UNDERSTANDING LEARNING ACTIVITIES OF CASEWORKERS

FOR THE DEVELOPMENT OF THEIR

PROFESSIONAL COMPETENCE


A Dissertation
presented to
the Faculty of the Graduate School
at the University of Missouri-Columbia

_____

In Partial Fulfillment
of the Requirements for the Degree

Doctor of Philosophy

_____

by

JANICE M. ISEMINGER

Dr. Joe F. Donaldson, Dissertation Supervisor

May 2007

The undersigned, appointed by the dean of the Graduate School, have examined the dissertation entitled

<div align="center">
UNDERSTANDING LEARNING ACTIVITIES
OF CASEWORKERS FOR THE
DEVELOPMENT OF THEIR
PROFESSIONAL COMPETENCE
</div>

presented by Janice M. Iseminger,

a candidate for the doctor of philosophy,

and hereby certify that, in their opinion, it is worthy of acceptance.

_____
Professor Joe Donaldson

_____
Professor Julie Caplow

_____
Professor Kimberly Hoffman

_____
Professor Von Pittman

_____
Professor Bonnie Zelenak

This dissertation is dedicated to my husband, Stephen E. Iseminger, without whose support and consideration I would not have finished my degree.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

Chapter

Chapter

Chapter

viii

LIST OF FIGURES

ABSTRACT

Learning activities involved in the development of professional competence were explored using the qualitative method of in-depth unstructured interview. Data were collected from participants who worked in two mental health community centers located in a metropolitan area in the mid-west. Nowlen's (1988) Update, Competence, and Performance Models of Competence, personal/professional knowledge, and situated/social learning theories constituted the theoretical foundations that informed the study. Supervisors nominated caseworkers who they perceived to be competent caseworkers. Eleven nominated caseworkers volunteered to participate and were interviewed about their professional learning activities. Supervisors and co-workers/team members were also interviewed concerning perceptions of the competence of the nominated caseworkers. Trustworthiness, consistency, and transferability were maintained by using multiple sources of data; member checks; a peer debriefer/coder; an audit trail; a rich and thick description of the study's context and the participants' perspectives; and triangulation of data collected from supervisors, nominated caseworkers, and peer team members. Four areas of competence emerged from the findings: personal, work, tools, and learning competence. Two major learning categories emerged: learning from formal opportunities and from experiences and situations. Four major relationships between learning activities and the development of professional competences were identified: integrated learning was related to the competence of learning, establishing external relationships was related to the tools competence, problem solving was related to work competence, and developing the "self" was related to personal competence.

CHAPTER 1

BACKGROUND OF THE PROBLEM


Many trends and forces are reshaping professional practice. McGuire (1993)

discussed three changes that she perceived that are occurring in professional practice—in

the "inherent characteristics of the professions" (p. 7), in the technological innovations

used in the professions, and in the conditions and settings of professional practice. She

predicted that the knowledge explosion will place demands on the professions for

increased professional specialization and division of labor. Technology has made

possible global communication information storage and retrieval systems. National and

multinational for-profit corporations are increasingly employing professionals, thus

limiting practitioners' autonomy and associated power, status, and prestige. Professional

practice has become increasingly controlled by formal government regulations.

Harris (1993) added insight into the trends and forces reshaping professional practice

when she wrote about the new expectations for professional competence. Professionals

must be able to make "judgments in specific situations, with conflicting values about

which problems need to be solved and how to solve them. . .[termed] practical

knowledge—[or] 'knowing how'. . . .[which] is best learned through practice and through

reflection on practice. . . ." (p. 29). Because most practice situations contain many

elements that are ambiguous, uncertain, and unstable, professionals must be able to use

their knowledge-in-action, learning-through-experience, reflection-in-action, and

reflection-about-action while solving problems and making decisions embedded in

practice contexts (Eraut, 1994; Schon, 1983).

Three other major trends and issues influence professional practice. Government, professional associations, and the general public are demanding professional accountability in the forms of recertification and re-licensure (Norcini & Shea, 1993). Issues have arisen about how best to connect professional education to practice (Cavanaugh, 1993). Issues have arisen also about what are the most effective techniques to use in order to teach critical thinking and problem-solving skills which are often regarded as the heart of competent professional performance in practice (Wales, Nardi, & Stager, 1993).

*Accountability* is an important word currently used when discussing professional competence—or how professionals are best able to minimize risk and errors while rendering the most effective and efficient service to clients. Continuing education has been the predominant medium through which to ensure such competence. Cervero (2000) characterized professional continuing education systems primarily as "devoted mainly to updating practitioners about the newest developments, which are transmitted in a didactic fashion and offered by a pluralistic group of providers (workplaces, for-profit agencies, and universities) that do not work together in any coordinated fashion" (p. 4). According to Cervero, two main problems exist in continuing education. Continuing education struggles between updating professionals' knowledge and improving their practice. Also, as Cervero asked: who or what will provide the most effective continuing education programs? As he concluded: "[T]he building of a coordinated system of continuing education for any profession is a political process that will be marked by fundamental struggles over the educational agenda and the. . .multiple stakeholders in continuing education" (Cervero, p. 11)

2

Thus, the professions share many fundamental problems, trends, and issues. How do professionals perform competently in practice contexts? How can professionals maintain accountability in their performance? How will professionals continue to learn in order to improve competence and accountability? These problems, trends, and issues have impacted allied health professions as practitioners have encountered many difficulties related to them.

The Impact of Problems, Trends, and Issues on Allied Health Practitioners

Allied health professional practice has changed in the past several years through efforts to reform the American healthcare system as the public, professional associations, and legal agencies have recognized the importance of maintaining professional accountability in today's healthcare settings. Payment providers, managed care, and the shift from inpatient to outpatient settings for patient care have contributed to more complex practice environments. Further, clinicians continually face problematic situations that call for sound clinical reasoning and critical thinking while practicing in contexts that are ambiguous and uncertain (The Education Council of the American Academy of Physician Assistants, 1996). Therefore, one main focus of accountability emphasizes the need for professionals to maintain up-to-date and effective use of skills, knowledge, information, and clinical judgment. The explosive growth of knowledge and information related to healthcare, the obsolescence of skills with advances in technology and scientific research, the public's demand for professional accountability, and the specialization and differentiation of professional practice have influenced the need for continued maintenance of professional competence (The Education Council of the American Academy of Physician Assistants) and learning activities that support the development and maintenance of competence.

The understanding of professional development and learning activities in professional competence with-and-in-practice is important for professional practice settings because "collaboration between health professionals is increasingly popular in organizations that are managed under the corporate governance model that demands clinical accountability and integrated care. . . ." (McCallin, 2001, p. 419). Professionals must be able to develop their competence in order to more effectively serve both clients and team members with effective clinical work processes. Professional competence development is important in all areas of healthcare practice settings, including the development of competence in professionals who practice in mental health contexts. Problems exist, however. According to Farkas and Anthony (2001),

> Historically, mental health and rehabilitation programs, both in-service and pre-service, have not placed a high value on training staff to serve people with severe psychiatric problems. . . .Many authors have lamented the lack of interest among the 'core disciplines' (social work, psychology, nursing, and psychiatry) in developing personnel trained to work with people who have severe psychiatric disabilities. . . .However, the shift toward community-based programs resulted in a growing demand by state mental health agencies for workers with the required knowledge and skills to staff them. . . .The shift toward community-based care also enhanced the growth of psychiatric rehabilitation programs, creating a further demand for trained personnel (pp. 119-120).

Managed health care in mental health mandates shorter hospital visits with greater emphasis on community-based treatment as an alternative for hospital treatment (Cohen, Gantt, & Sainz, 1997). Treatment services based in communities are less expensive and have improved accountability over hospitalization; community-based treatment produces better outcomes for patients with mental illness as defined by mental health stability. Social workers, psychiatrists, counselors, and caseworkers are but a few of the professionals who comprise the mental health teams that provide services for people with severe and persistent mental illness. Like other professionals, members of mental health

casework teams work in complex, ambiguous, uncertain, and "chaotic organization environments" (Stark, Skidmore, Warne, & Stronach, 2002, p. 178). Prescribed protocols for work decisions do not exist. Understanding their professional learning activities is important to helping members of mental health teams develop their competence in clinical work processes: "The field of mental health delivery is one of change and rapid development as new technology and research provide tools for clinicians and service providers who service persons with severe and persistent mental illness. . . .To achieve goals of normalization and community integration requires the availability of a range of quality mental health services which must be individualized and responsive to client needs" (Pathways Behavioral Healthcare, Inc., 1999, p. 1-2).

