring activities was not associated with many core components of job satisfaction, such as co-workers, supervisors, and job tasks. Rather, comprehensiveness of mentoring was only significantly associated with satisfaction with benefits (B = -.20, p =.032). In addition, satisfaction with pay showed the same trend (B= -.15, p = .150), such that individuals who completed more mentoring activities, tended to be less satisfied with pay and benefits.

4.2 STUDY I RESULTS

4.2.1 Thematic Analysis of Mentor Interviews

Upon completion of the case management mentor certificate course, semi-structured interviews were completed in April 2009 with 18 mentors who completed the course. There were a total of 19 mentors in the original class and one person withdrew due to illness. Mentors were asked about how they perceived the program, what was helpful and not helpful in the course, what changes had occurred for them in their jobs as a result of participating in the mentor certificate program, how the implementation was occurring in their agencies, what the impact was on clients, and if they thought mentoring was helpful for new case managers. These interviews were typed by each of the interviewers. Some of the interviews were extremely detailed and included quotes and comprehensive documentation. Other interviews were less detailed and did not include direct quotes. These interview notes were read and re-read and reviewed to identify themes that were identified in the second set of interviews.

The second set of semi-structured interviews was completed in November 2009. 16 mentors participated in this set of interviews. The same semi-structured interviews that were used in April were administered again with minimal modifications to adapt for the passage of time. For example, some questions were phrased in the past tense, so that mentors were also able to share their experiences with implementation after the course ended and were able to speak to any issues that were unresolved since the first interview. These interviews were taped and transcribed for qualitative analysis.

All of the Service Coordination Units (SCUs) were represented in the first set of interviews, and six of them in the second set. Each mentor had different numbers of current active mentees in both sets of interviews, ranging from one to six people.

Transcripts of the mentor interviews were read and re-read by this researcher prior to initial coding process. First, they were reviewed in the process of open coding. Open coding involves the researcher giving preliminary labels to the data that will later be grouped and categorized. In this initial process of open coding, codes were identified about collaboration, learning processes, issues about time management and feelings of being overwhelmed, supervisory and administrative challenges, lack of consistency and unmet expectations, morale issues, and transition issues with clients.

Once the open coding process was completed, the transcripts were checked for "focused codes". In focused coding, codes are identified that are more conceptual than the earlier open codes and explain larger segments of the data (Charmaz, 2006). A second reader also coded the transcripts and collaboratively, common themes were identified.

4.2.1.1 Auditing and Co-Raters

Ongoing check-in about the analysis with faculty and graduate students who have advanced training in research provided an opportunity to examine the coding process and to gain clarity about emerging themes. These discussions also helped in the consideration of the data in different ways and to challenge personal assumptions in the analytic process.

To audit, transcripts, memos, and notes were kept so that there would be a paper trail that could be checked and rechecked as needed.

4.2.2 Mentor Interview Themes

Three main themes emerged from the analysis of both sets of the mentor interviews (Table 10). The first theme was called *Perceptions of Mentoring*. This theme emerged from the descriptions by the mentors of the need for mentoring in case management, ways that mentoring had occurred in the past, and how the Case Management Mentor Certificate Program transformed their roles in the workplace. The first subtheme, *Mentoring is Needed*, evolved from the reports by the mentors that they believed mentoring was essential in case management. During the conversations about the need for mentoring, mentors shared their perceptions of why they believed mentoring was necessary and this subtheme was titled *Why Mentoring is Needed*. The third subtheme was called *Formalizing the Informal* and referred to the way that mentors described informal mentoring within agencies. The final subtheme was called *Empowering New Roles*. This described the way that mentors visualized themselves and their roles differently after becoming mentors.

The second theme was called *Real World Mentoring: From Classroom to Practice*. This theme explained how mentors transferred what they learned in the mentor certificate class into practice. There were two subthemes in this category. The first, *Roll-Out Techniques*, examined that process of pre-implementation and includes how mentors were selected for participation and the need for immediate changes in job descriptions and productivity requirements when a person became a mentor. The second subtheme, *Implementation*, explored the barriers and facilitators to implementation. It had five components including mentor involvement in hiring, mentor assignments, use of core elements in mentoring, issues about space for mentoring, and supervisory and organizational support.

The third theme was titled *Course Evaluation*. Mentors shared their experiences in the course including feedback about its content, the instructor, and the opportunity to interact with peers from other organizations.

Table 11. Mentor Interview Themes and Subthemes

Theme	Subtheme
Perceptions of Mentoring	• Mentoring is needed • Why mentoring is needed • Formalizing the informal • Empowering new roles
Real World Mentoring: From Classroom to Practice	• Roll-out techniques o Mentor Selection o Expectations and Duties o Productivity and Job Descriptions • Implementation o Mentor assignments o Involvement in hiring process o Mentor use of core elements o Space o Supervisor and agency support
Course Evaluation	

4.2.3 Theme I: Perceptions of Mentoring

4.2.3.1 Mentoring is Needed

In both sets of interviews with the mentors, there were repeated articulations of the perception by mentors that mentoring was absolutely necessary in case management. One mentor compared the need for a mentor to the way in which people are mentored in other professions, such as education.

> "The mentor role is absolutely needed. You go into dangerous situations or into an agency you've never worked before. There are student teachers, so why not case management mentors. If you work with the public, you work with other people. It's not like working with a computer" (0101).

This quote speaks to the perception of the case manager of the enormous variety of the hands-on work they are expected to perform, and the importance of direct experience to master it. The mentor recognized that new case managers have direct contact with seriously ill people and their families and often enter their work in case management with limited knowledge about the illnesses, treatments, and available services.

4.2.3.2 Why Mentoring is Needed

Mentors from all of the agencies described their initial experiences of being newly hired into case management positions. They seemed to draw on their own personal experience as a specific point of reference for why the program is critically needed and ways that the mentoring program can help newly hired staff members. As the mentors talked about their experiences, they used descriptors like feeling "thrown in", "overwhelmed", and "lingering around" to seek out help

from whoever was available to answer questions. The following passages are examples of some of the mentors' personal descriptions of being a new case manager.

> "If I would have been designated a mentor instead of running from team to team- Can I go with you? Can I go with you? Can I go with you? I believe I would have learned better. I learned but I hit a couple bumps and bruises and a couple of slaps on the wrist and so on, but I learned" (1201).

> "I started five years ago, and I had literally nobody, I was kind of thrown into it and followed people around for awhile and all of the sudden I had my cases…they didn't seem like they had the time to bother with somebody new, they were so wrapped up in their own work, I think it was needed and I'm glad somebody finally thought about it and developed it" (0302).

> "When I started I felt like a burden. Then I had my first case and it's just kind of flying by the seat of your pants. I didn't know what I was doing and thought I would get in trouble for not knowing, and I didn't want to ask anybody" (0601).

> "When I started, I can remember losing three people in the first four weeks that they worked here because they were overwhelmed and weren't prepared. Now that same person would at least understand that the company understands that they don't know yet and that they need time to learn, whereas this guy quit because he was in a situation he couldn't handle" (0801).

In each of these examples, the mentors portrayed themselves and others as being unprepared, overwhelmed, and alone. Drawing on these experiences, they demonstrated an acute awareness and genuine understanding of the experience of being newly hired and the feelings of fear and anxiety that a person has when he is assigned too much work before being adequately prepared. The mentors used these memories to guide them in their roles and to explain why they believed that mentoring was a crucial service.

They indicated that being a mentor allowed them to give to others something that they had needed, but had not received. They identified their roles as mentors as part of the correction of what they perceived as an ongoing and long-standing problem, which was the lack of needed mentoring when they initially began to work.

This theme explains how the lived experience of being a case manager is an essential component of how mentors develop an awareness of the importance of mentoring. They draw on their experiences as a frame of reference for how to engage the newly hired case manager, to make the person feel welcome, and be able to get settled in the agency and in a new position, and to provide meaningful opportunities for learning.

4.2.3.3 Formalizing the Informal

While each agency has some type of formal process for orienting case managers, there is wide variation in how this is manifested. Mentors from all of the agencies described ways that new employees are oriented or informally mentored in their agencies. “It was just an assumed way that people who do the job will train the next people to come…that’s just the way it’s always been” (1302). This subtheme is called “formalizing the informal”, because the word “informal” was emerging as the descriptor for how people learned their jobs as new case managers prior to the implementation of mentoring and “formalizing” was the word used to describe the current

implementation. One mentor said, “This is how case managers learn their jobs, as they do it, watching others, asking questions, of co- workers, supervisors, and consumers” (0501).

Case management is a direct practice occupation that requires a transfer of classroom knowledge and training into the field. Once in the field, case managers learn by “doing”, so that the ideal way to learn about people, communities, services, and entitlements is to acquire basic knowledge and then to go into the field to observe, interact, and apply the knowledge and skills that have been learned and practiced. In almost all of the programs, there was some type of informal mechanism in place to achieve this goal. One mentor said, “We always kind of mentored people… it was just more hit or miss” (0702). Most mentors explained that when they were hired they would rotate among available team members, or try to find someone who was not too busy to work with them, or learn as they did things.

The Case Management Mentor Certificate Program has the potential to provide a formalized process to help new case managers to learn and understand their jobs and the expectations of their agencies. As the mentoring certificate program was initially conceptualized for implementation, specific standards were developed. These included the mentor being involved in the hiring process, linking mentors with newly hired staff on the first day of employment, having progressive caseload growth for the newly hired staff members, having a checklist for the mentor to assure that learning tasks were accomplished, use of the Gray Manual to teach, and having structured planned time to meet with the mentees in addition to being able to shadow and be observed by the mentor. Additionally, there were standards around the mentor’s workload, job description, and the role of the supervisor.

With this formalized process, ideally, agencies may to continue with the “informal” processes, but also could shift to the implementation of a more structured model. This would

allow for consistency in training across all of the Service Coordination Units (SCUs). It would also make the training opportunity available for people immediately upon hire, so that they would not have to wait for scheduled training, but would immediately get started with their assigned mentor. The mentee would be assigned to their mentor on the first day of employment, so that from the very beginning there would be a contact person that they could count on to work with them. There would be an incremental and planned process for building a caseload, while simultaneously learning, observing, and practicing skills. Similarly, the mentor would have accommodations in place to support mentoring through supervisor and agency support. Each mentor represented an effort to provide a different way of orienting and training new employees than what had previously existed in each respective agency

4.2.3.4 Empowering New Roles

Each agency identified which case managers it would select to become mentors in a different manner. Despite the diversity in the selection process, mentors were all chosen because they were recognized as being role models and having the skills to mentor effectively. Universally, the mentors reported favorably about the course. They enjoyed being at the university, liked the instructor, and were happy that they had the course. The mentors spoke very positively about their experiences. They were enthusiastic about how they saw their role as different and how they filled a unique and important role in the agencies. In this passage one of the mentors shares about how he is recognized as "different" by his peers.

> "Now more staff comes to me with questions. In the past, they would go to supervisors. They ask me job related questions…my co-staff look at me differently now. It's good and

> bad. There was a twinge of resentment from some of them at first because of my raise and promotion" (0501).

One mentor talked about having a very challenging experience connecting with the mentee who was assigned and initially. He said that he had difficulty mentoring her and had concerns about her abilities. At the six month interview, this mentor gave a very different report. He shared the ways that they were able to work together and establish an effective mentoring relationship and the rewards that both he and the mentor experienced.

> "The one mentee I had, we had some issues, in the beginning she will speak up now about how the experience was and how much it helped her and how much she learned from it. She actually stood up and gave a speech to the whole service about how great of a job I did…I think I helped her profoundly" (0402).

In the mentor role, the case managers had a chance to do something different at work. Instead of their entire workload being in direct practice, they now saw themselves as teachers, role models, and professionals.

> "There is more of a guideline…instead of that perception that a mentor just teaches how you do the paperwork part of the job... that such a small part of what we do, we teach engagement, we teach crisis intervention, we teach community orientation, we teach community resources, we teach the correct way-- of learning as you go…" (1402).

As teachers, mentors explained that in the course they learned about adult learning and the mentoring relationship in the course, so that they were able to use these skills in their new roles.

> "A lot of it is perhaps planting seeds, you know. I guess like any type of teaching, you may not see the fruits of your labor immediately, but I have full confidence in my words and my time. And my efforts are not being wasted" (0902).

There were several stories of mentors who worked with people who were struggling in their new positions and were able to use the mentoring process to effect change.

> "We even used the mentoring program on one individual who had been with us for six months but was having ongoing problems and was close to quitting or getting fired...I went through the course with him and it really, really, helped him. I have subsequently talked to his supervisors and he is doing really, really well" (0902).

The mentor explained that the mentoring relationship made a clear difference and helped to enable a person to stay in his job as a case manager.

The changed self-perception helped the mentors to approach their role in a different way. In the following passages, mentors share how being a mentor has transformed how they view themselves in a different light since they received the training.

> "It's a duty that I take really seriously, I do a lot of preparation and I meet regularly for session, it's not just a question passing in the hall" (1102).

> "You know I go about my job differently now. I'm more setting an example and in the way I present myself to them, you know, and then I see they get the sense that they're just not out with one of their coworkers screwing around, you know, take it a little more seriously" (0801).