Casework teams deliver the majority of the services provided by community mental health centers and fulfill three basic functions (Peck & Norman, 1999): (a) continued proactive client care, (b) 24-hour access to treatment and crisis interventions, and, (c) an organizational response to requests for help from primary supports and care givers. However, every decision about a client's care involves risk: "The complexity and the difficulty of the balancing exercise which clinicians have to make daily as the guardians of the patient's health and public safety should not be underestimated. . . . Clinicians are often placed in an invidious position forced to choose between options which are not ideal. . . ." (Fish & Coles, 1998, p. 2). Therefore, understanding the professional learning activities that influence the development of professional competence of casework team members is important in order to ensure risk minimization, delivery of error-free quality services, and improved professional accountability.

Purpose of the Study

The purpose of this study was to identify and describe patterns in professional learning activities that caseworkers in a community mental health center experience in order to develop and maintain professional competence with-and-in practice. These practitioners provide direct psychosocial care for the treatment of clients who suffer from a severe and persistent mental illness.

Research Questions

While many researchers have studied professional learning in the contexts of other professions, this study concentrates on the professional learning activities of mental health caseworkers. The central question in this study is: From the perspectives of the study participants, what are the learning activities that caseworkers use in order to develop and/or maintain competence with-and-in professional practice? Two sub-questions lend understanding to the central question. According to the perspectives of the study participants:

1. What different learning activities do caseworkers use in their professional development?

2. How do these learning activities contribute to their professional competence development?

Theoretical Foundations

Nowlen's (1988) Update, Competence, and Performance Models were used in order to lend perspectives to understanding the dimensions of *competence*. Eraut; Schon; Schmidt, Norman, and Boshuizen; Curry, Wergin, and Associates; Dreyfus; and Epstein and Hundert's contributions to theories were incorporated into this study in order to understand the development of competence on a personal/professional basis through the

development of personal knowledge. Situated learning theories lent understanding to the development of professional competence in terms of the professional-within-the environment and within-interactions with environmental social factors.

*Nowlen's Models*

Nowlen (1988) developed three models that lend understanding to the dimensions of professional competence. The Update Model views competence as maintaining currency and relevancy with the knowledge base, theories, principles, and concepts associated with one's profession. The Competence Model views competence as the ability of professionals to effectively, efficiently, appropriately, and skillfully perform generic skills, tasks, and responsibilities—both cognitive and behavioral—that are mandated by professionals for competent performance, including maintaining currency and relevancy with the profession's knowledge base. The Performance Model likewise specifies that professionals must maintain updated knowledge and use of skillful behaviors but also views competence as being able to perform skillfully and effectively in interactions with other professionals within their practice. These models demonstrate how complex and difficult *competence* is to define in order to understand what "being a competent professional" entails.

*Personal and Professional Knowledge*

Personal knowledge includes those cognitive and behavioral skills that professionals bring to practice settings/contexts (Eraut, 1994). Knowledge is the accumulation of experiences that are produced by people through their actions, thinking processes, and conversations (Wenger, McDumott, & Snider, 2002). Knowledge resides in the skills, understandings, and relationships with people as well as in the tools, documents, and daily processes encountered within practice contexts. Knowledge

7

requires the ability to be engaged actively, to be able to accumulate data, facts, and information; and to put to use these data, facts, and information through engagement. Knowledge becomes a "product" (Tikhomirov, 2003, p. 357) that is generated by human thinking activity and is a means of performing this activity that is expressed in various personal and professional forms (Eraut, 1994): explicit knowledge, metacognition, practical knowledge, procedural knowledge, propositional knowledge, and tacit knowledge. The different types of knowledge that professionals bring to the practice settings play an important role in the acquisition of new knowledge, forming the foundational blocks that support new learning (Ellis, Worthington, & Larkin, 2004). Memory, cognition, thinking, and experience assist professionals in applying knowledge to learning situations when developing professional competence.

Memory assists professionals with thinking skills. Information from the environment enters a person's mind through the sensations of sight, hearing, touch, imagery, sounds, and vibrations. When processing information, mental activities are used in such a way as to put information into memory (which is a perspective on learning) or store information for use as needed at a later date (which is a perspective on remembering). Information, therefore, is encoded or acquired by the receiving person, stored or retained for future use, and retrieved from storage when needed.

Cognition is defined as "information acquisition and processing" (Scribner, 2000). Scribner made a connection between cognition and action: "thought is related to action in ways that facilitate psychological reconstruction of knowledge and operations brought to bear in the accomplishment of a task" (p. 15). Lave and Wenger (2002) added further insight into cognitive processes when they defined cognition as "understanding" (p. 17): it is "something a person does in his [sic] head, ultimately

involving mental representations of the individual. . . .[Understanding] arises out of the mental operations of a subject on an objective structure" (p. 17). According to Scribner, the mechanisms that underlie cognition include perception, recognition, information storage, information retrieval, language acquisition, comprehension and production, concept acquisition, problem solving, and reasoning.

For people, learning from experience (Eraut, 1994) depends upon on what is personal to them, on their perspectives, on their cognitive frameworks and expectations, on their available timeframes for reflection, on their abilities to make sense of experiences, and on their capabilities to link specific experiences with other personal knowledge. The process of experiential learning involves remembering experiences, evaluating them, and relating them to what is already known, thus developing "new knowledge" (Eraut) and transforming this new knowledge into new learning.

Personal knowledge influences professional practitioners in the development of their competence. In this study, personal and professional knowledge in the forms of personal experiences, cognitive and reasoning abilities, skillful professional performance with deliberative processes and skilled behaviors, relational skills, meta-processes, and reflection about performance informed the understanding of the learning activities caseworkers use in the processes of developing their competence.

*Situated/Social Learning Theories*

The former paradigm of learning focused on the individual as the unit of analysis: the person is seen either as a receiver of environmental stimuli or as the one who constructed his or her own learning (Rogoff, 1990). Today, the focus is on how learning occurs in social contexts (Brown & Duguid, 2000; Lave & Wenger, 2002; Rogoff, 1990).

9

Rogoff (1990) refined this concept through her idea that "the solutions to problems often occur in social situations that define the problems and provide the opportunities for learning from social transactions" (p. 6). Wenger (1998) posed that the central aspect of social learning concerns how humans are social beings and acquire knowledge through active engagement and participation in practice by interacting with other people and activities with-and-in their professional work contexts.

Thus, learning involves more than individualized mental processes, studying facts, or absorbing information. Social learning theories (Brown & Duguid, 2002; Lave & Wenger, 2002; Rogoff, 1990; Rogofff & Gardner, 2000) stress the idea that learning is situational and social. Resources for learning lie in practices that allow learners to make sense of and use information with others who "know how to use information" (p. 9). To learn means to interact with more experienced people, who model learning skills through apprentice-like activities that include observational learning, imitation, and modeling (Graves, 1998; Rutledge, 2000).

An emphasis on social learning is also provided by Curry, Wergin, and Associates (1993) when they note "Effective learning depends on the availability of peers and their willingness to act as mentors and coaches" (p. 19). Brown and Duguid (2002) described learning in communities of practice as: ". . .becoming a member of a community of practice and thereby understanding its work and its talk from the inside. Learning is more than acquiring information" (p. 126). Lave and Wenger (2002) added that "Learners participate in communities of practitioners and mastery of knowledge and skills requires newcomers to move toward full participation in the sociocultural practice of a community" (p. 29).

Rogoff (1990) presented the idea that learning consists of "task characteristics and cognitive performances" which are considered "in the light of the goal of activities and the interpersonal and sociocultural context" (p. 6). Learning is "the means and methods transmitted to them [learners] by others in the process of cooperative labor and social interaction" (p. 6).

Professionals use both cognitive processes and sociocultural processes as they engage in social processes. With observation and discrimination skills, they acquire the ability to ignore unimportant information in order to focus on the essential parts of a task (Rogoff, 1990). Communication allows for shared meanings to be developed through participation in tasks, including both words and actions (Rogoff). Professionals learn when others share rules with them, demonstrate practices through examples, and offer informal instruction (Rogoff & Gardner, 2000). Professionals learn by doing, by repeated practice in tasks rather than by merely watching or imitating a person in a learning situation (Rogoff & Gardner). Professionals learn by participating in cooperative activities in which their learning is supported as needed until they become competent in their learning skills and processes. In this study, situated/social learning theories informed the understanding of the learning activities caseworkers use in developing their competence.

<center>Definitions</center>

Three dimensions of *professional competence* were used in this study. The first dimension concerned the professionals' abilities to maintain up-to-date knowledge with their disciplinary-based theories and concepts specific to their professions. The second dimension focused on the professionals' effective, efficient, thorough, and appropriate

<center>11</center>

use of skills and abilities.  The last dimension concerned effective performance within the social and practice context.

*Professional learning* involves learning activities that are shaped through contexts in which professionals interact.  Professionals constantly engage in practice, job performance, and on-going interactions with the environment in which they work.  Such environments include "all physical surroundings, psychological and emotional conditions, and social and cultural influences affecting the growth and development of the person engaged in the learning process" (Tuijnman & van der Kamp, 1993, p. 57).  Thus, the culture, the environment, and peer interactions influence professional learning and development as well as performance in actual practice and work settings (Donaldson, 1997; Hara, 2001).

*Caseworkers* are the practitioners in community mental health centers who provide direct patient care in terms of psychosocial skills development.  In most instances, caseworkers have at minimum a bachelor's degree in a human service discipline.

The Role of the Researcher

In qualitative research, the researcher is an active participant in the research process because the researcher is the major data collection instrument and tells the stories from the participants' perspectives (Creswell, 1998).  According to Heppner and Heppner (2004), the researcher brings his or her assumptions and biases into the research process which will assist in shaping the researcher's "understanding and interpretations of the phenomena under analysis and the stories [the researcher] narrate[s]" (p. 137).  Strauss and Corbin (1996) concluded that the role of the researcher, through his or her immersion in the data, is to hear the voices of the participants and thus to represent these voices as

12

accurately as possible.  Through written rich and thick descriptions, the researcher

presents interpretations of the phenomenon under analysis (Heppner & Heppner, 2004).

I have ten years of experience in the mental health field, five years as a

caseworker and five years as the supervisor of a casework team.  Therefore, I was able to

interpret the reality of the research participants more clearly than other researchers who

do not have experience in the mental health field.  However, my experiences in the

mental health field may also have interfered with my ability to interpret participants'

experiences from more analytical perspectives.

<center>Limitations</center>

The research project was circumscribed by the number of participants and the

specific geographic area.  A small group of professional caseworkers and two mental

health centers were the focus of the research study, thereby limiting the sample and

settings in terms of size and location.  The results of this research project, therefore, will

not be transferable to every situation.

<center>Ethical Considerations</center>

The confidentiality of the participants was protected by assigning pseudonyms to

the individuals participating in the project.  Each participant was informed of the focus

and purpose of the study.  The researcher did not engage in any deception about the

nature of the study.  Participants included caseworkers, supervisors, and team

members/co-workers who signed a consent form before they became involved in the

project (See Appendices 1, 2, and 3).  Participants were able to withdraw at any time

from the project since their participation was strictly voluntary.  However, none

withdrew.  Most important, this research project was not conducted until permission was

granted to do the study by the Institutional Review Board (IRB).

<center>13</center>

Assumptions

Data collection was limited to interviewing caseworkers who were identified by their supervisors as being competent. An assumption was made that direct-line supervisors knew their caseworkers sufficiently in order to inform me of the workers who displayed professional competence in service delivery activities to clients and in interactions and performance with co-workers.

Significance of the Study

Understanding professional development and learning has become important today for various reasons: the shift to a service-providing economy, the globalization of work contexts, and the explosion of knowledge and technology. The ability to learn has become a vital skill in today's workplace and workforce in order to ensure transferability among employment contexts. The learning organization has developed into a setting in which many types of learning take place, "allowing employees to learn individually and collectively" (Merriam & Caffarella, 1999, p. 14). Such learning increases an employee's or a professional's ability to "manage diversity, complexity, and ambiguity" (Merriam & Caffarella, p. 14).

Understanding the factors affecting the development of professional competence is important, and it has been suggested that updated knowledge, competencies, and performance-in-practice play a significant role in the process of developing competence. As a result, exploration of the relationship between competence and learning activities would enhance the understanding of patterns associated with professional competence development, suggest ways to integrate theory with practice, and produce information that would add to the literature and perhaps even point to new directions for studies pertaining to professional competence-in-practice. It suggested ways to integrate some of

these professional learning processes into the education/learning situations with which clinicians must have experience in order to develop their professional competence.

This study was designed to expand the understanding of professional competence and explore associated learning activities. By expanding the knowledge concerning the linkage between competence and learning activities and the types and situations associated with the developing professional and competence-in-practice, it was possible to increase the effectiveness of the professional practice of mental health caseworkers, the delivery of services, and the attainment of continued accountability or point out potential deterrents that restrict the development of these processes.

CHAPTER 2

REVIEW OF THE LITERATURE


The study examined the professional learning activities that caseworkers who work in the mental health field experience in order to become and/or maintain competence in professional practice. For the broader literature base, a literature review was conducted by reading information about *competence*. First, a search was executed via *Medline*, *CINAHL*, and the Internet using the words *professional*, *clinical,* and *competence* in the titles of scholarly journal articles related to healthcare professional practices. Articles were then limited to those edited in journals published in the United States from the years 2000-2005 in order to limit the number of journal articles; this search yielded a total of 87 journal articles.

In addition, information was drawn from the works of Eraut (1994); Curry, Wergin, and Associates (1993); LaDuca (1980); LaDuca, Engel, and Risely, (1978); Wenger (1998); Rogoff (1990); Vygotsky (1986); Engestrom (2000); Schon (1983); Bennett, 1996); Dreyfus (1998); Schmidt, Norman, and Boshuizen (1990); and Brown and Duguid (2002). This broader literature base added insight into the understanding, conceptualization, and assessment of *professional competence*. By using Nowlen's (1988) Update, Competence, and Performance Models as lenses through which to view professional competence, clearer understandings developed about how to conceptualize professional competence. Conceptualization of competence was limited to that of the competence of healthcare practicing professionals.

First the complexities and difficulties of defining professional competence will be discussed, using Nowlen's Models as the basis for the discussion. The Update Model

looks at how professionals must remain current with their professional knowledge-base. The Competence Model focuses on maintaining one's professional skills as well as remaining current with the professional knowledge-base. The Performance Model views professional practice through the social interactions of professionals located within a performance period. In addition, LaDuca's (1980) Situated Model of Competence lends understanding to professional performance in terms of the interactions of activities among clients, professionals, the clinical problem, and the context in which the activity/situation is located. Situated factors include the performance period, time, activity processes, and all interactional processes. The role of expertise is also addressed in professional performance.

For the literature review concerning competence of mental health caseworkers, the review of the literature was obtained from an Internet search of major psychiatric-related journals using *mental health training, education, mental health competencies, psychiatric rehabilitation, psychosocial rehabilitation, recovery* and *professional development* as key terms; 73 articles were obtained and covered the years 1986-2005. The review of the literature was framed through referencing the background information obtained from the broader review of the literature concerning healthcare professional competence, using Nowlen's Update, Competence, and Performance Models as lenses through which to view mental health professional competence.

Mental health caseworkers work within the psychosocial rehabilitation model of patient care (which emphasizes psychiatric rehabilitation) and the recovery model for psychiatric care. Psychosocial rehabilitation is an emerging discipline which does not have a unified disciplinary base; therefore, the core principles of both models are presented.

17

The approach for this review of the literature is to first introduce three different types of competence: staying up-to-date with the knowledge base of one's profession; maintaining effective and efficient use of skills, abilities, and aptitudes; and performing effectively, efficiently, thoroughly, and appropriately in-and-within practice settings and with other participants involved in the practice context. This review addresses issues broadly and then becomes more narrow and specific in order to address mental health caseworkers. After the broad perspectives about competence are addressed, each type of competence will be illustrated using health care examples drawn from medicine and allied health. Last, each type of competence will be applied specifically to caseworkers who work in psychiatric rehabilitation.

<center>The Complexities of Professional Competence</center>

Professionals undergo an educational process, completing an educational program that is designed to provide experiences in the core clinical, technical, and problem-solving skills fundamental to competent practice. After graduation, the prospective professional successfully passes some type of national certification/licensure program that verifies to the various stakeholders that the entry-level practitioner has demonstrated a minimal level of knowledge and skills. But the process of ensuring competent professional practice must go on throughout the lifetime of the practicing professional.

Part of the complexities and difficulties with the conceptualization of competence concerns the differing perspectives of this word (The Education Council of the American Academy of Physician Assistants, 1996). According to the Education Council of the American Academy of Physician Assistants, in the 1970's, *competence* was viewed from a one-dimensional perspective of specialized knowledge. In the 1980's, the term was defined to include the knowledge, skills, and abilities observable in performance. In the

<center>18</center>

1990's, the term was expanded to include the important role the professional practitioner has in specific practice settings. Not only did the professional need to perform clinical tasks, but also, he or she had to be able to interact competently with both patients and other practicing professionals.

Other views concerning how to conceptualize competence exist that also complicate its conceptualization. Does the term mean that one possesses a special capability acquired from "intellectual training" or a "specialized intellectual technique" acquired through "prolonged training'—in other words, intellectual competencies as opposed to "practical skills" (Eraut, 1994, p. 164)? These thoughts in turn raise questions about how to identify and understand if a person is properly qualified to do a job through performance; what types of contextual situations are required for competent performance; and what part do professional roles, tasks, and situations play in the development of competence.