> "What is going to make people stay in case management is getting people to see us as the professionals, getting people to see us as the go to person, and the biggest thing is money…? (0702).

4.2.4 Real World Mentoring: From Classroom to Practice

4.2.4.1 Roll-Out

In both sets of mentor interviews, the mentors were asked to discuss how mentoring was implemented. They discussed how they and their respective agencies operationalized the mentoring program and explained "how it works". They shared ways that the concept of mentoring was introduced to newly hired staff, ways that they utilized the core elements of mentoring, and components that were beneficial to the process, such as having a space to meet with the mentees.

From the interviews with the mentors, it appears that there was wide variation in how mentoring was operationalized in each agency. The mentoring program provided the availability of mentors in each agency and offered a more formal method for training and orienting new case managers, but practices were widely variable.

4.2.4.1.1 Selection of Mentors

Selection of the mentors is an important early implementation step. One mentor said, "We do this anyway, but to be certified, trained and compensated—that's going to be beautiful. I was thrilled to hear we are going to do it and thrilled to be picked" (0601). She felt that she was given a special opportunity, would have changes in her job description, and would able to use a different skill set than her peers in the workplace. The mentor indicated that she was identified because she was recognized as a leader and a role model. This is was consistent with the way that the mentor program was envisioned. Agencies would identify people who were natural leaders and had potential to be dynamic role models for new staff members.

There was one agency that required people who were interested in becoming mentors to interview for the position. Interviews are useful because the employee can learn what will be expected from mentors. Additionally, it creates a sense of formality from the beginning of the process.

4.2.4.1.2 Expectations about Training and Duties

Many mentors felt that they were not adequately prepared for the expectations of mentoring. Several mentors said that they were not made fully aware of the course and its requirements. In this passage a mentor shares her stress about the requirements of the course.

> "I love the classes, I love Shaun, it's just putting this into practice in my job is almost impossible. I'm working 60 hours a week making $28,000 a year with no overtime. I hate to say this,

> but I was told it's a training, it's not a training, it's a class and it has assignments" (0701).

There were at least five mentors that said that they thought that they were attending a one day training at a local university, only to arrive and discover that they were enrolled in a fifteen week course. While they all had a favorable responses to the classroom experience and universally reported that the instructor was excellent, many felt that they were misled about the amount of time and effort that the class would entail."That was a very horrible time. We were told it was a one day training and we had no clue what we were getting into" (1002).

4.2.4.2 Implementation

4.2.4.2.1 Mentor Assignment

In the conceptualization of the program, it was expected that newly hired staff would be assigned to a mentor immediately. In most agencies, mentees were assigned to a mentor on their first day of employment. The mentors indicated that this was important because it helped to welcome the new staff member and to immediately begin the process. One case manager explained how he initiates the relationship with a new mentee.

> "I meet with the new employee right away and give that person a base. You know someone to count on and not feel alone right at the beginning—they have somebody to answer questions without feeling weird "(0102).

In contrast, one mentor said that he was not always informed of when a new person was starting and had difficulty keeping up with mentors. He was concerned that there were people being hired who were not connected to a mentor.

There was one agency where the mentors reported that they made a decision to "share" mentees, so that each mentee worked with both of them and they thought that this was beneficial because it provided increased mentor accessibility to the mentees.

4.2.4.2.2 Mentor Involvement in Hiring Process

Including the mentor in the hiring process of case managers was not specified as part of the duties of the mentor. However, in two of the agencies, mentors participated in the hiring process of new case managers. The mentors either sat in during interviews or actually did an interview with the prospective candidate. While this was not a practice in the other agencies, there were mentors who indicated that they would find it helpful if their agencies would adopt this practice. They felt that this would help to introduce the concept of mentoring even before a person was officially hired and to allow the mentors to anticipate what the learning needs might be of the newly hired staff member.

4.2.4.2.3 Mentor Use of Core Elements

As stated earlier, the core elements of mentoring include didactic training, which incorporates teaching from the gray manual case reviews, observation by the mentors, shadowing the mentors, and crisis support from the mentor. Mentors were asked in both sets of interviews to describe how they used the core elements of mentoring in their work.

One mentor shared how he had regularly scheduled individual weekly meetings with the mentees and described spending a great deal of preparation time. After reviewing the assigned

reading from the gray manual, sometimes he would have the mentees complete a quiz. This mentor also wrote a progress note after the meeting with the mentee about the content, progress, and plan. Here is his description:

> "We have a specific curriculum, or protocol about how the mentoring training is applied…I am finding out that it's kind of necessary to do a little testing, they weren't retaining the information that I kind of wanted them to know…the general categories and understand what the symptoms are, risk factors…" (0902).

One of the mentors said that she wanted to do a group with her mentees, but was unable to allocate the time in her schedule to continue to do this on an ongoing basis.

> "I meet with them once a week and was trying to do a group with mentees on Mondays but that dropped off because I need to meet with all my folks and get my notes done and I can't really have another meeting that lasts an hour out as opposed to talking in the car on the way to appointment" (8020).

The mentees reported that one of the things that was most helpful, but occurred with less frequency was being observed by the mentor when they were in the field. Instead, it was more commonly reported that the mentee accompanied the mentor on visits and shadowed the mentor in practice. One mentor shared about a visit when she took three mentees with her at one time to see a client, "I have taken three. And my patients have been pretty good about that. I was always saying the clown car is coming" (1302).

Consistent with the quantitative results from the mentees, the mentors reported using a wide array of the identified core elements of mentoring. They used them in different combinations, depending on the needs of the mentees and their ability to include them.

4.2.4.2.4 Space

Mentors talked about importance of having a quiet space where they could meet with their mentees. In two of the agencies, the mentors were given a private office so that they could work individually and privately with the mentees. Another one of the mentors indicated that this is something that his agency did not do, but that he felt was very important because it is very hard to work individually with the mentees in a crowded shared space. Most agencies have large open areas, where case managers share computers, desk space, and resources when they are in the building. The mentor felt that by having an office, it would send a message that the mentor was different and more important role in the agency. At another agency, the mentors shared an office, so while they did not have their own private space, they were separated from the large shared area, which is called a "bullpen". The need for space was identified as an important piece of mentoring implementation.

4.2.4.2.5 Supervisory and Agency Support

Supervisory support and agency support were important factors in the implementation of mentoring. One mentor talked about this, saying, "I have support from the supervisor. But I have to say that the agency hasn't really acknowledged that this is even going on yet" (0801). Even at the six month interviews, mentors talked about issues involving inconsistent support at various levels.

There was variability about the amount and type of support that mentors reported receiving from their supervisors. As would be expected in any work situation, supervisory styles are distinct and in some cases there were challenges in the relationship between the mentor and supervisor that had nothing to do with mentoring. Despite that, with regard to the mentoring program, some mentors had supervisors who were extremely well versed in the program, expectations, and the responsibilities of all involved. In other cases, the mentors reported having supervisors who were not fully aware.

When a mentor had a supportive supervisor, it was described as a person who regularly checked in with them and went over the work that they were doing as mentors in supervision. These supervisors provided support for the mentors by making sure that their caseloads were decreased, that they had time and space for mentoring activities, that they had available resources and that the program was implemented. By doing these things, the supervisor demonstrated a commitment to the success of the implementation process. One mentor shared an example of his supervisor providing coverage so that he could take his mentee to tour a program.

> "If I say, I need to do this... I want to take my mentee to this rehab and introduce her and explain it he's like absolutely, go ahead, do it man! I'll have somebody, you know, pick up the slack, Don't worry about productivity, You know this is important, you got to do this, go ahead, you know, whatever I need...He is very supportive" (0801).

In contrast, there were mentors who reported having very poor experiences with their supervisors. "The supervisors need to be on the same page of what is being told to the mentors and what's expected of us and the agency needs to know that" (1301).

In cases where the supervisor was supportive, the mentors were better able to give time and attention to mentoring. In cases where this did not occur, mentoring was often explained as something that was extra, a burden, or hard to keep up with.

As with the supervisors, each agency varied in how it demonstrated its support of the program to the mentors and staff. In agencies where productivity expectations did not change or pay increases did not occur, the mentors perceived this a lack of organizational "buy in". "I assume the county said listen there are pretty clear guidelines that those should be…we shouldn't have our own rules... there should be rules in place" (1202). Mentors spoke to the importance of having agency support, regardless of whether or not they had it from their agency. "It is critical that the agency stay abreast of the mentor's role and how the mentor would need support" (1002).

One of the aspects of coming to class each week was that the mentors discussed amongst themselves what steps each agency had undertaken towards implementation. This created awareness among the mentors that some agencies offered different incentive programs, productivity requirements, salaries, and supervisory and organizational support. In the next passage, a mentor discusses the encouragement and support that she received from the CEO of her agency.

> "My agency's CEO believes in this program. You can't talk it unless you're willing to do it. You need enthusiasm, but you also need incentive to go forward. I get supportive emails from the director and CEO. They acknowledge that you're trying to do what you're doing. They tried to give me flexibility…I can talk to them

anytime… If they hadn't been supportive, I don't know if I could have done it" (0501).

One case manager talked about how he felt that the financial implications of mentoring are too much for agencies to bear. He said that he thought that while they probably wanted to have the mentoring program, they would not be able to justify the ongoing lowered productivity for the mentors, and the cost associated with limiting a new case manager's productivity. "The last time I looked each service coordinator brings in $850,000 a year, so to forgo that after three months, it'll be hard pressed" (1001).

Mentors talked about frustration with trying to implement mentoring without the full support of the agency. One mentor was told by the agency to write up a proposal to help them to understand his role. He felt that this was not within his scope, since the program was initiated at the county level. "What would help me is a clear frickin outline of what my expectations are" (0402). These examples of frustration continued across both sets of interviews. In the next passage a case manager talks about feeling that he is being "played" by his agency, "The administration hasn't said anything, so it's the type of thing were, you just kinda, it's like playing poker, you just play your cards, let them, call their bluff, or you know, they can call mine" (0801).

One of the mentors indicated that the agency never really clarified how his role would be included in the agency. These structural discrepancies were of concern in both sets of interviews. "My supervisors and the rest of the agency just did not understand what we were doing and we did not get much support from the agency" (1102).

4.2.5 Course Evaluation

Mentors talked about having a very favorable experience by participating in a class with other case managers from other agencies and some of their other co-workers. They described it as a chance to get to know people in a different way and one said, "I actually made some good friends" (0902).

This type of collegiality is not common in case management, largely because people work in the field, and often do not have extended periods of time to get to know their coworkers. The course gave them time each week to dedicate to study and learning and to interface with other professionals and to develop familiarity with other mental health provider agencies.

> "Every agency has unique problems, strong points, and a lot of other stuff has some up. We do interact with a lot of other agencies, and it's been helpful, it's given me a better understanding of how some of the other agencies operate and when I have to interact with them, hopefully I can do it more effectively" (0901).

Several mentors reported wanting opportunities to meet again with the class and to maintain contact over time with the peers that they met in class.

They reported that the content of the course had been helpful and that they learned a lot about mentoring and teaching. The course taught the mentors skills to coach, teach, and model for adult learners and although these were skills that while they may have utilized as case managers, it was never in such a structured format. A mentor says, "One of the main things that this course has taught me is how to be a better teacher" (1001).

4.3 QUALITATIVE ANALYSIS OF MENTEE FOCUS GROUPS

Three focus groups were held to explore the perceptions of the mentees about the barriers and facilitators to the implementation of the case manager mentor certificate program and how the experience of being mentored impacted the way that they learned to understand and do their jobs. Mentees in the groups represented Mercy Behavioral Health, WPIC, Turtle Creek, Mon Yough, Chartiers, and Family Services of Western Pennsylvania. When contacting the mentors to get information about mentees, several mentors indicated that some of the people who they had mentored had already resigned and left their case management positions.

Thirty-five mentees were contacted to participate in the focus groups. While some people responded that they were not available due to vacations and maternity leave, and some did not respond at all, there were a thirty people who participated in the groups. In the focus groups, the mentees were encouraged to respond openly to the questions, and to clarify anything that they felt was not being understood.

4.3.1 Focus Group Themes

In the focus groups, mentees were asked to talk about how they had experienced the mentoring program. They shared their introduction to mentoring, experiences with their mentors, and perceptions of the barriers and facilitators to implementation. The themes that emerged in the focus groups mirrored those of the mentors, with varying degrees of convergence and divergence.