*Webster's Dictionary* defined *competence* as sufficiently able, qualified, or adept and *competency* as ability or fitness. Competence is often conceptualized as the ability to perform with sufficient skills. People (especially those designated as "experts in the profession") have usually taken the concept *competence* for granted, intuitively knowing if a person is competent or not. When applied to professional practice, competence is a much more global term (The Educational Council of the American Academy of Physician Assistants, 1996), because this term represents the sum total of the knowledge, skills, and abilities (competencies) necessary for practice.

Huggins (2003) discussed the idea that competence includes "knowledge, skills, attitudes, performance, and levels of sufficiency" (p. 41). Brenner's definition of *competence* provided another view of the dimensions of *competence*: "the ability to

demonstrate appropriate professional behaviors with desired outcomes" (cited in Gates, 2003, p. 2). Brenner concluded that a competent professional must be proficient with discipline-specific knowledge, technical skills, and problem-solving abilities as well as possess the characteristics of intellectual ability, personality traits, motivation, attitudes, and values appropriate to the profession and practice.

Thus, competence can be conceptualized as being up-to-date with one's professional skills and knowledge, adequately and sufficiently possessing the skills necessary to perform one's professional job proficiently, and being able to use individual personal skills in specific social situations effectively and efficiently. Nowlen (1988) devised three models that provide lenses through which to view these three dimensions of professional competence.

*Keeping Up-to-Date with Knowledge and Skills: The Update Model*

The Update Model (Nowlen, 1988) is the first model of three models that will be used as lenses to view *competence*. The Update Model emphasizes the idea that practicing professionals must maintain a minimal knowledge-base. Being up-to-date is also a principal part in the relationship between knowledge, skills, and performance. Professionals, as viewed through this model, are consumers of knowledge that they use in practice settings. When used as a lens for viewing professional competence, the Update Model asks, "What must a professional know?" (Nasseh, 2004, p. 2).

Professionals must keep up-to-date with their knowledge because of the rapid rate at which knowledge increases, the need for organizations to remain competitive in the market place, the public's demand for professional accountability, the rapid rate at which technology expands, new governmental mandates, and the threat of malpractice suits (Lenburg, 2000). Therefore, professional organizations mandate that their members

20

maintain up-to-date knowledge about the profession's background, trends, and disciplinary knowledge base, often through mandatory continuing education as a prerequisite for re-licensure (Epstein & Hundert, 2002). These organizations also mandate that their members participate in continuing education as a mechanism to become re-certified in order to continue working as a professional (Epstein & Hundert).

The precepts of the Update Model are consistent with ideas from other models and theories. For instance, McGaghie (1993) discussed the idea that professional schooling is the first source of credentials to which a prospective professional is exposed; without a diploma or certificate from an accredited professional school, the person is not qualified to enter professional practice: "One has to earn a professional degree as a prerequisite to obtaining a license to practice" (McGaghie, p. 235). Professionals undergo many years of education, being assessed for knowledge at the end of their formal educational process. Then, after graduation, the prospective professional successfully passes some type of national certification/licensure program that verifies to the various stakeholders that the entry-level practitioner has demonstrated a minimal level of knowledge and skills.

Eraut (1994) discussed the use of propositional knowledge—which he termed "technical knowledge" (p. 102)—as the type of knowledge that the professional learns in pre-service training in higher education. Propositional knowledge includes the theories, concepts, and principles related to one's profession as well as to a professional's actions and decisions. This process of ensuring up-to-date skills and knowledge of competent professional practice goes on throughout the working life of a practicing professional.

*Competence of Physicians and Allied Health Practitioners as Framed by Nowlen's*

*Update Model*

The Update Model focuses on how professionals must remain current with their professional knowledge base.  For example, all physicians educated in the United States complete approximately four years of education in a medical school, earning the doctor of medicine (MD) degree.  After medical school, physicians undergo up to seven years of graduate medical education, the length of training depending on the specialty the physician pursues.  After completing residency training, physicians must then pass the medical specialty board certification in order to practice.  They must then continue to update their certification by participating in continuing education activities, participating in fifty or more hours of continuing medical education annually.  Physicians must be licensed to practice in the United States; licenses are granted to ensure that the physicians have successfully completed the required sequence of training.

As with physicians, allied health practitioners must remain current with their professional knowledge base in order to continue to practice.   For example, nurses must graduate from an approved/accredited school with a nursing degree and then engage is an examination process in order to obtain a nursing license.  All states require periodic renewal of these licenses, often involving continuing education.

 Like nurses, physical and occupational therapists must obtain a minimum of a baccalaureate degree from an accredited higher education institution; a master's degree is more common for practice as a therapist.  After graduation, physical and occupational therapists must pass a national examination in order to obtain licensure for practice.  And, as nurses must do, physical and occupational therapists must renew their licensure periodically by updating their credentials through continuing education.

As with other allied health practitioners, therapeutic recreation specialists must obtain a bachelor's degree from an accredited higher education institution and then pass a national examination in order to become certified for practice. They, too, update their certifications periodically through continuing education.

*Competence of Mental Health Professionals as Framed by Nowlen's Update Model*

The Update Model looks at competence from the viewpoint of finishing professional schooling as the first step in becoming a professional. Then, a professional keeps up-to-date with knowledge and skills through participation in formal and informal continuing education/learning processes. In most instances, professionals have undergone some sort of licensure/certification process. Physicians and allied health practitioners must remain up-to-date with their profession's knowledge base. Another category of allied health practitioners who must remain current with their knowledge base consists of caseworkers who practice psychiatric rehabilitation in the mental health field.

Professional community mental health service provision is relatively new. The introduction of antipsychotic medications during the 1950's into the treatment of persons suffering from severe and persistent mental illness changed the methods of mental health patient care. These medications assisted in stabilizing the brain's chemistry thereby reducing symptomatology, hallucinations, and delusional and disorganized thinking. Because these new medications enabled the population suffering from psychiatric disabilities to become more stable with related symptoms, many such people were discharged from psychiatric/state hospitals to live in community settings in the least restrictive environments possible. Responsibility for treatment shifted from hospitals to local communities with hospitalizations for crisis and decompensation.

However, many of the persons suffering from mental illness lived in poverty, were socially isolated, had low functioning ability, and subsisted with the help of financial welfare benefits (Boyd, 1994). A variety of services were needed to help improve the quality of their lives, increase their vocational and social skills development, and maintain their stability (Lamb, 1994). Through the establishment of day/community treatment programs, treatment was rendered through outpatient services (Martini, 1996). This shift toward community-based programs has resulted in an increased demand by mental health agencies for workers "with the required knowledge and skills to staff them" (Farkas & Anthony, 2001, p. 120).

In 1977, The National Institute of Mental Health (NIMH) launched the Community Support Program (CSP) (Anthony, 1992; McReynolds, 2002). The Institute defined these community services as a "community support system" which was an alternative to hospitalization (Martini, 1996). The goal was to "treat the patient as close to his [sic] familiar environment as possible" (Anthony & Liberman, 1986, p. 542). The primary current treatment discipline used today in the treatment of people who suffer from severe mental illness is called psychosocial rehabilitation, which is delivered through these Community Psychosocial Rehabilitation Programs. Case management is the essential direct care service (McReynolds, 2002), with community support workers delivering the bulk of the treatment interventions. "In the field of psychiatric or psychosocial rehabilitation alone there has been an increase in the supply of workers from 35,000 in 1994 to 100,000 in 1996" (Farkas & Anthony, 2001, p. 121). 77% of these workers provide direct service (Farkas & Anthony).

The community support worker must be knowledgeable in two areas of service treatment provision when working with people with psychiatric disabilities: psychiatric

rehabilitation and the recovery model of treatment. These two concepts form the core disciplinary knowledge-base for the professionals working in psychosocial rehabilitation. However, psychosocial rehabilitation does not have an unified knowledge base; the majority of the professional community support workers have diverse disciplinary or educational backgrounds obtained prior to working in the mental health profession (Farkas & Anthony, 2001).

*Psychiatric rehabilitation.* Traditionally, medication and psychotherapy have been the two major treatment approaches for people with psychiatric disabilities, with little attention given to improving functional limitations and handicaps. Currently, psychiatric rehabilitation is the main component of psychosocial treatment services provided by community-based support systems and serves persons with severe and persistent mental illness as a rehabilitation modality (Cook, Kozlowski, & Rozzano, 1993; Peterson, Patrick, & Risemeyer, 1990). Psychiatric rehabilitation enables the person served to develop skills needed to remain in the community and to offset life stressors (Cohen, Gantt, & Sainz, 1997). By providing interventions that address the functional deficits of the client but do not increase stress levels, psychiatric rehabilitation "attempts to break the cycle of relapse and re-hospitalization" (Brekke, Long, Nesbitt, & Sobel, 1997, p. 464).