Table 12. Focus Group Themes and Subthemes

Theme	Subtheme
Perceptions of Mentoring	• Made it easier • Tells it like it is

Real World Mentoring: From Classroom to Practice	• Clarity of Expectations
	  o Supervisors vs. mentors
	  o Understanding role of supervisor
	  o Closure
	  o Premature case load
	• Promises not kept
	• Learning from consumers

Course Evaluation	• Field is great • Jury out on gray manual • Everyone helps

In the first theme, *Perceptions of Mentoring*, mentees indicated that they thought that mentoring was needed, but that they could have learned their jobs without being mentored. The subtheme is *Made it Easier*, because the mentees said that having a mentor made it easier to learn their jobs more quickly. The mentees explained that the mentor was someone who gave them the information they needed to get the job done without a lot of the extra unnecessary details and this subthemes was called "tells it like it is". In the second theme, *Real World Learning: From Classroom to Practice*, mentees described areas where roles and processes were

not entirely clear and the subtheme was called *Clarity of Expectations*. Within the subthemes, there are examples of areas where things were unclear. They include these categories: *Mentors versus Supervisors, Understanding the Role of Supervisors, Closure*, and *Premature Caseloads,* and *Promises Not Kept.* The last subcategory was called *Learning from Consumers* and it explains how the mentees reported learning from the consumers that they worked with in addition to being mentored. The final theme, *Course Evaluation*, explored how the mentees experienced the benefits of the course in practice. The mentees reported that that they found it especially helpful when the mentor was able to accompany them on field visits and reported that they would like more time with their mentors in the field. This subtheme is called *Field is Great*. When asked about the use of the gray manual, the mentees provided mixed responses and this subtheme is called *Jury Out on Gray Manual*. The last subtheme is *Everybody Helps*. This refers to the fact that while the trained mentors were important to the mentees, they repeatedly said that many people helped to train and teach them.

4.3.2 Perceptions of mentoring

The first theme that emerged was *Perceptions of Mentoring*. The mentees shared their experiences about how they were introduced to case management in their initial interview and when they were newly hired. Some of them indicated that mentoring was explained to them as part of that process, but most did not. Most reported that they were assigned a mentor when they were first starting their job, and the mentor was described as someone who would help them to orient, learn, and be available to answer questions and offer guidance. When asked to describe how they felt when they initially started working as case managers, they used word like “scary”, “overwhelming”, “intimidating”, “confusing”, and “extremely busy”. These adjectives mirrored

the ones that the mentors used when they talked about their memories of being new in their case management positions.

4.3.2.1 Made it Easier

For the most part, the mentees indicated that they had a positive experience with the mentoring process and found it helpful when they started their new jobs. They indicated that they would have learned their jobs, but having a mentor made it easier. In this passage, a mentee shares about how having a mentor was helpful to her.

> "I think it got to the point quicker. I think eventually, it's not rocket science I would definitely catch on and even you know, without a mentor you would figure the job out, it's not that hard. But because I think I had a mentor it was easier for me to learn the job and to learn like what need to be done or you know, just specifics" (FG03).

From the perspectives of the mentees, no one indicated that without the mentor, they would not have been able to learn or perform their jobs, or that it was the single most important relationship in the process of learning how to do their jobs. They described it as a helpful way to understand their jobs, and to provide information that they would need as they performed job tasks.

Some of them also explained that even with formal or informal mentoring, they would have been able to learn their jobs.

> "You really don't-- it's not like anybody teaching you how everything works as far as how it worked and what they need to

do. You just figure it out over time. Because you go to the social security office, you go to welfare, you go to whatever it might be, And you just figure it out., That improves greatly over time, your efficiency at getting them hooked up with stuff" (FG03).

4.3.2.2 Tell it Like it is

One of the mentees explained that the mentor was someone who "tells it like it is". The mentor was able to give useful tips, examples of ways to complete job tasks, and approaches that were not part of scheduled training.

> "My mentor she pretty much told me like it is—like word for word she you know let me know that this is the way I have to be organized, this is the way I do my notes when I am out, this is the kind of thing I write down, and this is how I do this on the side" (FG03).

Mentees in the focus groups shared these perceptions and reported that mentors told them what was really important and the most efficient way to get things done. They seemed to value to relationship with their mentors and frequently shared how the mentors had helped them, taught them, and gone "above and beyond" for them.

> "Just the support, being there, being available to answer questions. Like she never told me "Okay no I am too busy, I am in the middle of doing this service plan, or I can't talk to you right now" Anytime I needed her, I even called her when she was on maternity leave and she was still there for me" (FG01).

4.3.3 Real Learning: From Classroom to Practice

Similarly to the mentors, the mentees explained how they experienced the implementation of mentoring in practice. They described the benefits of a supportive supervisor with the implementation of mentoring and explained that when there is lack of clarity between the roles of the supervisors and the mentors, the implementation process can be hindered. Mentees explained that in some cases it was not clear when the mentoring relationship ended and some of them said that they would like a defined endpoint. Mentees described the challenges of having a caseload assigned prematurely, before they were adequately oriented or had a chance to thoroughly engage in the mentoring process. They also shared about the rich learning that occurred when they worked with consumers.

4.3.3.1 Clarity of Expectations

4.3.3.1.1 Supervisors vs. Mentors

The role of the supervisor made a difference in how mentees experienced mentoring and learned in their new positions. One person said that if they had a question that related to job performance or human resources, he would go to his supervisor, but if he had a question about a skill or a clinical issue, he would seek advice from the mentor. Mentees indicated that the optimal arrangement was when the supervisors clearly understood the program and allowed the mentors time and autonomy to fulfill their roles. One of the mentees explained that he felt improved collaboration between the supervisor and mentor would be beneficial. “I think better collaboration, or better understanding between supervisor and mentor and working together”

(FG01). There were also mentees, who reported a smooth process in their agencies, where the supervisors clearly supported the mentors and understood the program.

Mentees explained that when the supervisor would not allow the mentor to function autonomously that it added to the overall burden of work. “Part of that is you don’t want to get your mentor in trouble, if it’s something that she recommends, but then you have to ask your supervisor…” (FG01). It required extra work on the part of the mentee to ask the mentor a question, but then to have to double check with the supervisor.

4.3.3.1.2 Understanding the Role of the Supervisor

Mentees explained that they understood that the roles of the mentors were different from the roles of the supervisors, but that sometimes it was not clear if the supervisors understood this. In this passage, a mentee discussed how she felt that the supervisors only used the mentor when they needed additional coverage due to their workloads.

> “The supervisors use it as a crutch, As like kind of like if say they-they don’t feel like dealing with it or they need the extra help because they are overwhelmed as a supervisor then they utilize the mentor. But if that’s not the case then the mentor is just not really utilized or utilized in the wrong way” (FG01).

In some cases the mentors shared perceptions that the supervisors did not appropriately use the mentor or demonstrate a clear understanding of the role of the mentor. “Some people walk around lost and really stressed because their supervisor really didn’t talk to them that much.” (FG03).

4.3.3.1.3 Closure

Several mentees brought up the lack of a definitive end date for mentoring as one of the areas for change in the implementation process. Some of the mentees reported that mentoring stopped abruptly, and others felt that it went on with no clear end. In general, they indicated that it would be helpful to have a clearly defined start and end point, so that both the mentors and the mentees could have closure.

4.3.3.1.4 Premature Caseload

One of the similarities in the responses of both the mentors and the mentees was that both groups would have liked to have more time mentoring, but they had to absorb a caseload early in their tenure and did not have as much time as they would like to spend with the mentor. This is referred to as *Premature Caseload*. Several mentees explained that they were assigned caseloads very quickly due to short staffing elsewhere in the department for various reasons including vacancies, or staff being off on medical leave, vacations, or maternity leaves. "*I came in in the midst of two people leaving on my team, so I was kind of thrown in with twelve people, so it was like, wow…they could have given me a little more time" (FG01).* In the original design of the mentoring program, the mentees were expected to gradually increase their caseloads over the first few months of employment, but many of them reported being assigned a caseload early in their tenure, which was prohibitive because it limited available time for mentoring.

4.3.3.2 Promises Not Kept

While most of the mentees shared that the experience of having a mentor was beneficial, in every focus group, mentees spontaneously brought up what they perceived to be the struggles of the mentors and their sense that agencies had not lived up to their commitment to the

implementation of the program. Examples of this included discussion about the challenges the mentors face without adequate adjustment to their required productivity levels. The mentees would say that at times they know that the mentor had a heavy burden of work associated with their own caseloads, but still would make an effort to be of assistance as a mentor.

> "Our mentor wears a lot of hats" (FG01).

> "He explained that he was supposed to have less productivity and things, but it never happened he just got the mentor added" (FG02).

> "I think they were promised things that never ended up happening" (FG03).

> "It doesn't seem like they followed through being supportive because he was told that he was going to have less requirements as far as productively and he didn't" (FG01).

> "If you have a mentor that has a high caseload, they really don't have the time to sit and spend with you…because their productivity suffers…it was overwhelming for the mentor" (FG01).

In each of the groups, there was discussion of the mentor's salaries and some of the mentees indicated that the mentors were not being adequately compensated for the work that they were doing. "When I started mentors were in a tough situation because their productivity still had to be the same as everyone else and I hear they didn't get the raise or bonus. We felt bad asking them for help, because we knew they were just doing extra work (FG02).

In one group, the mentees had a side discussion where they debated among themselves about their shared mentor's pay increase. "I think they should get more for doing more work" (FG01).

The other area where mentees shared information about the mentors was around the issues of the mentor's supervision. Some of the mentees were very knowledgeable about challenges that their mentors were having with getting inadequate supervisory support, or conflicts between the supervisors and the mentor. There were a few mentees who indicated that the adversarial relationship between the supervisor and the mentor had compromised the role of the mentor because anytime the mentees would seek guidance from the mentor, the mentor would respond, but then also had to direct the mentee to review with the supervisor also.

> "Like we would go to our mentor, but then they would be afraid to tell us what to do because you never knew what the supervisor would do. So what is the role of the mentor? I mean if we're always running back to our supervisors then kind of the mentor is pointless" (FCO1).

The mentees indicated that this ended up being additional work, so that it was easier to bypass the mentor, and go straight to the supervisor. "I would go to the supervisor first, and it [the mentor] was just like a back up if none of them were there, then I would go to the mentor" (FG02).

One mentee described feeling as though mentoring was too much for the mentor. "You felt bad asking can you show me how to do something because they have their own stuff to do, and they were helpful about it, but they were just put in a tough situation I think, time-wise" (FG03).

4.3.3.3 Learning from Consumers

The mentees described having experiences when they would not know what to do, for example, how to apply for a service, or access a resource, or how to find a location, and the clients would be able to help them, direct them, or take them and show them. In each group, when a mentee shared an experience like this, there were others who added or shared their experiences. In this passage, a mentee speaks to this experience. "The consumers are pretty knowledgeable... they will tell you, or be like, on I need a voucher for this or that" (FG01). One mentee talked about having to help a client with her taxes and said, "I don't do my own taxes, and now I have to help someone else…" (FG01).

In addition to learning about resources and entitlements, the mentees talked about how they learned about mental illness from the consumers. "Sometimes the clients teach you more…they are the ones living with it every day, they know about it" (FG01). Again, these comments led to other group members sharing and talking about similar experiences.

These types of learning encounters cannot be adequately taught in the classroom or in a text, but were the experiences that often provided meaningful learning opportunities. These experiences and lesson were not forgotten, and remained clear in the minds of the practitioners. One of the mentees said, "There is a uniqueness to everyone that a book can't teach you" (FG01). When mentees shared these stories, they were animated, engaged, and seemed connected to how their jobs made a difference in the lives of the consumers.

4.3.4 Course Evaluation

4.3.4.1 Field is Great

Almost all of the mentees reported that they spent time shadowing their mentors or other staff members. They described spending time shadowing their mentors, observing, and asking questions while out in the community seeing consumers. A lesser number of mentees indicated that their mentors observed them on visits. This was reported to be helpful by many of the mentees and the majority said that they would have liked more time to do this. In all of the focus groups, mentees indicated that they had expected to have more time and opportunities to be observed in the field by their mentors.

4.3.4.2 Jury out on Gray Manual

There was a wide variability about how the Gray Manual was used in the mentoring process across the mentees and agencies. Some of the mentees described regularly having scheduled reading assignments, which were followed by a discussion of the content with their mentors. There were two mentees who reported that they had quizzes administered by their mentors on assigned readings from the gray manual. Others said that they read it at their leisure and would ask the mentor if they had any questions. Several mentees said that the sections that were of particular usefulness were the ones containing information about diagnoses, symptoms, and medications. In contrast, there were a few mentees who said that it was of limited usefulness and there were two mentees that said that they had never seen or heard of the Gray Manual.

Access to the Gray Manual seemed to be problematic at times, and while some of the mentees indicated that they had received their own copies, in many cases, the mentees reported that the entire agency was sharing one copy, or no one knew where the copy was kept.

From the focus groups, it seems that the gray manual was a resource that was used with wide variation and the level of perceived helpfulness varied as well. This may have been a function of access to the manual, the mentees previous experience and knowledge and commitment to reading and asking questions, or the mentors approach to the manual, if it was used as part of a scheduled weekly meeting or a "use if you want" approach.

4.3.4.3 Everyone Helps

Repeatedly, mentees articulated that they sought guidance and direction from a myriad of people in the workplace. Many discussed seeking help from other team members, and in one group, the mentees talked about the secretarial staff being a source of help. Although the mentor was a preferred "go to" person, they indicated that if the mentor was not available, there were a number of people who were accessible who they could approach for direction. Mentees shared anecdotes about seeking and receiving help and guidance from other team members. "It was basically whoever was around that could help me at the time. Like if you're in the bullpen and the mentor's not there, if someone else is there, you will ask them (FG01).