Psychiatric rehabilitation is a relatively new concept in the treatment services for persons with mental illness. Bachrach defined psychiatric rehabilitation as a therapeutic approach to treatment that encourages the most effective development of a person's capacities (Bachrach, as cited in Boyd, 1994). Anthony and Liberman (1986) conceptualized psychiatric rehabilitation as the recovery of functioning to the maximum through skills learning and environmental supports. According to the International

Association of Psychosocial Rehabilitation Practitioners (as cited in Boyd, 1994),

psychiatric rehabilitation is "the process of facilitating an individual's restoration or

rehabilitation to an optimal level of independent functioning in the community" (p. 15).

Psychiatric rehabilitation helps the person "perform those physical, emotional,

social, and intellectual skills needed to live, learn, and work in the community with the

least amount of support from agents in the helping professions" (Anthony & Liberman,

1986, p. 542).   The professional either teaches the specific skills needed to function in

the community or arranges the necessary environmental supports that will compensate for

deficits in skills (Anthony & Liberman).  The principal goal of psychiatric rehabilitation

is the prevention of unnecessary re-hospitalizations through symptom stability and

functional skills development (Cook, Graham, & Razzano, 1993).

Psychiatric rehabilitation is an individualized process for the persons in services.

Treatment provided is based upon several important treatment principles (Boyd, 1994;

Cnaan, Blackertz, Messinger, & Gardner, 1989; Cook et al., 1993; Lamb, 1994).   The

person served can acquire skills and needed support systems and is involved as a partner

in his or her treatment plan and design.  Treatment services are provided in as normal an

environment as possible and are based on the unique needs, abilities, and deficiencies of

each person served.  The client is able to learn social, vocational, educational, and daily

living skills; and professionals use the environment to assist in developing these skills.

Emphasis is on a client's social well-being rather than on the medical model of care, and

early interventions offset relapse and crisis; therefore, treatment focuses on the client's

strengths, talents, skills, and improvement of abilities rather than on his or her

weaknesses and/or pathologies.

The rehabilitation process begins with an assessment of the individual's competencies and with an identification of environmental supports and stressors (Levin & Brekke, 1993). Interventions are formulated and individualized to meet the different needs of different individuals (Brekke, Long, Nesbitt, & Sobel, 1997; Hansburg, Solomon, & Meyerson, 1990; Kazarian & Joseph, 1994; Nagaswami, 1995). Social supports help to develop socialization skills so that the person can participate in meaningful social and leisure activities. Through independent living skills learning and development, the client learns activities of daily living, appropriate role behaviors, and medication management. Through education, the individual gains needed insight to manage symptoms in order to decrease chances of crisis and learns coping mechanisms and stress management techniques in order to remain stable. Through vocational skills development, the client becomes employable or acquires the necessary financial support services for living expenses. Through clinical supports, the client has access to protective living arrangements based on functional ability; crisis interventions that help prevent re-hospitalizations; medication monitoring; and community integration support through case management services and day programs provided by outpatient treatment centers.

*Recovery model.* The concepts contained in psychosocial rehabilitation have also influenced the application of 'recovery concepts' to psychiatric services (Jacobson & Curtis, 2000). In psychosocial rehabilitation, recovery refers to functional ability: "To recover is to improve and maintain functioning in one or more of the major domains of life: work, housing, relationships, recreation—and by so doing to live a satisfying, hopeful, and contributing life even with the limitations caused by the illness" (Jacobson & Curtis, p. 334) According to Jacobson and Curtis, "recovery has been applied to the process of learning to live a full life through the restoration of normal health and

27

functioning; the challenge is wresting control of one's life away from a chronic disease" (p. 333).

Knight  (2004) stated that the "term 'recovery' is increasingly being used to describe a movement toward a more humane and ultimately more effective approach to the treatment of people with serious mental illness.  The recovery model has some well-defined elements:  hope, choice, support, and education" (p. 2).  Recovery, thus, includes helping the client choose meaningful life goals and teaching skills that assist the person with a severe mental illness to become self-sufficient by learning or re-acquiring skills lost due to the symptoms and debilitating effects of the mental illness (Knight).  The major goal of recovery is to assist the client to return to a level of functioning that will allow the client to work and live independently.

Recovery can be seen as a "continuum" (Fitzpatrick, 2002, p. 2).  The medical model of recovery focuses on the ideas that once a serious mental illness is diagnosed, then the client needs medication to help stabilize symptoms, with the ultimate goal of maintaining a life that is symptom-free.  Chances of recovery depend on the diagnosis, the duration of the illness, and the level and effects of the disability.  The rehabilitation model of recovery focuses on the ideas that once a person has acquired a mental illness and diagnosis, with medication, skills training, and psychological and social supports, the client can achieve a life that approximates what life would have been without the mental illness.  The empowerment model of recovery focuses on ideas of the use of peer support, wellness programs, empowerment, and meaningful relationships with people who believe in the client's capacity to recover from a mental illness.

Staff at the Mental Illness Recovery Center (2005) wrote about key points in the recovery process.  During the recovery process, clients who are disabled with a mental

illness and in professional treatment services are taught skills that will enable them to learn to manage their symptoms. Skills taught include symptom management, social skills, vocational and educational skills, and daily living skills. Supports are also put into place to assist clients with recovery--crisis response when needed, access to brief hospitalizations for crisis interventions, medications, and professional support from mental health providers. Through assistance, clients acquire basic material resources in the forms of safe/livable housing, healthcare, transportation, money management, and food. Family and social supports are developed in order to connect clients to family, friends, peers, and neighbors in meaningful and beneficial ways. Clients are encouraged to participate in meaningful activities in order to connect to the community—through jobs, education, volunteering, and participation in group activities. The ultimate goal is empowerment and independence of clients by their learning to makes their own choices and decisions about their lives.

*Problems with education and training.* According to Farkas and Anthony (2001), professionals from varied disciplines provide services to people who suffer from mental disabilities. Community support practice is not limited to a specific discipline; community support workers come from human service disciplines of social work, psychology, medicine, psychiatry, nursing, sociology, occupational therapy, and therapeutic recreation (Anthony, 1992; Aubry, Flynn, Gerber, & Dostaler, 2005; Farkas & Anthony, 2001). This "eclectic nature of community support" (Farkas & Anthony) poses problematic areas in the education and professional development of such workers: "the field of psychiatric rehabilitation has a history of employing practitioners with a high school diploma or bachelor's degree who have been trained on the job. . ." (Anthony, 1992, p. 167). Liberman, Hilty, Drake, and Tsang (2001) echoed this thought as they

29

stated that the majority of the workers in psychosocial rehabilitation are paraprofessionals.   In addition, the various disciplinary educational/professional schools do not provide specific studies in psychosocial rehabilitation (Anthony, 1992; Farkas, & Anthony, 2001).   Farkas and Anthony concluded that "many authors have lamented the lack of interest among the 'core disciplines' . . .in developing personnel trained to work with people who have severe psychiatric disabilities" (p. 1).  In addition, few community mental health centers require any type of certification or licensure for people to work in community mental health centers.  The Association of Psychosocial Rehabilitation Practitioners has established a certification process for people who work in psychosocial rehabilitation; however, very few community mental health centers mandate their workers to undergo this process and become certified.

Therefore, as Anthony (1992) stated, most of the knowledge about psychosocial rehabilitation is acquired by mental health workers through on-the-job-training processes. According to McReynolds and Garske (2003), the goal of training mental health workers stems from the goals and objectives of rehabilitation in general:  "for practitioners to acquire the knowledge, the skills, and the values necessary to affect positive client outcomes" (p. 16).  McReynolds and Garske concluded that, without proper training and exposure to effective psychiatric rehabilitation strategies,

> The unprepared rehabilitation professional can become overwhelmed and unable to contribute to successful intervention planning with individuals who have psychiatric disabilities. . . .Because individuals with psychiatric disabilities often struggle with a wide variety of challenges and needs, rehabilitation professionals need training in the provision of effective intervention strategies regarding positive. . .outcomes for individuals who have psychiatric disabilities (p. 15).

Practical solutions for meeting training needs do exist.  McReynolds and Garske (2003) suggested that possible solutions include covering psychiatric rehabilitation

principles, interventions, and strategies within programs such as counseling, nursing, and social work.  Also, disciplines could establish specialized psychiatric educational tracks within the core areas of the disciplinary study or develop and offer special topics courses covering psychiatric rehabilitation.  Research papers, special projects, and internships are other possible solutions.