Despite the fact that mentors were formally trained and assigned, people continued to use the informal network of coworkers for learning. "We know if you have somebody assigned to you, you can other people that are sort of mentors-who might not be your mentor but indirectly be a mentor-like person" (FG01). If case managers had received specialized training and expertise in mentoring and changes to their job descriptions and workload, in additional to a pay increase, it would be expected that they would be the people who functioned in the mentor role. It was not discussed in the focus groups whether the other team members were bothered by this or not. "He has too much going on. He is as helpful as any other employee or supervisor. So as far as being a mentor, it's not all coming together" (FG02).

4.3.5 Summary of Themes

The mentees seemed to think that the mentoring program was of benefit and provided examples of how it had helped them. "It's a good program. It has to be utilized in the way it is intended to be utilized "(FG01). Nonetheless, the mentees did provide feedback that suggested that they saw a need to improve or change the program. They reported that the program needs to be more organized. "To be honest with you…I expected more. Its kind of helter skelter" (FG03). Another mentee shared his perceptions below.

> "It should be more structured. If there was a pattern that you are supposed to service and do with your mentor, a progression on a regular basis, otherwise you are just going into things and you don't know what's going on and you have to ask questions and sometimes it's a little too much and then it's hard to get a hold of your mentor" (FG03).

The mentees' and the mentors' themes were unique to their individual experiences, but there was overlap around the need for mentoring, time limitations, caseload sizes, productivity requirements, informal learning, and supervisory and agency support.

5.0 DISCUSSION

The following section summarizes the findings from Study 1, the mentor qualitative interviews and Study 2, the quantitative and qualitative findings of the mentees.

Strength and limitations are reviewed in this section. Implications for social work and future research, as well as practical recommendations for implementation are discussed.

5.1 MENTOR INTERVIEWS DISCUSSION

5.1.1 Mentoring

In the first theme, *Perceptions of Mentoring*, mentors explained that they felt that mentoring was needed in case management and used their own difficult experiences when they were newly hired as evidence for this need. The mentors' descriptions of having positive feelings about their work because of their experience are consistent with the literature about mentoring. Mentoring is a reciprocal process that affords mentors an opportunity to become re-energized by the experience of sharing knowledge and wisdom about the work that they do (Kram, 1985). The mentors explained that, through mentoring and the increased responsibilities and salary that came with it, they felt more enthusiastic about their jobs.

Models for mentoring include teaching, de-briefing, co-planning, and journaling (Harrison et al, 2009). Mentors used what they learned from the course and added in their own unique styles of mentoring. Mentors shared many skills that they used for engaging their mentees including case reviews, quizzes, review of the gray manual, shadowing, and observation.

The most significant challenge to successful mentoring relationships are time limitations, low staffing, and competing commitments (Harrison et al., 2009). The mentors repeatedly indicated that finding adequate time for mentoring was problematic for them. Mentors indicated that they would have liked to have more time to meet with the mentees individually and in groups and to spend more time observing the mentees in the field. Due to their own productivity and caseload requirements, this was often not feasible. Instead, it was more common for mentees to shadow the mentors, which allowed the mentors to bill for the time. It might be useful to consider adaptations that would permit the mentors to have available time to spend observing the mentees in the field. In general, without adequate caseload reduction and change in productivity requirements, the mentoring process is compromised.

5.1.2 Implementation

In the second theme, *Real World Mentoring: From Classroom to Practice*, the mentors described their experience of implementation. There were issues associated with the initial implementation that were explained in the subtheme, *Roll-Out Techniques*. The process of implementation typically takes between two and four years (Prochaska & DiClemente, 1982). The Case Management Mentor Certificate Program is only in its second year, so it would be expected to have ongoing implementation issues. One of the benefits of this study is the changes can continue to be instituted now while implementation continues.

Successful implementation has various stages—exploration, initial implementation, full implementation, and innovation and sustainability (Fixsen et al, 2009). This evaluation focused on initial and full implementation. There are opportunities for continued innovation and for meeting the requirement to sustain the program on an ongoing basis.

There are factors that are known to directly affect implementation. These include readiness of the system, organizational culture, attitudes of employees, training and behavior of leaders, incentives for change, and availability of support (Brekke, Ell, & Palinkas, 2007; Kimberly & Cook, 2008). It is likely that the mental health system was not entirely ready for the implementation of the program. Repeatedly, participants described not having a full awareness of the responsibilities of mentoring, supervisors who did not understand the program and organizations that were not prepared for implementation. Recommendations to address these issues include meeting with supervisors prior to implementation, providing full disclosure of expectations to potential mentors prior to training, and addressing job descriptions, pay increases, and productivity changes prior to initiation of the mentor course.

One of the components of successful implementation is completing a needs assessment to assess the readiness of the system (Kochevar & Yanop, 2006). This helps to consider how training will be offered, how providers prefer to practice, the level of receptiveness of the provider, and patterns of organizational decision making (Proctor & Rosen 2008). For the Case Management Certificate Program, there was preliminary work to assess and prepare for implementation. There were needs assessments, stakeholder meetings, and work groups to develop this program.

Some of the mentors were not advised of the expectations of mentoring. These issues were described in the categories *Mentor Selection*, *Expectations and Duties*, and *Productivity*

and Job Descriptions. Some mentors went to the first day of the course expecting to attend a one day workshop, only to realize that they were enrolled in what was essentially a college course. Others did not have their caseloads or productivity expectations changed until the course was completed. Since they began mentoring while the course occurred, this made things very difficult. Mentors reported that they were promised a pay increase for mentoring, and in some cases, this did not occur in a timely fashion. Concerns about productivity, caseload size, lack of pay increase, and new job descriptions detracted from the mentors' ability to focus fully in their mentoring responsibilities. Interviewing potential mentors in a pre-selection process would afford agencies and opportunity to fully explain the program, expectations, and allow the potential mentor to ask questions.

There may be a need for more mentors. If more mentors were trained it would be possible to spread out the mentees over a group, which may help to alleviate the time constraints. Also, mentors should devise a plan for closure. Some of the mentees said that mentoring does not ever formally end, but "fades away" or "sort of stops", and naturally, ongoing mentoring relationships with multiple mentees would be burdensome for the mentors.

Successful implementation requires changes at all levels and the support of leadership is crucial (Klinger et al., 2003). When mentors had good supervisory support, they reported a better ability to follow through with mentoring. In cases where the supervisors did not fully understand or support mentoring, mentors reported difficulty being able to effectively fulfill their roles and this was mirrored in the responses of the mentees.

5.1.3 Transfer of Learning

The third theme, *Course Evaluation,* can be conceptualized through the core concepts of Transfer of Learning. There are estimates that only 10-13% of training translates to practice (Wehrmann, Shin, & Poertner, 2002). Realistically, this means that there will be a plethora of training material that does not translate into practice. However, it is hoped that there will be some transfer from classroom to the field.

The most important factor in successful transfer of learning is supervisory support that demonstrates a commitment to the integration of new learning into practice (Lobato, 2006). Both the mentors and the mentees shared examples of experiences when supervisors did or did not support the mentoring process. When a supervisor understood the program and could support the mentor without feeling threatened, the mentor could work more effectively to transfer the course knowledge to the mentees. Meeting with supervisors prior to implementation is essential to provide them with information about the program and the role of the mentor. This would prevent supervisors from having misconceptions that the mentors are assuming supervisory roles and allow the supervisors to request clarification prior to implementation.

The work of case management is unpredictable and requires far transfer skills. Far transfer occurs when learning is adapted to highly variable circumstances and requires higher level critical thinking (Macaulay & Cree, 1999). Far transfer is achieved by practicing the transfer in contexts where it might be used. In case management, this occurs in the field. Mentors need to have available time away from their caseloads and productivity requirements if they are to spend more time in the field with the mentees where far transfer can occur.

5.2 QUANTITATIVE DISCUSSION

The quantitative data provided by the mentees provided information about what was actually occurring in the implementation of mentoring.

Mentoring was happening on a regular basis. The majority of mentees (93%) reported that they met with their mentors on a daily or weekly basis. In order for implementation to progress, it will be important that mentoring continues to occur regularly. If people stop mentoring, then implementation will gradually diminish.

50% of the mentees reported that they used all five of the core elements of mentoring with their mentors. 30% reported that they used four of the core elements. This information indicates that 80% of mentees are using the techniques that their mentors were taught in class in implementation. Mentees reported that the tools that mentors use with them are helpful, with the exception of the gray manual, which appeared to be less helpful than the other mentoring tasks.

It would be useful to consider an assessment tool for mentors to use with mentees to determine what areas of learning are most needed and to identify the corresponding activities that would best address these areas for potential development.

The core element of mentoring that the quantitative data indicated was used the least was observation of the mentee by the mentor. This was consistent with the qualitative data from both groups. The mentors wanted to have more time to observe the mentees in the field, but felt constrained by time and productivity requirements.

The gray manual was used with less frequency (76.7%) and that was also consistent with the qualitative responses of the mentees who indicated that at times they did not have access to the gray manual or they used it infrequently. It is unclear whether the manual would have been

more helpful if it was used regularly. It may be useful to consider ways to increase access to the gray manual, including offering it electronically or at a discounted rate.

It appears that mentoring does contribute to improved job satisfaction. Mentees reported being most satisfied with their co-workers and supervisors. This was consistent with the qualitative data from focus groups. Mentees shared about how much they enjoyed the people on their teams and the support of their supervisors. Mentees reported being least satisfied with their pay and benefits, this is not surprising since case management is typically a low paying occupation. Case managers have difficult jobs and do important work, but are not comparably paid with other occupations with the same expectations. Of interest was that mentees, who reported the least satisfaction with pay and benefits, were the ones who reported having the most comprehensive experiences with mentoring. It may be the case that smaller agencies provide more thorough and organized mentoring. It may also be the case that people who are just beginning their careers are the lowest paid and most inexperienced, and require the most mentoring.

The mentoring activity that was most associated with job satisfaction was crisis support by the mentor. Since a new case manager might be very overwhelmed in a crisis situation, it is not surprising that having the support of a mentor during this time would contribute to increased satisfaction.

5.3 STUDY II: DISCUSSION OF MENTEE FOCUS GROUPS

5.3.1 Mentoring

Mentees indicated that working with a mentor was helpful. They said that while they would have learned their jobs without a mentor, having one made it easier and helped them to learn more quickly. In the subtheme, *Tell it Like it is*, they described the mentor as a person who would explain to them what they needed to do to effectively do their jobs. Their descriptions of their relationships with their mentors were consistent with the literature about effective mentoring. Mentors help people to acquire learning, manage transitions, and maximize potential (Samburijak & Marusic, 2003). The mentees gave examples of how mentors helped them to learn their jobs, navigate the larger system and difficult situations, and become competent in their ability to perform their jobs. The mentors also helped them to meet co-workers and to feel more comfortable in their new jobs. Since 70% of the mentees had no previous work experience, the mentor helped them to understand the work culture and their specific roles.

5.3.2 Implementation

Mentees who participated in the study were part of the initial implementation process. In the second theme, *Real World Mentoring: From Classroom to Practice*, mentees described their experiences. In the subtheme, *Clarity of Expectations*, mentees explained the importance of supervisory support in implementation. There were mentees who indicated that some supervisors would not allow the mentor to function autonomously. Mentees described feeling frustrated when a supervisor would not support a mentor to make decisions. Supervisors may not have

been updated sufficiently prior to implementation, since this emerged repeatedly with the mentors and the mentees. When supervisors did not demonstrate that they trusted, understood the role, and supported the mentor, the mentee was less certain of the organizational support for the mentoring program.

Many mentees were assigned caseloads before they were through the mentoring process. In the initial conceptualization of the program, mentees were to have a small caseload that gradually increased. In reality, it may not be possible that new case managers are not assigned cases quickly. However, this limits the time available for mentoring and impedes implementation.

Mentees verbalized an acute awareness if the realities of front-line mental work. They often described their mentors as having an overwhelming schedule, inadequate compensation, and inadequate organizational support for their mentoring assignments.

5.3.3 Transfer of Learning

Mentees repeatedly stated that they wanted to spend more time with their mentors in the field. Since far transfer is best achieved through the practice of transfer in contexts that resemble situations where the knowledge will be implemented this is an important part of the mentoring course that needs to be transferred into practice (Johnson, 1995). This is not occurring with regular frequency.

Supervisors who are overwhelmed with work or have frequent unplanned work have difficulty supporting transfer of learning (Garavaglia, 1993). Mentees provided examples of supervisors who were not able to provide the support that was necessary for the mentor to be

able to provide autonomous mentoring experiences that would have fostered greater transfer of learning.

The mentees seemed to be objective about the challenges presented by the supervisors. Despite their honest discussion about the challenges of some supervisors with mentoring implementation, most of them reported having favorable relationships with the supervisors and often saw the supervisors' challenges with mentoring to be function of the other work related stress associated with the field of case management.

5.4 LESSONS LEARNED

5.4.1 Clarify Mentor Expectations Early in Process

Many of the mentors talked about not knowing what to expect when they got into mentoring. It would be beneficial for them to have an opportunity to interview for the mentoring position. This would involve a pre-selection interview with a supervisor and an administrator if possible. In this meeting, there would be an opportunity for the applicant to explain why they wanted to become a mentor and what they hoped to gain from the experience. Also, the agency staff could clearly review mentoring expectations. In addition to formalizing the process early on, the agency could identify people who have an expressed interest in mentoring, so that these people could be cultivated for future opportunities. One agency interviewed candidates for mentoring positions and the mentors reported favorably about the experience and indicated that they had a clear understanding about what would be required. Prior to the class starting, mentors should be

asked to come to a prep meeting, or be provided with some type of "pre-class" information, so that they understand the workload of the class.