In professional development, local professionals who work within the field of psychiatric rehabilitation could host workshops, in-service programs, and lectures about this type of rehabilitation.  As Anthony (1992) concluded:  training should be made a "viable component" (p. 167) of mental health systems through professional development and in-service programs.  As can be viewed through the review of the literature, a program of study that pertains to psychiatric rehabilitation and related recovery models only rarely exists in disciplinary professional education; most knowledge about rehabilitation and recovery is learned in the majority of cases from on-the-job experiences and training.

*Maintaining Skills and Abilities to Perform:  The Competence Model*

Not only is maintaining up-to-date knowledge about one's profession necessary; maintaining one's professional capabilities and abilities is equally as important.  Nowlen's (1988) Competence Model is the second model that focuses on professional competence.  The model focuses on being up-to-date with professional skills and knowledge; but the model goes beyond staying current and focuses, in addition, on the development of effective use of individual skills needed within professional practice.

The Model looks at the up-to-date knowledge and abilities that meet professionals' specified requirements in the sense of being able, adequate, suitable, and capable to perform a professional role.  Nowlen (1988) stated that competence concerns

31

those intellectual skills, attitudes, and performance abilities that are stated in performance terms of the individual. These capabilities cover a broad range of behaviors and objectives that involve a "synthesis of behavior objects as well as some elements of covert behavior" (p. 32). Current and relevant knowledge is combined with generic or general skills that are valid across a range of jobs and professional practices. When used as a lens for viewing professional competence, the Competence Model asks, "What is the professional best capable and able to do?" (Nasseh, 2004, p. 4). Nowlen (1988) concluded that

> Competence is most generally defined as marked or sufficient aptitude, skill, strength, judgment, or knowledge without noticeable weakness or demerit. Implicit in definitions of competence are two ideas: context [i.e., the individual working as a professional], that is, a job, role, function or task; and, requirements, that is, context-related demands or standards expressed in terms of level of expectation or sufficiency (p. 31).

Eraut (1994) echoed the essential idea of the Competence Model when he stated that competent use of skills needs to be identified in order to understand what constitutes the essence of competent professional work. In this sense, the focus is upon the analysis of tasks and skills required for each individual practitioner to perform across a variety of jobs and contexts. Eraut also discussed generic approaches to competence when he stated, "generic competences are concerned with what enables [professionals] to do [what is required of them]; and this includes what are sometimes called 'personal qualities'" (p. 172). Eraut further stated that generic competences are used in order to distinguish between average and top-notch workers, and he noted that generic competencies are designed to be valid across a range of job areas.

Another example of generic skills is identified by Norman (as cited in Eraut, 1994). Norman stated that a generic model of competence in medicine includes five

categories.  Clinical skills give professionals the ability to gather clinical information and interpret what is significant about the patient's information.  With knowledge and understanding, professionals have the ability to remember relevant clinical information in order to provide appropriate care for patients.  Professionals use appropriate interpersonal skills in order to maintain appropriate interactions with patients.  With effective and efficient problem solving and judgment skills, professionals are able to apply knowledge and skills in order to diagnose and manage client problems efficiently and effectively. With the use of technical skills, professionals are able to use special processes and practices specific to solving client problems.

*Competencies in Healthcare as Framed by Nowlen's Competence Model*

In another important example of generic skills, The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) have identified six general competencies (or abilities) that are essential for professionals to be able to use, and these competencies have been mandated for use in competent healthcare practice (The American Board of Internal Medicine, 2004; Epstein & Hundert, 2002; Leach, 2000; Lypson, Frohna, Gruppen, & Wolliscroft, 2004):  patient information management, clinical practice procedures, application of discipline knowledge, interpersonal and communication skills, professionalization, and systems-based practice.  The Institute of Medicine has made several reports that identify the importance of using these skills in alignment with ensuring quality patient care and safety when practicing professional healthcare.

*The Institute of Medicine:  Maintaining Quality Care.*  The Institute of Medicine (IOM) focuses on policy issues concerning public health.  In 1988, the IOM defined public health as "the collection of society's efforts to achieve conditions in which people

can be healthy" (Tilson & Gebbie, 2004, p. 343).  The IOM also stated that "it is an essential service of public health to assure a competent public health and personal healthcare workforce" (p. 347).  The IOM concluded that "All those in the public health workforce should be competent, in all competency domains, at the level to which they will be called upon to apply the competency" (p. 348).

According to the IOM, eight domains for public health practice competencies exist:  analytic/assessment skills, basic public health science, cultural competency, communication, community dimensions of practice, financial planning and management, leadership and systems thinking, and program development and planning.  The Institute for International Medical Education (2003) took the emphasis on competent professional practice in health care even further when this Institute stated that professionals should demonstrate "professional competencies which will ensure that high quality care could be provided with empathy and respect for patients' well-being" (p. 2).

The IOM (Alliance for Community Health Plans, n.d.) defined quality of care as: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"(p. 2).  Six goals for quality health care are listed by the IOM:  care that is safe, effective, patient-centered, timely, efficient, and equitable.  Patient care and safety are two important issues involved with quality of healthcare practices.  The Institute for International Medical Education (2003) concluded that the teaching of patient safety and minimal medical errors should be implemented during medical school and continued throughout medical personnel's residency and clinical practices.  Both Institutes recognize the importance of aligning patient safety and care issues with the ACGME and ABMS core competencies of patient information management, clinical practice

procedures, interpersonal and communication skills, professionalization, application of discipline knowledge, and systems-based practice.

*Personal Knowledge Factors in the Development of Competence*

Competencies include individual professionals' personal knowledge factors that influence their competence; such personal knowledge lends further understanding to Nowlen's (1988) Competence Model. In addition to the use of propositional knowledge and competencies, other factors specific to individual professional practitioners' competence include the professionals' use of personal experiences, personal knowledge, cognitive and reasoning abilities, skillful professional performance with deliberative processes and skilled behaviors, relational skills, meta-processes, and reflection about performance.

*Personal experience and knowledge.* Professionals have had a "continuous flow of experiences" (Eraut, 2004, p. 5) throughout their lives. Some discrete pieces of experiences catch the attention of the professionals and form sets of impressions that are committed to long-term memory. Such impressions form the bases for developing intuitive understanding of situations: "Throughout our lives we make assumptions about people and situations based on aggregated information [derived from experiences] which we cannot easily recall and may not even be able to describe. We instinctively 'know' that a particular action is appropriate" (Eraut, p. 7).

Personal experiences thus assist in the development of professional competence when personal experiences are translated into personal knowledge: "personal knowledge is what individual persons bring to situations that enable them to think, interact, and perform" (Eraut, 2004, p. 17). Personal knowledge includes personalized propositional knowledge, impressionistic knowledge of people and situations, competencies, memories

of episodes and events, and knowledge about oneself and attitudes/emotions. Eraut stated that accumulated personal experiences develop into a personal knowledge system that assists the professional in developing the intuitive ability to address new situations by "recognizing a pattern and activating a readily available script, which they [professionals] never consciously attempt to compile" (Eraut, p. 7). Personal experiences influence the development of professionals' tacit understanding when they need to draw upon such experiences when making decisions about professional performance.

*Cognitive and reasoning skills.* In addition to summarizing theories about the role that personal knowledge plays in the acquisition of competent performance, Eraut (2004) also summarized other theories that involve the development of increasingly more complex cognitive and reasoning skills that practicing professionals develop as they increase their competence in work-related performances. Schmidt, Norman, and Boshuizen (cited in Eraut, 1994) proposed the Four-Stage Model of Clinical Expertise. Stage 1 involves the development of "elaborated causal networks" (p. 132), "interrelated detail[s]" (p. 132) that add to professionals' understandings of clinical processes, the use of accumulated experiences that professionals acquire from working with patients, and the professionals' development of "scripts" (p. 132). Experienced and competent professionals use "tacit knowing-in-action:" the practitioner "develops a repertoire of expectations, images, and techniques. He [or she] learns what to look for and how to respond. . . .His [or her] knowing-in-practice becomes tacit, spontaneous, and automatic" (Harris, 1993, p. 30).

The Dreyfus Model (cited in Eraut, 1994) is another model that focuses on the development of professionals' cognitive and reasoning skills. The Dreyfus Model emphasizes that a professional advances through the five stages of professional

development: novice, advanced beginner, competent, proficient, and expert, gaining

experiences with using "perception and decision-making rather than routinized action"

(Eraut, p. 124). The professional begins to intuitively act in abnormal circumstances with

"analytical approaches" and "tacit understanding" (Eraut, p. 124). The professional

practitioner becomes able to engage in "skillful performance" (Eraut, p. 126).