5.4.2 Train Supervisors and Co-workers about Mentoring Prior to Implementation

Mentors and mentees recounted how some supervisors did not appear to fully understand the mentoring program. To address this, supervisors should be brought in to meet as a group prior to the start of the course for orientation about the program. This would insure that they have a clear understanding of their role and responsibilities for supporting the mentors and the mentees. This is especially important so that supervisors understand that the mentors are not assuming or taking away from their roles, that the mentoring role instead separate and distinct.

Mentors indicated that case management had traditionally had an informal mentoring process. Consistently, the mentees indicated that while they could seek out their mentors for guidance, they could also continue to seek out other team members. From the accounts of the mentees, they described ongoing use of the informal support and training. Since there is now a structured program in place, and staff members are being compensated to function as mentors, it may be beneficial to educate all staff members about the role of the mentor.

5.4.3 Provide Ongoing Contact With Mentors and Agencies

The mentors indicated that they would like to have ongoing opportunities to connect with the people from other agencies who also attended the course. A recommendation is to hold biannual meetings for the mentors to get updated on new information, have an opportunity to problem solve and report on mentoring, and to provide an opportunity for networking. Another possible

way to maintain connection with the mentors might be a listserve or a monthly "email blast" for the same purposes.

5.5 LIMITATIONS

This was an inductive exploratory study that was designed to understand the implementation of a new program for case managers. The nature of the design was to hear the experiences of the people involved in the process. The timing of this study worked well with the course schedule and the initial phase of implementation. It afforded an opportunity for all of the people in the mentor certificate program to share their experiences over time and to invite all of the mentees to attend the focus groups. Since it was a small sample, the study is not generalizable. By design, this was never the intention of the study. However, if it were to be expanded, there could be a comparison group, or a design with a larger sample.

Beyond the sample size, another limitation was the variance in the stages of mentoring of the mentee sample. There were mentees who were newly hired and just starting to engage with their mentors, as well as mentees who were finished with the mentee process. Segregating the mentors based on their stage in the mentoring process might have restricted the ability to have enough people attend the focus groups. In the focus groups, the mentees did not seem to have difficulty participating, regardless of where they were in the process and if the discussion involved something that they were not familiar with, they would wait to contribute again until the topic changed.

A potential threat to internal validity was investigator bias. The researcher is a social worker who has interfaced with various case managers and agencies throughout the county. It

was important to consider whether her experience would bias her ability to be an unbiased researcher. Faculty members were consulted to continuously assess and monitor the research so that any issues could be addressed as they arose. Additionally, there were graduate students who attended and observed the focus groups and were part of ongoing review of the progress of the study.

The last limitation was the issue of variability among agencies and mentors. Each agency is owned and operated in a unique way. They have different fiscal imperatives, standards of practice, human resources policies and procedures, and serve different communities. All of these factors contributed to how the program was implemented at the agency level. Even if there was consistency in how the mentors followed through on their tasks, the approach of each agency was very different. This was revealed in the analysis since people from different agencies shared very different perspectives on how their agencies handled similar issues.

5.6 STRENGTHS

One of the strengths of the study was the timing of the data collection. This study was designed to follow the mentors and to assess what was happening within a reasonable timeframe. This study was able to talk to people while they were actively engaged in the process, and not years after it was finished. This was important to get "real time" information about what people were experiencing and to be able to provide feedback for ongoing implementation.

This study provides preliminary information that can be used to plan for ongoing, more expansive study around this topic and provides practical recommendations that can inform

practice. There are implications from this study that could be incorporated into ongoing work with the current mentors and future planning for other cohorts of mentors.

The information from this study would be of interest to stakeholders, the agencies, and mentors. The results of this study might help them to consider what potential areas exist for growth and development in the mentoring program, particularly as the implementation process continues.

5.7 IMPLICATIONS FOR PRACTICE

This study provides information about a program that is operated through a School of Social Work. The information can be used for ongoing curriculum planning and development in mentor and case management trainings in continuing education, and undergraduate and graduate coursework.

In the current system, there continue to be barriers to implementation, which include the current billing structure within case management. The reality of this work is that case managers spend most of their day closely monitoring the passage of time. Although the mentees and the mentors recognized that it would be most beneficial for the mentor to be in the field observing mentees, the mentors have to bill for their caseload, so it was more practical for the mentee to accompany them, even though this was not the preferred method of teaching.

There is a need to additional training about the mentoring program for supervisors and agency staff. Without sustained support from organizational leadership and supervisors, the mentors will not be able to effectively maintain the mentoring program. Agency administrators

need to be consistently engaged in the implementation process and demonstrate ongoing support and commitment to the process.

5.7.1 Recommendations

There are practical recommendations that can be considered for use in “real time”, as well as for future planning.

These recommendations include:

- Maintaining ongoing communication within the mentor cohort, perhaps biannually or a quarterly email newsletter.
- Pre-meeting with supervisors prior to course initiation.
- Pre-course Selection which includes interviewing candidates who are interested in becoming mentors.
- Agency fulfillment of reduced productivity requirements and pay increases.
- Increasing access to the gray manual, the case management mentor training manual.
- Establishing clear and consistent time lines for mentoring initiation and closure.
- Maintaining private or shared office space for the mentors.
- Training additional mentors if needed.
- Individual assessment of learning needs of mentee to determine what mentoring activities will be most beneficial.
- Mentoring progress and process be a continuous agenda item at SCU directors meeting as implementation continues.

- Participation by agency administrators in a steering committee or advisory group chaired by DHS/OBH.
- Education for all agency case managers about the roles of the mentors.
- Continued adaptation of the mentor curriculum.

5.8 FUTURE RESEARCH

Future research could be done to expand the study. Supervisors could be interviewed individually or in focus groups to explore their experiences of the implementation of mentoring. The study could further be expanded to include consumers and gather their perceptions of how mentoring has impacted their experience of direct service from their case managers. This could be done in focus groups, interviews, or an ethnographic study. Further research could also include studying how administrator support and organizational readiness for change impacts adoption of an expanded role and function of case management across organizations.

Finally, this study could continue longitudinally to assess if over time, mentoring changes or continues and to understand how it is ultimately implemented. This would have broader implications for implementation research since it could provide information about an innovative program implementation from start to finish. It would be interesting to assess whether mentoring has any impact on job retention or decisions to continue to work in case management over extended periods of time.

APPENDIX A

MENTEE FOCUS GROUP QUESTIONS

1. What was it like starting your job as a service coordinator?

2. Usually there are things in a new job that you need to learn when you get started. How did you do this?

3. Did someone help you when you first started? How did you identify this person? Was the person formally assigned to you or was it someone that you cultivated as a teacher at work?
   PROBE: How were you introduced?

4. Can you describe specific ways that you interacted with that person?
   PROBE: How did you spend your time with them? How often did you meet?

5. How did you spend your time with them?
   PROBES: Did you ask for help when you needed it? Where did you usually meet? Did they go with you to see clients?

6. How did this change the way that you practiced?

7. Have the things you learned benefit the clients with who you worked? How?

8. What is the learning environment like in your workplace? Did you have organizational support for learning/mentoring?
   PROBE: Was your interaction with your mentor different than with your supervisor?

9. What were the barriers to learning/mentoring?

10. What were the things that were most helpful?
    PROBE: What should a new person learn? Is there anything you missed? What would you do differently?

APPENDIX B

JOB SATISFACTION SURVEY

	JOB SATISFACTION SURVEY Paul E. Spector Department of Psychology University of South Florida 	
	PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT.	Disagree very much Disagree moderately Disagree slightly Agree slightly Agree moderately Agree very much
1	I feel I am being paid a fair amount for the work I do.	1 2 3 4 5 6
2	There is really too little chance for promotion on my job.	1 2 3 4 5 6
3	My supervisor is quite competent in doing his/her job.	1 2 3 4 5 6
4	I am not satisfied with the benefits I receive.	1 2 3 4 5 6
5	When I do a good job, I receive the recognition for it that I should receive.	1 2 3 4 5 6
6	Many of our rules and procedures make doing a good job difficult.	1 2 3 4 5 6
7	I like the people I work with.	1 2 3 4 5 6
8	I sometimes feel my job is meaningless.	1 2 3 4 5 6
9	Communications seem good within this organization.	1 2 3 4 5 6
10	Raises are too few and far between.	1 2 3 4 5 6
11	Those who do well on the job stand a fair chance of being promoted.	1 2 3 4 5 6
12	My supervisor is unfair to me.	1 2 3 4 5 6
13	The benefits we receive are as good as most other organizations offer.	1 2 3 4 5 6
14	I do not feel that the work I do is appreciated.	1 2 3 4 5 6
15	My efforts to do a good job are seldom blocked by red tape.	1 2 3 4 5 6
16	I find I have to work harder at my job because of the incompetence of people I work with.	1 2 3 4 5 6
17	I like doing the things I do at work.	1 2 3 4 5 6
18	The goals of this organization are not clear to me.	1 2 3 4 5 6

APPENDIX C

FREQUENCY/QUALITY OF MENTORING SURVEY

Frequency/Quality of Mentoring Survey

Please specify:

Today's Date:	
Your Age (years):	
Your Gender (Check one)	☐ **Male** ☐**Female**
Education (Check highest level attained):	☐ **High school** ☐ **Undergraduate** ☐ **Graduate** ☐ **Other:_____(please specify)**
Mentor Code: _____	**Agency Code: _____**
Your Date of Agency Hire (Month/Year):	
Your Amount Service Coordination Experience prior to becoming a mentee:	**_____Years; _____ Months**

1. On average, how frequently did you and your mentor meet? (Check one)

☐	☐	☐	☐	☐
None	**Monthly**	**Weekly**	**Daily**	**As Needed**

2. If you met with your mentor:

Activity	**(check one)**	**If yes, how often? (check one)**	**Please RATE the helpfulness of each activity? (check one)**				
			Extremely helpful	**Very helpful**	**Neither helpful nor not helpful**	**Somewhat helpful**	**Not at all helpful**
a. Did you use the gray manual?	☐ **YES** ☐ **NO**	☐ Monthly ☐ Weekly ☐ As needed	☐	☐	☐	☐	☐
b. Did your mentor shadow you in the field?	☐ **YES** ☐ **NO**	☐ Monthly ☐ Weekly ☐ As needed	☐	☐	☐	☐	☐
c. Did you observe your mentor in practice?	☐ **YES** ☐ **NO**	☐ Monthly ☐ Weekly ☐ As needed	☐	☐	☐	☐	☐
d. Did you contact your mentor for crisis situations?	☐ **YES** ☐ **NO**	☐ Monthly ☐ Weekly ☐ As needed	☐	☐	☐	☐	☐
e. Did you meet with your mentor to discuss specific cases or questions related to work?	☐ **YES** ☐ **NO**	☐ Monthly ☐ Weekly ☐ As needed	☐	☐	☐	☐	☐

APPENDIX D

CASE MANAGEMENT MENTOR INTERVIEW GUIDE

Introduction: Thank you so much for taking the time to tell us about your feelings about the mentoring program. I thought we would just chat for about 30 minutes or so to ask you how things have been going since we last talked, what changes you might make, and how the mentoring program is working for you. I don't have any bias one way or another toward the mentoring project; I just want to hear your honest feelings and thoughts. Everything you say will remain completely confidential. Do you have any questions before we start?

I'd like to tape – is that ok with you? (If not, take notes).

So, tell me what you think about mentoring thing – how do you see what it is, exactly now that you have been doing it for a while?

PROBES:
Mentor's role, what mentor does, how mentor helps mentee, mentor's place in the agency
Have you had mentees? How has it been set up?
Have you had more than one at a time? How have you handled that?

How has your job changed since you became a mentor?

PROBES:
More/less work
More/less time with caseload

Have things changed at all at work as a result of starting this mentoring program?

PROBES:
If so, how?

Do you think "mentor" is a role that's needed in service coordination/case management?

PROBES:
Why?

Mentors need some support from their employers. Did you have:

A promotion?
A change to a different title?
A raise?
A change in your productivity expectation?
Does your agency have merit pay?
Did mentoring affect your ability to get it?
How?

Is there anything else you'd like to tell us about these parts of the structure at work to help you become a mentor and function in that role?

Did you have any other problems or obstacles in getting the mentoring program going or in trying to be a mentor to the person you worked with?

PROBES:
What were they?
How did you/your agency deal with them?

How do you think it is for new people coming on board?

PROBES:
Do you think having a mentor makes a difference for the mentees? (it's ok if you don't think it's different for them…)

Do you think playing a mentor role as part of the service coordination job will affect consumers in any way?

PROBES:
How?
Better/Worse services?

What can you tell us about the materials and course set up that would make it work better?

PROBES:
Is there anything you'd like to see changed about the class, if it were to be offered again?
Pragmatics (schedule/location)
Homework/course preparation time
The "gray manual"

What did you like about the materials and course set up?

Have you been using the gray manual with your mentees? Your mentees also used the gray manual – did you get any feedback from them about it?

PROBES:
What did they have to say?
What helped?
What should be changed?

APPENDIX E

INSTITUTIONAL REVIEW BOARD NOTIFICATION

University of Pittsburgh
Institutional Review Board
3500 Fifth Avenue
Pittsburgh, PA 15213
(412) 383-1480
(412) 383-1508 (fax)
http://www.irb.pitt.edu<http://www.irb.pitt.edu/>

Memorandum

To: Catherine Greeno
From: Sue Beers , Vice Chair
Date: 7/27/2009
IRB#:
PRO09020016<https://www.osiris.pitt.edu/osiris/Rooms/DisplayPages/LayoutInitial?Container=com.webridge.entity.Entity[OID[B0C86FAB89114C4399F2C4AF85F029BC]]>
Subject: SPA Evaluation Study

_____

Based on the information provided to the IRB, this activity does not meet the DHHS definition of research in accordance with 45 CFR 46.102(d); Research as defined by HHS regulations (45 CFR 46.102(d)) shall mean a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Should that situation change, the investigator must notify the IRB immediately.

Given this determination, you may begin your project.

Please note the following information:

* If any modifications are made to this project, use the " Send Comments to IRB Staff" process from the project workspace to request a review to ensure it continues to meet the exempt category.
* Upon completion of your project, be sure to finalize the project by submitting a "Study Completed" report from the project workspace.

Please be advised that your research study may be audited periodically by the University of Pittsburgh Research Conduct and Compliance Office.

BIBLIOGRAPHY

Acker, G.M. (2009). Role conflict and ambiguity: Do they predict burnout among mental health service providers. *Social Work in Mental Health, 1* (3), 63-80.

Acker, G. & Lawrence, D. (2003).Measuring competence, burnout, and role stress of workers providing mental health services in a managed care era. *Social Work and Managed Care, 9,* 269-282.

Aegisdottir, S., White, M.J., Spengler, P.M., Maugherman, A.S., Anderson, L.A., Cook, R.S., et al. (2006). The meta-analysis of clinical judgment project: Fifty six years of accumulated research on clinical versus statistical prediction. *Counseling Psychologist, 34* (3), 341-382.

Albizu-Garcia, C.E., Rios, R., Juarbe, D., & Alegria M., (2004). Provider turnover in public sector mental managed health care. *Journal of Behavioral Health Services research, 31*(63), 255-265.

Allegheny County Department of Human Services. *Single Point of Accountability*: *Executive Summary,* 2009.

Anderson, C.M., Reiss, D.J., & Hogerty, G.E. (1986). *Schizophrenia and the family.* New York, NY: Guilford.

Anderson, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: toward and empirically validated stage model. *Australian and New Zealand Journal of Psychology, 37,* 586-594.

Anderson, E.M. & Shannon, A. L (1988). Toward a conceptualization of mentoring. *Journal of Teacher Education, 39* (1), 38-42.

Angell, B. & Mahoney, C. (2007). Reconceptualizing the case manager relationship in intensive treatment: A study of staff perceptions and experiences. *Administration and Policy in Mental Health and Mental Health Services Research, 34,* 172-188.

Anthony, W. (1993). Recovery from mental illness: the guiding vision of service research. *Innovation and Research, 1,* 13-14.

Anthony, W. (2000). A recovery oriented service system: setting some level of standards. *Psychiatric Rehabilitation Journal, 24,* 159-168.

Anthony, W. (2003). Studying evidence-based practice processes, not practices. *Psychiatric Services, 54,* 7-15.

Anthony, W. & Blanch, A. (1987). Supported employment for persons who are psychiatrically disabled: a historical and conceptual perspective. *Psychosocial Rehabilitation Journal, 11,* 5-23.

Anthony, W., Chen, M., Farkas, M., & Gagne, C. (2002). *Psychiatric Rehabilitation.*(2nd Ed.) Boston: MA: Boston Center for Psychiatric Rehabilitation.

Apesoa-Varano, E.C. (2007). Educated caring: The emergence of professional identity among nurses. *Qualitative Sociology,* 30, 249-274.

Arches, J. L. (1997). Burnout and social action. *Journal of Progressive Human Services, 8* (3), 51-61.

Armstrong, R., Water, E., Grockett, B., & Keleher, H. (2007). The nature of evidence: resources and knowledge translation for health promotion practitioner. *Health Promotion Interventions, 22,* 254-260.

Avirum, U. (2002). The changing role of the social worker in the mental health system. *Social Work in Healthcare, 35* (1/2), 617-633.

Bachrach, L. (1989). Case management: toward a shared definition. *Hospital and Community Psychiatry, 40,* 883-884.

Baker, F., Jodrey, D., Intglaiata, J., & Strau, H. (1993) Community support services and the function of the seriously mentally ill. *Community Mental Health Journal, 29* (4), 321-331.

Baldwin, T.T., & Ford, J. K. (1988). Transfer of training: A review and directions for futre research. *Personnel Psychology, 41,* 63-101.

Ballard, D., Klein, M., & Dean, A. (2007). Mentoring for success in criminal justice and criminology: Teaching professional socialization in graduate programs. *Journal of Criminal Justice Education, 18* (2), 284-296.

Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist, 44,* 1175-1184.

Barak, M., Nissly, J., & Levin, A. (2001). Antecedents to retention and turnover among child welfare social workers and other human services employees: what can we learn from past research? A review and meta-analysis. *Social Service Review, 75* (4), 626-661.

Beck, H.S. & Carper, J.W. (1956). The development of identification with an occupation. *The American Journal of Sociology , 61* (4), 289-298.

Bellack, A.S. (2006). Scientific and consumer models of recovery in schizophrenia: Concordance, contrast, and implications. *Schizophrenia Bulletin, 32,* 432-442.

Benson, P.R. (1996). Mental health policy and practice: International perspectives. *International Journal of Law and Psychiatry, 19* (3/4), 1996.

Bernfield, G.A. (2001). The struggle for treatment integrity in a "disintegrated" service delivery system. In G.A. Bernfield, D.P. Farrington, & A.W. Leschied (Eds.), *Offender Rehabilitation and Practice: Implementing and Evaluating Effective Programs.* London: Wiley.

Bhattacharyya, O., Reeves, S., & Zwarenstein, M. (2009) What is implementation research?: Rationale, concepts, and practices. *Research on Social Work Practice, 19,* 491-592.

Bledsoe, S., Lukens, E., Onken, S., & Cardillo-Geller, L. (2008). Mental illness, evidence-based practice, and recovery: Is there compatibility between service user-identified recovery facilitating and hindering factors and empirically supported interventions. *Best Practices in Mental Health, 4*(2), 34-58.

Bliss, J., Gillespie, D., & Gongaware, N. (2010). Dynamics of caseworker turnover and clinical knowledge. *Administration in Social Work, 34 (*1), 4-26.

Bond, G.R. (1991). Variations in an assertive outreach model. *New Directions for Mental Health Services, 52,* 65-80.

Bond, G.R., Becker, D.R., Drake, R.E., Rapp, C.A., Meisler, N., Lehman, A.F., et al (2001). Implementing supported employment as an evidence-based practice. *Psychiatric Services, 52,* 313-322.

Bond, M. & Holland, S. (1998). *Skills and clinical supervision for nurses*. Buckingham, UK: Open University Press.

Bragg, A. (1989) Is a mentor program in your future? *Sales and Marketing Management, 141,* 54-59.

Brekke, J.S., Ell, K., & Palinkas, L.A. (2007). Translational science at the NIMH? Can social work take its rightful place? *Research in Social work Practice, 12,* 123-141.

Bromberg, E. & Starr, R. (1991). The New York city ICM training program: The first two years. *Psychosocial Rehabilitation Journal, 15* (1), 98-104.

Buchanan, D., Fitzgerald, L., Ketley, D., et al. (2005). No going back: a review of the literature in sustaining organizational change. *International Journal of Management Review, 7,* 189-205.

Busch, A.B. & Shore, M.F. (2000). Seclusion and Restraint: A review of the recent literature. *Harvard Review of Psychiatry, 8,* 261-270.

Carson, J., Brown, D., Fagin, L., & Bartlett, H. (1996). Do larger caseloads cause greater stress in community health nurses? *Journal of Clinical Nursing, 5,* 133-134.

Charmaz, K (2006) *Constructing grounded theory*. Thousand Oaks: CA: Sage.

Chassin, M.R. & Galvin, R.W. The National Roundtable on Healthcare Quality (1998). The urgent need to improve healthcare quality: Institute of Medicine National Roundtable on Healthcare Quality, *Journal of the American Medical Association, 280,* 1000-10065.

Cherniss, C. (1993). The role of professional self-efficacy in the etiology and amelioration of burnout in W.B. Schaufeli, C. Maslach and T. Manek (Eds). *Professional Burnout: Recent Developments in Theory and Research.,* New York, NY: Taylor & Francis.

Chorpita, B.F. (2002) Treatment manuals for the real world: Where do we build them? *Clinical Psychology: Science and Practice, 9,* 431-433.

Chorpita, B.F. (2003). The frontier of evidence based practice. In A.E. Kazdin and J.R. Weisz (Eds.), *Evidence based psychotherapies for children and adolescents* (pp. 42-59). New York, NY: Guildford.

Clouder, L. (2003). Becoming professional: Exploring the complexities of professional socialization in health and social care. Learning in Health and Social Care, 2 (4), 213-222.

Corrigan, P.W. & Ralph, R.O. (2005). Introduction: Recovery as a consumer vision and research paradigm. In R.O. Ralph and P.W. Corrigan (Eds.), *Recovery in Mental Illness: Broadening our understanding of Wellness*. Washington D.C.: American Psychological Association.

Coursey, R.D., Curtis, L., Marsh, D.T., Campbell, J., Harding, C., Spaniol, L., Lucksted, A., McKenna, J., Kelley, M., Paulson, R., & Zahniser, J., (2000). Competencies for direct service staff members who work with adults with severe mental illnesses: Specific knowledge, attitudes, skills, and bibliography. *Psychiatric Rehabilitation Journal, 23* (4), 378-389.

Crabtree, B.F. & Miller, W.L. (1999). *Doing qualitative research*. (2nd Ed.) Thousand Oaks, CA: Sage.

Crane-Ross, D., Lutz, W., & Roth D. (2006) Consumer and case management perspectives of service empowerment: relationship to mental health services. *Journal of Behavioral Health Services and Research, 42,* 142-155.

Curry, D., McCarragher, T., & Dellman-Jenkins, M. (2005). Training, transfer & turnover: Exploring the relationship among transfer of learning factors and staff retention in child welfare. *Children and Youth Services Review, 25,* 932-948.

Daleiden, E.L., Chorpita B.F., Donkervoet, C.M., Arensdorf, A.A., & Brogan, M., (2006) Getting better at getting them better: health outcomes and evidence based practice within a systems of care. *Journal of the American Academy of Child and Adolescent Psychiatry, 45,* 749-756.

Damanpour, E. (1991). Organization Innovation: A meta-analysis of the effects of determinants and moderators. *Academy of Management Journal, 34,* 555-590.

Davidson, L., Drake, R., Schmulte, T., Dinzeo,T., & Andres-Hyman, R. (2009) Oil and water of oil and vinegar? Evidence-based medicine meets recovery. *Community Mental Health Journal, 45,* 323-332.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health 16* (4), 1-12.

Dawes R.M..(2001). *Everyday Irrationality: How pseudoscientists, lunatics, and the rest of is systematically fail to think rationally.* Boulder, CO: Westview.

Dearing, J. (2009). Applying diffusion of innovation theory to intervention development *Research on Social Work Practice (19),* 503-518.

Deary, I., Agious, R., & Saler A., (1996). Personality and stress in consult psychiatrist. *International Journal of Psychiatry, 42,* 112-113.

Deegan, P.E. (1998). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.

Deegan, P.E. & Drake, R.E. (2006) Shared decision making and medication management in the recovery process. *Psychiatric Services, 57,* 1636-1639.

Denzin, N.K (1978) *The research act: A theoretical introduction to sociological methods*. (2nd ed.). New York: McGraw-Hill.

Department of Health and Human Service (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: US Department of Health and Human Service, US Public Health Service.

Department of Health and Human Services (2003). Achieving the Promise: transforming Mental Health Care in America. Presidents New Freedom Commission on Mental Health. Final Report (DHHS Pub. No. SMA-03-3832). Rockville, MD: US Department of Health and Human Services.

Department of Health and Human Services (2007). National Consensus Statement on mental health recovery, retrieved 2.27.2010 from http://mentalhealth.samhsa.gov/publication/allpubs.sma05-4129.

Department of Health and Human Services (2005). Transforming Mental Health Care in America. Action Agenda: First Steps. Rockville Maryland: Substance Abuse and Mental Health Services Administration.

Detterman, D.K. (1993*). "The case for the prosecution: transfer as an epiphenomenon,"* In D.K. Detterman and R.J. Sternber (Eds), Transfer on trial: Intelligence, cognition, and instruction (pp 1-24. Norwood, NJ: Ablex.