*Skillful professional performance.* Eraut (1994) discussed some factors that are

related to skillful professional performance—skilled behaviors and deliberative

processes. He stated that skilled behavior is one of the core ingredients in competent

professional activity performance, especially when used in conjunction with the

professional's knowledge and skills. He defined "skilled behavior" as a "complex

sequence of action that has become so routinized through practice experience that it is

performed almost automatically" (p. 111). Likewise, deliberative processes comprise a

core part of professional work and activity. According to Eraut, deliberative processes

include planning, problem solving, analyzing, evaluating, and decision-making.

Deliberative processes also include the use of propositional knowledge and professional

judgment. Two types of information are needed when using deliberative processes:

"knowledge of the context/situation/problem and conceptions of practical courses of

actions/decision options (Eraut, p. 113). These two processes allow a competent

professional to demonstrate skillful performance.

*Relational skills.* Relational factors specific to individual professionals also

influence professional competence. For instance, Epstein and Hundert (2002) stated that

professional competence involves a "relational function" (p. 227). Dimensions of these

generic competencies include effective communication, building therapeutic

relationships, responding to clients/patients' emotional situations, including

clients/patients in decision-making processes about treatment, and reducing clients/patients' anxieties about treatment and other issues. Because relational factors assist in effective treatment outcomes for patients, effective communication, emotional support, and interpersonal skills are needed for professional practice (Callahan, Erdman, Hojat, et al., 2000; Duffy, Gordon, Whelan, Cole-Kelly, & Frankel, 2004; Epstein & Hundert, 2000; von Gunten, Ferris, & Emanual, 2000).

*Meta-processes.* Eraut (1994) discussed the role of meta-processes in conjunction with professional competence. He defined meta-processes as "the thinking involved in directing one's own behavior and controlling one's engagement in the other processes" (p. 115). Meta-processes involve self-evaluation of what one does and thinks, redefinition of priorities, and self-management of one's activities and behaviors. In other words, meta-processes involve the effective use of skills involved in how professionals control their thinking, use deliberative processes when engaged in situations, conceptualize problems and solutions, and continuously evaluate personal progress in working through activities.

*Reflection.* Reflection is also an important individual professional factor when viewing competence. Derived from the theories of Schon (1983), reflection is viewed as an integral part of the developmental process of professional competence. Schon discussed two types of reflection: reflection-in-action and reflection-on-action. When engaged in professional performance, professionals draw upon their own practical experiences while reflecting upon what they are doing. Reflection-in action is triggered by some unusual aspect of a situation in which the professional is engaged, and the professional thinks about what she or he is doing, while thus engaged. Reflection-on-action refers to the process of making sense of what was going on after the action and the

engagement in the activity has occurred; such reflection possibly assists the professional with learning something from the experience of the engagement that will improve future professional performance. Schon stated that these reflective processes extend the professional's knowledge bases.

Thus, describing professional competence is complex. Competence involves more than the ability to stay up-to-date with knowledge and capabilities/skills; competence involves the individual personal factors that each practicing professional brings to the practice situation. Viewing the individual personal factors that each professional brings to a situation brings a depth to understanding *competence* that goes beyond capabilities and a current/relevant knowledge base. Activity and involvement in activities also influence professional competence.

*Competence of Mental Health Professionals as Framed by Nowlen's Competence Model*

Because of the increased need for competent behavioral healthcare practice within the United States, accountability for mental health workers—as for healthcare professionals in general—has increased (McReynolds, & Garske, 2003). According to McReynolds and Garske, "Mental health programs are under pressure to develop, train, and retain staff who can deliver quality services. . .[with] the development of training curricular that emphasize competencies defined in terms of service requirements" (p. 120). Clasen, Meyer, Brun, Mase, and Cauley, (2003) added insight into this need when they wrote:

> Interest in a better-prepared workforce extends across many human
> service professionals. Over the past decade or so, the need to define,
> develop, and disseminate a set of core competencies has been discussed.
> Establishing and maintaining a competent and skilled mental health care
> workforce is seen as crucial for meeting the expanding needs of
> Americans with mental illness. Benefits include improved outcomes for
> persons with severe and persistent mental illness, decreasing the need for

39

acute hospitalization, and contributing to the retention of workers in the mental health field. (p. 10)

Likewise, Anthony (1992) wrote that the benefits of using quality competencies with service provisions and interventions include opportunities for improved client self-determination, increasing clients' use of skills, and lessening "opportunity restrictions" (p. 166) such as discrimination, stigmatism, and a lack of economic resources and reasonable accommodations.

"Competencies" in mental health have been defined as "the ways that clinicians are expected to interact with clients as they provide care, but are distinct from and more comprehensive than practice guidelines and standards of care, in that the guidelines specify standardized procedures for treating specific mental illnesses while competencies encompass interpersonal interaction and attitudes" (Clasen, et al., 2003, p. 2). Anthony (1992) also defined competencies as "the capacity of the individual in a particular position to apply knowledge and skills in an effective manner in the full range of situations associated with that position" (p. 346). Aubry, Flynn, Gerber, and Dostaler, (2005) discussed the make-up of competencies as including personal attributes such as values, beliefs, attitudes, and judgments that guide a professional in his or her practice/performance contexts.

Diverse perspectives exist pertaining to competencies that are important to mental health professional practice. According to Aubry et al. (2005), community support workers have very demanding roles that require them to be able to use a combination of personal attributes, knowledge, and skills. Personal attributes include having a respectful, optimistic, accepting, sincere, and personal approach to service provision as well as being "committed, reliable, flexible, and cooperative" (p. 352). Knowledge

40

competencies include general knowledge relevant to delivering services, specific knowledge related to mental illness, and knowledge about community and health resources. Skills competencies include the ability to assess clients, providing education in skills development, and being able to "brokerage" (p. 352) needed services for clients.

Clasen et al. (2003) ranked competencies according to those that are the most important for direct care of clients and those that are the ones that direct care staff would most benefit from through additional training. Those competencies most important for direct care of clients include treating clients with respect, dignity, and as equal partners in treatment; knowing the symptoms/characteristics of mental illnesses; knowing about and how to use crisis interventions; working in a professional manner; and inclusion of support systems within client care and treatment. Those competencies that staff would benefit the most from additional training include reducing work-related stress levels, knowing the symptoms/characteristics of mental illness, knowing how and using crisis interventions, using computer technology, and keeping accurate documentation and records.

Liberman et al. (2001) stated that community support workers have three distinct areas of competencies: clinical skills, relationship skills, and advocacy skills. Clinical skills include treatment planning, symptom and functional assessment, and skills training. Relationship skills include the ability to make and maintain a collaborative, a supportive, and a mutually respectful therapeutic relationship with clients. Advocacy skills include the ability to develop and maintain interagency contacts with outreach resources such as housing, financial entitlements, and vocational rehabilitation (Liberman et al.).

41

Coursey, Curtis, Marsh, Campbell, Harding, Spanio, et al. (2000) identified specific knowledge, attitudes, and skills competencies for direct service staff members who work with adults with psychiatric disabilities (see Appendix 4). Service providers should engage clients with "dignity. . .and as full collaborators" (p. 4) in service planning, interventions, and assessment. Whenever possible, family members and other supports should be included in all aspects of service processes. Staff members should be able to demonstrate current knowledge of issues related to mental illness, of biological aspects of severe mental illness, and of the best practices of interventions and support strategies. Services must be delivered in individualized manners. Staff must be able to effectively access and use community resources, demonstrate knowledge of legal issues and client rights that are relevant to the work and to clients, work collaboratively with all resources and systems for the best interests of the clients, conduct activities in a professional and ethical/culturally competent manner, and be able to use and apply evaluation methods.

Thus, the training in competencies and their effective use with clients is part of the important elements of training processes for the development not only of the community support workers but also for the effective use of treatment modalities within psychosocial rehabilitation. As Aubry et al. (2005) concluded: "If community support is considered a cornerstone of community mental health, then it is critical that the proper structures and resources be put in place to help individuals offering these services to be equipped with the necessary competencies to be effective" (p. 353). The effective use of competencies aligns with the goals of the Institute of Medicine and ensures quality of care, patient safety, and risk minimization in the delivery of care and services.

*Nowlen's Performance Model*

The Competence Model is cumulative as is the Performance Model. The Performance Model, however, goes beyond the Update and Competence Models to view professional practice as a social activity within the interactions of practicing professionals and their environments. Nowlen (1988) stated: "Performance is a function of both individuals and ensembles. Even when viewed as an individual matter, performance is the result of interacting social and personal influences" (p. 86).