Drake, R.E., Goldman, H.H., Keff, H.S., Lehman, A.F., Dixon L., Mueser, K.T., & Torrey, W.C. (2001). Implementation of evidence based practices in routine mental health service settings. *Psychiatric Services, 5* (2), 179-183.

Drake R., Green G., Mueser, K., & Goldman, H.(2003) The history of mental health treatment and rehabilitation for persons with severe mental illness. *Community Mental Health Journal*, *39* (5), 427-440.

Eack, S.M., Greeno, C.G., Christian-Michaels, C., Denis, A., & Anderson, C.M. (2009). Case managers' perspectives on what they need to do their job. *Psychiatric Rehabilitation Journal, 4* (32), 309-312.

Eack, S., Anderson, C., & Greeno, C. (2008). *Mentored Case Management For Individuals With Severe Mental Illness: A Guide for Practitioners and Mentors.*

Eccles, M.D. & Mittman, B.S. (2006). Welcome to implementation science, *Implementation Science 1,*1.

Etzioni, A. (1969). *The semi professions and their organization: Teachers, nurses, and social workers.* New York; The Free Press.

Falloon, I., Boyd, J., & McGill, C. (1984). *Family care of schizophrenia: A problem-solving approach to the treatment of mental illness.* New York, NY: Guilford.

Farkas, M.D., Anthony, W.A., & Cohen, M.R. (1989). An overview of psychiatric rehabilitation: The approach and its programs. In M.D. Farkas and W.A. Anthony (Eds.), *Psychiatric program: Putting theory into practice.* Baltimore, MD: Johns Hopkins.

Fiortine, R. & Grusky, O. (1990). When case managers manage the seriously mentally ill: A role contingency approach. *The Social Service Review, 64* (1), 79-93.

Fisher ,W.H., Geller, J.L., & Pardiani, J.A.(2006). The changing role of the state hospital, *Health Affairs, 28* (3), 676-684.

Fixsen, D., Blasé, K., Naoom, S., & Wallace, F. (2009). Core implementation components. *Research in Social Work Practice, 19,* 531-540.

Fochuk, C., Ouwerhark, A., Yamashita, M., & Martin, M.L. (2002). Mental health case management in Canada: Job description analysis. *Issues in Mental Health Nursing, 23,* 477-496.

Froland, C., Brodskey, G., Olson, M. & Steward, L. (2000) Social support and adjustment: Implications for mental health professionals. *Community Mental Health Journal 35,* 61-75.

Garavaglia, P.L. (1993). How to ensure transfer of training. *Training and Development, 47,* 63-68.

Garb, H.N. & Grove, W.M.(2005). On the merits of clinical judgment. *American Psychologist, 60* (6) 658- 659.

Garet, M.S., Porter, A.C., Desimone, L., Birman, B., & Kwang, S.Y. (2001). What makes professional development effective? Results from a national sample of teachers. *American Education Research Journal, 38* (2), 915-945.

Gellis, Z.D., Kim, J, & Hwang, S.C. (2004). New york case manager survey: Urban and rural differences in job activities, job stress,, and job satisfaction. *Journal of Behavioral Health Services & Research, 31* (40), 430-440.

Gibbs, L. & Gambrill, E. (1999). *Critical Thinking for Social Workers: Exercises for the Helping Professions.* Thousand Oaks: CA: Pine Forge.

Gill, S.J. & Murray, S.P. (2009). *Getting more from your investment in training: The 5As framework.* Seattle, WA: Realtime Performance.

Glaser, B. (1978). *Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B. & Straus, A. (1967). *The discovery of grounded theory.* Chicago: Aldine.

Glasgow, R. (2008). What types of evidence are most need to advance behavioral medicine? *Annals of Behavioral Medicine, 35,* 19-25.

Glaszious, P. & Haynes, B. (2005). The paths from research to improved health outcomes. *ACP Journal Club, 142,* A8-A10.

Gregiore, T., Propp, J., & Poertner, J. (1998).The supervisor's role in the transfer of training. *Administration in Social Work, 22* (1), 1-18.

Grimshaw, J.M. & Russell, I T. (1994). Achieving health gain through clinical guidelines: ensuring guidelines change medical practice. *Quality Health Care, 3,* 45-52.

Hall, M.L. & Kepfe, R.H. (2000). Exploring the management behavioral health care provider self-perceived competence scale: A tool for continuing professional education. *Professional Development: The Journal of Continuing Social Work Education, 3*(3), 27-35.

Hangan, C. (2006). Introduction of an intensive case management style of delivery for a new mental health service. *International Journal of Mental Health Nursing, 15,* 157-162.

Harding, C.M., Brooks, G.W., Ashikaga, T., Strauss, J.S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness: Long term outcomes of subjects who retrospectively met DSM III criteria for schizophrenia. *American Journal of Psychiatry, 144,* 727-735.

Hargreaves, A. & Dawe, R. (1990). Paths of professional development: Contrived collegiality, collaborative culture, and the case of peer coaching. *Teaching & Teacher Education, 6* (3), 227-241.

Harrison, N., Lyons, C., Baguley, C., & Fisher, D. (2009). An education evaluation of supervisor and mentor experiences when supporting primary care mental health workers. *Journal of Psychiatric and Mental Health Nursing, 16, 416*-423.

Harrison, W.D. (1980). Role strain and burn out in child protective service workers. *Social Service Review, 54,* 31-44.

Hoge, M.A. (2002). The training gap: An acute crisis in behavioral health education. *Administration and Policy in Mental Health, 29* (4), 305.

Hoge, M.A., Morris, J.A., Daniels, A.S., Huey, L.Y., Stuart, G.W., Adams, N., Paris, M., Goplerud, E., Horgan, C.M., Kaplan, L., Storti, S.A., & Dodge, J.M. (2005). Report of recommendations: The Annapolis coalition conference on behavioral health work force competencies. *Administration and Policy in Mental Health, 32* (30), 651.

Holstein, J. & Gubrium, J. (1995). *The active interview.* Sage: Thousand Oaks, CA.

Howgego, I., Yellowlees, C.O., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: The key to effective patient outcomes. A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry, 37,* 169-183.

Howkins, E. J. & Ewens, A. (1999). How students experience professional socialization. *International Journal of Nursing Studies, 35,* 41-49.

Hromco, J. G., Lyons, J.S., & Nikkel, R.E. (1997). Styles of case management: The philosophy and practice of case managers. *Community Mental Health Journal, 33* (5), 415-428.

Hromco, J. G, Moore M.W. & Nikkel, R.E. (2003) How managed care has affected mental health case management activities, caseloads, and tenure. *Community Mental Health Journal, 39* (6), 225-268.

Hughes, E.C. (1958). *Men and their work.* New York: Free Press.

Insel, T. (2003) From Science to Service: Mental Health Care Following the Decade of the Brain. Presentation given at Columbia University in New York.

Intagliata, J. (1982). Improving the quality of care for the chronically disabled: The role of case management. *Schizophrenia Bulletin, 8,* 655-674.

Institute of Medicine (IOM). (2001) Crossing the quality chasm: A new mental health system for the 21st century: Washington, D.C.: National Academy Press.

Jacob, S., Bond, J., Galinsky, E., & Hill E.J.(2008). Six critical ingredients in creating an effective workplace. *Psychologist Manager Journal, 11,* 141-161.

Jayaratne., S. & Chess W., (1991) Job satisfaction and burnout: is there are difference? *Journal of Applied Social Science, 15*(2), 245-262.

Jensen-Doss, A., Cusack, K. J., & deArellano, M.A (2008). Workshop base training on trauma focused CBT: An in-depth analysis of impact on provider practices. *Community Mental Health Journal, 44,* 227-244.

Jinnet K. & Alexander J. (1999).The influence of organization context on quitting intention. *Research on Aging 121* (2), 176-204.

Jobe T.H. & Harrow M. (2005). Long term outcomes of patients with schizophrenia: A review. *Canadian Journal of Psychiatry, 50,* 892-900.

Johnson, P., & Rubin, A. (1983). Case management in mental health: A social work domain? *Social Work, 45,* 49-55.

Johnson, S. D. (1995). Transfer of learning. *The Technology Teacher, 4,* 33-35.

Kanter, J. (1989) Clinical case management: Definitions, principles, and components, *Hospital and Community Psychiatry, 4* (40), 361-368.

Kazi, M.A. & Wilson, J. (1996). Applying single case evaluation methodology in a British social service agency. *Research on Social Work Practice, 6*(1), 5-26.

Kersbergen, A. L. (1996). Case management: A rich history of coordinating care to control costs. *Issues in Mental Health Nursing, 44,* 169-173.

Kessler, R.C., Berglund, P.A., Bruce, M.L., Koch, J.R., Laska, A.M., Leaf, P.J., Manderschied, R.W., Rosenheck, R.A., Walter, E.L., & Wang, P.S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36* (6), 987-1007.

Kimberly, J. & Cook, J.(2008) Organizational measurement and the implementation of innovations in mental health services. *Administration Policy in Mental Health*, 35, 11-20.

Kirk, S., Koeske, G.F., & Koeske, R.D. (1993). Changes in health and job attitudes of case managers providing intensive services. *Hospital and Community Psychiatry, 44,* 168-173.

Kirk S.A. & Oenka, L.E. (1992). Research utilization and MSW education: A decade of progress. In A.J. Grasso and I. Epstein (Eds.), *Research utilization in the social services,* (pp 407-421). Binghamton, NY: Haworth.

Klinger J., K., Ahwee, S., Pilonieta, P., & Menendez, C. (2003). Barriers and Facilitators in scaling up research based practices. *Exceptional Children, 69,* 411-429.

Kochevar, L. & Yano, E. (2006). Understanding healthcare organization needs: Context beyond performance gaps. *Journal of General Internal Medicine, 21,* 525-529.

Koegal, P., Burnam, A., & Baumohl, J. (1996). *"The case of homelessness",* in J. Baumohl (Ed.). Homelessness in America, (pg-24-33). Phoenix, AZ: Oryx.

Koeske, G.F. & Koeske, R.D. (1993). A preliminary test of a stress–strain-outcome model for reconceptualizing the burnout phenomenon. *Journal of Social Services Research, 17* (314) 107-135.

Kram, K.E. (1985). Mentoring at work: Developmental relationships in organizational life. Glenview: Illinois: Scott, Forman.

Kvale, S. (1996). *InterView: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage.

Lamb, H.R. (1994). A century and a half of psychiatric rehabilitation in the united states. *Hospital and Community Psychiatry, 45,* 1015-1020.

Lang, E.S., Wyer, P.C., & Haynes, B. (2007). Knowledge translation: Closing the evidence to practice gap. *Annals of Emergency Medicine, 49* (3) 355-363.

Langer-Ellison, M., Rogers, E., Sciarappa, K., Cohen, M. & Forbes, R. (1995). Characteristics of mental health case management: Results of a national survey. *Journal of Mental Health Administration, 22* (2), 1995.

Lee, P. & Kentworthy, M. (1929). *Mental hygiene and social work.* New York: The Commonwealth Fund.

Lieberman, R.P., Glynn, S., Blair, R.E., Ross, D., & Mander, S R. (2002). In vivo amplified skills training promoting generalization of independent living skills for clients with schizophrenia. *Psychiatry, 65,* 137-155.

Lilienfeld, S.O. (2002). When worlds collide: Social science, politics, and child sexual abuse meta-analysis. *American Psychologist, 37,* 176-188.

Lobato, J. (2006). Alternative perspectives on the transfer of learning: History, issues and challenges for future research. *Journal of the Learning Sciences, 15* (4), 431-449.

Looney, V.G., Harding, R.K., Blotchy, M.J. & Barnhard, F.D. (1980). Psychiatrist transition from training to career: Stress and mentoring. *American Journal of Psychiatry, 137,* 32-36.

Lozeau, D. Langly, A., & Denes, J.L. (2002) The corruption of managerial. *Organizational Human Relations, 55*, 537-564.

Lu, Y.E., Miller, M.H., & Chen, S. (2002) American revolution in mental health care delivery: Meeting the educational challenge. *Journal of Teaching in Social Work, 22* (1/2), 167-182.

Lubove, R. (1965). *The professional altruists: The emergence of social work as a Career, 1880-1930.* Cambridge, MA: Harvard.

Lyons, C., Eaton, D., & Bradley, S. (2006) Workforce, volume, and access: graduate workers: Contributions to primary care child and adolescent services. *Journal of Mental Health Workforce Development, 1,* 16-23.

Macauley, C. & Cree, V. (1999) Transfer of learning: Concept and process. *Social Work Education, 18* (2), 183-194.

Macias, C., Jackson, R.T., Schroeder, C., & Wang, Q. (1999) What is the clubhouse? Report on ICCD 1996 survey of United States of America. *Community Mental Health Journal, 35*(2) 181-189.

Maden, T., Kupfer, L., Hofman, K., & Glass, R. (2007). Implementation science. *Science 318,* 1728-1733.

Manderscheid, K.W., Atay, J.E., Male, A., Backlow, B., Forest, C., Ingrain, C., Madke, J., Sussman, & Ndikuwami, J. (2004). "*Highlights of organized mental health services in 2000. National and state trends in mental health US 2003"* edited by K.W. Manderscheid and M.J. Henderson. Washington, DC: US Government Printing Office.

Marini, A., Generaux, R., (1995). "*The challenge of teaching for transfer,"* In A. McKeough, Lupar J. & A. Marini (Eds.*)* Teaching for transfer: Fostering generalization in learning (pp.-20). Lawrence Erlbaum.

Maslasch, C. & Pines, A.M. (1982) Nurses Burnout lack of positive conditions and the pressure of negative conditions as two independent sources of stress. *Journal of Psychosocial Nursing in Mental Health Services, 20,* 30-38.

McCloughen, A. & O'Brien, L. (2005). Development of a mentor programme for new graduate nurses in mental health. *International Journal of Mental Health Nursing. 14,* 276-284.

McGlynn, E.A., Asch, S.M., & Adams, J. (2003). The Quality of healthcare deliver to adults in the United States. *New England Journal of Medicine, 348 ,* 2635-2645.

McLeod, T. (1997). Work stress among community psychiatric nurses. *British Journal of Nursing, 6*, 569-574.

Mechanic, D. (1991). Recent developments in mental health: Perspectives and services. *Annual Review of Public Health, 12,* 1-15.

Mechanic, D. & Aiken, L. (1987). Improving the care of patients with chronic mental illness. *New England Journal of Medicine, 317,* 634-638.

Mechanic, D. & Rochefort, D. (1990). Deinstitutionalization: An appraisal of reform. *Annual Review of Sociology, 16,* 301-327.

Mechanic, D., Schlesinger, M., & McAlpine, D. (1995). Management of mental health and substance abuse services: State of the art and early results. *The Milbank Quarterly, 72,* 19-37.

Mellman, T.A., Miller, A.L., Weissman, E., Crimson, M., Assock S.M. & Marder, S.R. (2001). Evidence based pharmacologic treatment for people with severe mental illness: A focus on guidelines and algorhythms. *Psychiatric Services, 52,* 619-625.

Mikkelsen, A., Saksvik, P., Eriksen, H.R., & Ursin, H. (1999). The impact of learning opportunities and decision authority on UCC. *Health, Work, & Stress, 13*(11) 20-31.

Miles, M.B. & Huberman, A.M. (Eds.) (1994). *Qualitative data analysis: An expanded sourcebook (2nd ed.).* Thousand Oaks, CA: Sage.

Moore, E. Ball, R.A.,& Kuipers, L. (1992). Expressed emotion in staff working with long term adult mentally ill. *British Journal of Psychiatry, 161,* 802-808.

Morse, J.M., Stern, P.N, Corbin, J., Bowers, B, Charmaz, K., & Clarke, A.E. *Developing Grounded theory: The second generation.* Walnut Creek, CA: West Coast Press.

Morton-Cooper, A.& Palmer, A. (2000). *Mentoring preceptorship and clinical supervision.* (2nd Ed.). Oxford: Blackwell Science.

Muesser, K.T., Drake, R.E., & Bond, O.R. (1997). Recent advances in psychiatric rehabilitation for patients with severe mental illness. *Harvard Review of Psychiatry, 5,* 123-137.

Mueser, K.T., Corrigan, P.W., Hilton, D.W., Tanzsman, B., Schaub, W., Gingerich, S. Essock, S., Tarrier, N., Morey, B., Vogel-Scibila, S., & Herz, M. (2002). Illness management and recovery: A review of the research. *Psychiatric Serivces, 53,* 1272-1284.

Mueser, K.T., Torrey,W.C., Lynde, D., Singer, P., & Drake,R.(2003). Implementing evidence based practices for people with serious mental illness. Behavioral *Modification, 27,* 387-411.

Mullen E.J., & Bacon, W.F. (2003). Practitioner adoption and implementation of practice guidelines and issues of quality control. In A. Rosen and E.K Proctor (Eds.), *Developing practice guidelines for social work intervention: issues, methods, and research agenda.* New York, NY: Columbia.

National Institute of Mental Health: Advisory Mental Health Council Behavioral Science Workgroup (1999). Translating Behavioral Science into Action: Rockville, MD. National Institute of Mental Health.

Noe, R.A. (1986). Trainees attributes and attitudes: neglected influences on training effectiveness. *Academy of Management Review 11* (4), 736-749.

Oliva, R. & Sterman, J.D. (2001) Cutting corners and working overtime: Quality erosion in the service industry. *Management Science, 47*(7), 894-914.

Olivero, G., Bane K.D., & Kolelman, R.E. (1997). Executive coaching as a training of training toll: Effects on productivity in a public agency. *Public Personnel Management, 26 (4)* 461-469.

Osborn, L. (2009). From beauty to despair: The rise and fall of the American state mental hospital. *Psychiatric Quarterly, 80,* 219-231.

Padget, D. K. (2004). *The qualitative research experience.* Belmont CA: Wadsworth.

Padget, D.K. (2008). *Qualitative methods in social work.* (2nd Ed.) Thousand Oaks, CA: Sage.

Perese, E.F. & Wolf, M. (2005). Combating loneliness among persons with serious mental illness: Social network interactions, characteristics, effectiveness, and applicability. *Issues in Mental Health Nursing, 26,* 591-609.

Pettigrew, A.M., Ferlie, E.& McKee, L.(1992). *Shaping strategic change: Making change in large organizations. The care of the National Health Service.* London, UK: Sage.

Philips, S.L. (1981). Network characteristics related to the well being of normals: A comparative base. *Schizophrenia Bulletin, 7,* 117-123.

Polak, P. & Warner R., (1996). The economic life of seriously mental ill people in the community. *Psychiatric Services, 47,* 270-274.

Proctor, E. (2003). Research to inform the development of social work interventions. *Social Work Research, 27,* 3-5.

Proctor, E., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual and methodological training challenges. *Administration and Policy in Mental Health, (36),* 24-24.

Proctor, E. & Rosen, A. (2008). From knowledge production to implementation: Research challenges and imperatives. *Research in Social Work Practice, 18*, 285-291.

Prochaska, J.O. & Diclemente, C.C. (1982) Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice, 19,* 276-287.

Prosser, D., Johnstown, S., Kuipers, W., Szmukler, G., Bebbington, P., & Thornicroft, G., (1996). Mental health burnout and job satisfaction among hospital and community based mental health staff. *British Journal of Psychiatry, 168,* 334-337.

Pyke, J. & Lancaster, J. (1997). Training for partnership. *Psychiatric Rehabilitation Journal, 21*(1), 64-67.

Ralph, R.O. (2002). Recovery. *Psychiatric Rehabilitation Skills, 4* (3), 480-517.

Rapp, C. (1998). The active ingredient of effective case management: A research synthesis. *Community Mental Health Journal, 34* (4), 363-380.

Rapp, C.A. & Gosha, R.J. (2006).*The strengths model: case management with people with psychiatric disabilities* (2nd ed.). New York, NY: Oxford.

Raudenbush, S.W. & Bryk, A. *Hierarchical linear models: Application and data analysis methods (*2nd. Ed.*)* Thousand Oaks, CA: Sage.

Reber, A. (1993). *Implicit learning and tacit knowledge: An essay on the cognitive unconscious.* New York, NY: Oxford.

Rice, D.P. (1999). The economic impact of schizophrenia. *Journal of Clinical Psychiatry, 60* (1), 28-30.

Richards, Lyn. (2005). *Handling qualitative data: A practical guide.* Thousand Oaks, CA: Sage.

Robiner, W. (2006). The mental health professions: Workforce supply and demand, issues, and challenges. *Clinical Psychology Review, 26,* 600-625.

Robinson, G.K. & Bergenman, G.T. (1989) Choice on case management. *Policy Resources Incorporated.* Washington, D.C.

Rosen, A., & Mutschler, E. (1982). Correspondence between planned and actual use of interventions in treatment. *Social Work Research and Abstracts, 18,* 28-34.

Rosen, A. (2003). Evidence-based social work practice: challenges and promise. *Social Work Research, 27,* 197-208.

Samburijak, D. & Marusic, A. (2003). Mentoring: What's in a name? *Journal of the American Medical Association (23),* 2591-2692.

Savicki, V., & Cooley, E. (1987).The relationship of work environment and client contact to burnout in mental health professions. *Journal of Counseling and Development, 65,* 249-252.

Scull, A., (1981). A new trade in lunacy: The recommodification of the mental patient. *American Behavioral Scientist, 198,* 741-754.

Scheyett, A. & Blyler, C. (2002). The exploration of case management courses in university curricula. *Psychiatric Rehabilitation Journal, 26*(10), 86-90.

Shafir, E. & LeBoeuf, R.A. (2002). Rationalism. *Annual Review of Psychology, 53,* 491-517.

Shea, G.F. (2002). Mentoring: How to Develop Successful Mentor Behaviors (3rd ed.) CA: Crisp Publications.

Silverman, D. (2004). *Qualitative research: theory, method, and practice (*2nd ed*.)* Thousand Oaks, CA: Sage.

Spector, P.E. (1985). Measurement of human staff satisfaction: Development of the job satisfaction survey. *American Journal of Community Psychology,* 13, 693-713.

Stanard, R.P. (1999) The effect of training in a strengths model of case management on client outcomes in a community mental health center. *Community Mental Health Journal, 35*(2) 169-179.

Starnino, V. (2009). An integral approach to mental health recovery: Implications for social work, *Journal of Human Behavior in the Social Environment, 19,* 820-842.

Stein, C.H. & Craft, S.A. Case managers' experiences of personal growth: Learning from consumers. *Community Mental Health Journal, 43* (2), 183-195.

Stetler, C. C., Ritchie, J.A., Rycroft-Malione, J. Schultz, A.A., & Charns, M.P. (2009). Institutionalizing evidence based practice: An organizational case study of strategic change. *Implementation Science, (94),* 78, 1-19.

Stewart, D .W. & Shamdasani, P.N. (1990). *Focus groups: theory and practice.* Thousand Oaks, CA: Sage.

Strauss, A. & Corbin, J. (1988). *The basics of qualitative research.* (2nd Ed.).Thousand Oaks, CA: Sage.

Sullivan, W.P. & Rapp C.A. (1991) Improving client outcomes: the Kansas technical assistance consultation project. *Community Mental Health Journal, 27*(5) 327-336.

Tannenbaum, S. & Yukl, G (2002) training and development in work organizations. *Annual review of psychology, 43*, 399-441.

Terkelson, K.G. (1983). Schizophrenia and the family: Adverse effects of family therapy. *Family Process, 22,* 191-200.

Test, M.A. (1992). Training in community living. In R.P. Lieberman (Ed.), *Handbook of psychiatric rehabilitation.* New York, NY: Macmillan.

Thornicroft, G. & Bebbington, P. (1989). Deinstitutionalization: From hospital closure to service development: a review of the literature. *British Journal of Psychiatry, 13,* 1220-1232.

Thornicroft, G.(1991) The concept of case management for long term mental illness. *International Review of Psychiatry, 3,* 125-132.

Titler, M., Everett, L., & Adams, S., (2007). Implications for implementation science. *Nursing Research, 56* (4), 553-559.

Torrey, E.F. (2001). *Surviving schizophrenia* (4th Ed.) New York, NY: Harper Collins.

Torrey, W.C. & Wyzik, P.F. (2000). The recovery vision as a service improvement guide for community mental health center providers. *Community Mental Health Journal, 36* (3), 209-216.

Torrey, W.C. (1986). Continuous treatment team in the care of the chronically mentally ill. *Hospital and Community Psychiatry, 37,* 1243-1247.

Torstendahl, R. (2005). The need for a definition of profession. *Current Sociology, 53* (6), 947-951.

Tsemberis, S., Gulcer, L., & Wakal, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94,* 651-656.

Tunis, S.R., Stryer, D.B., & Clancy, C.M. (2003). Practical clinical trials: Increasing the values of clinical research for decision making in clinical and health policy. *Journal of the American Medical Association, 290,* 1624-1632.

Tunner, T. & Salzer, M. (2006). Consumer perspectives on quality of care in the treatment of schizophrenia. *Administration and Policy Mental Health and Mental Health Services Research, 33,* 674-681.

Warr, D.J. (2005). "It was fun….but we don't usually talk about these things": Analyzing social interaction in focus groups. *Qualitative Inquiry, 11,* 2000-255.

Weill, M. (1985). Professional and educational issues in case management practice. In M. Weill & J.M. Karls (Eds.), *Case management in human services practice.* San Francisco, CA: Jossey-Bass.

Wehrmann, K.C., Shin, H., & Poertner, G. (2002). Transfer of training. *Journal of Health and Social Policy (15)* 93, 23-37.

Withridge, T.F. (1989). The assertive community treatment worker: An emerging role and its implications for professional training. *Hospital and Community Psychiatry, 40*(6), 620-624.

World Health Organization. (2001). The World Health Report: 2001. Mental Health: New Understandings, New Hope. Geneva Switzerland: World Health Organization.

Yoon, J. & Bruckner J. (2009). Does deinstitutionalization increase suicide? *Health Services Research, 44(*94), 1385-1405.

Ziguras, S.J., Stuart, G.W. ,& Jackson, A.C. (2002). Assessing the evidence on case management. *British Journal of Psychiatry, 181*, 17-21.