According to Nowlen (1988), the Performance Model is based upon three precepts of professional practice: professionals are influenced by their environments, self-images, roles and values when they perform their jobs; professionals work in complex and interrelated systems and networks; and professional performance is complex and affected by multiple forms of interventions. Factors include a professional's need to continually update baseline knowledge and skills; prepare for new roles by developing as a competent professional through both individual and organizational processes; effectively and efficiently use human relationship skills, cognitive critical skills, and life skills; and maintain competent performance throughout the multiple influences of social and environmental factors. Such factors are situated in the performance of the professional and include the performance period, time, activity processes, the interactions of time and hot/cold activity processes, communities of practice, legitimate peripheral participation, cognitive apprenticeship, guided participation, and the zone of proximal development.

*The Situated Model of Competence*

The Situated Model of Competence by LaDuca (1980) adds dimensions and understanding to the Performance Model. LaDuca stated (1980): "[P]erformance is not

simply equivalent to competence because an individual's competence does not reside

solely in the ability to perform a task or activity, but in performing the task correctly and

at the appropriate time" (LaDuca, Engle, & Risely, 1978, p. 151). LaDuca et al. stated

that appropriate performance is determined by the specific situation in which the

performance takes place and, therefore, "competence. . .implies the ability of an

individual to adequately deal with professional situations" (LaDuca, 1980, p. 151). A

specific situation will call for a specific task to be performed as well as the critical

aspects that are needed in the performance context. As LaDuca et al. (1978) concluded:

". . .adequate definition of professional competence implies a concern for what *should* be

done, not merely what *is* done" (p. 151).

The Situated Model focuses on the interactions of the client, the clinical problem,

and the setting. At any specific instance, the situation imposes requirements for

performance, and one cannot judge professional competence without "situation reference

for. . .described tasks" (LaDuca, 1980, p. 255). "What the health professional *should* do

is a consequence of the demands of the professional situation. The range of allowable

options is delimited by the parameters intrinsic to the encounter" (LaDuca, p. 255).

When a professional works with a client, his or her behaviors become part of the context

also (LaDuca). Competence, therefore, needs to be looked at from situational viewpoints.

*Situated Activity Factors*

Situated factors influence the development of competence. For instance, Eraut

(2004) discussed four general types of activities in which professionals engage. Much of

a professional's time is spent in assessing clients and their related situations and in

continuous monitoring of their conditions. Professionals also decide what actions must

be undertaken in order to care for clients; such activity can be short-term or long-term as

the professional proceeds with treatment—modifying, consulting, and reassessing treatment as needed. Last, the professional must manage his or her job and continue to learn. All these types of activities take place in the context of "constrained time and resources, conflicting priorities, and complex inter-and intra-professional relationships" (Eraut, 1994, p. 13).

*Performance period.* Eraut (1994, 2004) viewed such activities as operating within a performance period. He perceived the performance period as characterized by a beginning and an end and incorporating all the interactions and developmental situations contained within the defined performance period. He stated that "The analysis of a performance period is concerned with everything done by the performer during a specified period of time, particularly with such aspects as reading the situation, deciding what to do, changing one's plan, responding to unforeseen events, allocating time and managing the transitions to other periods" (Eraut, 1994, p. 150). Eraut further explained that instead of concentrating only on an individual problem, case, or task when viewing the performance period, all activities and interactions that take place are considered. Such considerations provide a more integrated and situated perspective in understanding the complexities about *professional competence*. He emphasized that the person involved in the activity, in order to be competent, must not only be able to make a correct reading of the situation involved in the performance period so that "appropriate action can be taken" (Eraut, p. 150) but must also be able to complete tasks on time.

*Time.* Eraut (1994, 2004) posed that time affects how professionals use their cognitive skills. He divided time on a continuum that has three sections; each section requires the use of different cognitive skills. First, in the instant/reflex mode of cognition, the professional reads a situation via patterned recognition, makes decisions

45

through instant responses, and uses routinized actions, which become semi-consciously used. Second, in the rapid/intuitive mode of cognition, the professional reads a situation via rapid interpretations, makes decisions through the use of intuition, and uses routine activities carried out with rapid decision-making skills. Cognition typically involves the recognition of situations by comparing the situation with other similar situations previously encountered. Third, in the deliberative/analysis mode of cognition, the professional reads a situation and makes decisions via discussions and analysis with others and uses activities that have planned actions with progress reviews. Cognition involves the use of prior knowledge.

*Activity processes*. The activities and related processes which are embedded in the performance period also influence the performance period. In essence, an activity process is comprised of the following actions. Professionals gather information about a client/patient and/or situation by recognizing patterns from previous situations that are similar to the situations in which the professionals are currently engaged. They, in turn, make interpretations about the situation. These interpretations assist the professionals in analyzing the situation in order to arrive at a solution for the situation with which they have been confronted. Along with interpretations and analysis of situations, professionals also use repertoires of theories and ideas in order to reach a final decision about a situation. Eraut (1994) concluded that "the skills of acquiring and evaluating information about. . .ideas and. . .forms of practice are probably more important than the retention in memory of an increasingly obsolescent block of propositional knowledge" (p. 113).

*The interactions of time and activity processes: cool vs. hot action.* The interactions of time and activity processes result in what Eraut (1994, 2004) termed *cool*

or *hot action*. *Cool action* occurs when situations are routine and a solution to a problem is very clear and definite. When enough time exists, decisions can be made with analysis, decision-making, and deliberation. The professional has enough time to think about the situation, analyze alternatives to actions that can be used, evaluate the best course of action to take, and reach a conclusion based upon his or her careful reading and analysis of the situation.

*Hot action* occurs when situations are non-routine, unclear, and ambiguous, and solutions to problems are not well defined and must be solved through the instant use of processes that include problem solving, decision-making, analysis, situational knowledge, judgment, and intuition. When time is in short supply, the professional has to instantly recognize a problematic situation, decide rapidly on what course of action to take, and proceed with instant responses to problematic problems while being constantly alert to what needs to be done. He or she must make rapid interpretations of information and rapidly make decisions "in the midst of action" (Eraut, 1994, p. 145).

Thus, the interactions of time, activity processes, and the performance period influence a professional's competence. In addition, the interactions of a group involved in a performance period and the social influences—all embedded in the practicing environment—also influence professional competence.

*Social interaction factors:  communities of practice.*  Professionals do not usually work in solitary environments. During a performance period, professionals interact with each other in social environments that have been termed *communities of practice* (Wenger, McDumott, & Snyder, 2002; Brown & Duguid, 2002). Wenger et al. (2002) provided an appropriate summary when they defined communities of practice as

. . .groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an on-going basis.  Typically, they share information, insight, and advice.  They help each other solve problems.  They discuss situations.  They ponder common issues, explore ideas, and act as sounding boards.  They create tools, documents.  They may simply develop a tacit understanding that they all share.  They accumulate knowledge, practice, and approaches.  They establish ways of interacting (p. 4).

Brown and Duguid (2002) also described their perspectives of communities of practice when they wrote about learning and practice:  "Learning a practice involves becoming a member of a community of practice and thereby understanding its work and its talk from the inside.  Learning is more than acquiring information.  It requires developing the disposition, demeanor, and outlook of practitioners" (p. 126). By being members of communities of practice, professionals interact with each other, develop goals and objectives as team members, and influence each other through activity and interactional involvement.

Wenger (1998) described dimensions of a community of practice that provide insight into how professional competence is influenced by a community of practice. First, through mutual engagement, members interact with each other in order to make the community a successful venture.  Second, all members of the community of practice work together, "ready to think, invent, and find solutions together. . .they share a basic body of knowledge that creates 'common ground' allowing members to work together effectively" (Wenger et al., 2002, pp. 37-38) to solve problems.  Third, teams provide "social structure" through which "practitioners themselves generate and share the knowledge they need" (Wenger et al., p. 11).

With opportunities to engage with those practitioners who have learned from situations and events, practitioners can use this knowledge base to develop competence. Brown and Duguid (2002) concluded that by becoming members of a community, individuals engage in the community's practice and thus acquire and make use of the knowledge and information of the community through work and performance. Communities of practice develop and transfer the most accepted professional practices and skills because members learn from each other and from the more skilled professionals in the community. This is an important part of professional activity/performance engagement, especially for the new person who enters the community of practice, a process that has been termed *legitimate peripheral participation* (Lave & Wenger, 2002).

*Legitimate peripheral participation: How new professionals develop professional competence.* As a newcomer/novice, the professional is new to a work context or situation, performance period, and social groups, and must learn how to become a full member of the group with which he or she is involved. People learn through activity (Lave & Wenger, 2002): "access to practice [is] a resource for learning. By taking part in on-going work activities, newcomers have the value of learning what is relevant. . . .(p. 93). Old timers (more skilled peers or experts) spread knowledge to the new professional through engagement of the new person in work activities that allow the new person to learn the practice and develop competence, even expertise. The newcomer develops a sense of identity as a "master practitioner" (Lave & Wenger, p. 111).

Lave and Wenger (2002) defined learning in the context of social interactions when they stated that a person "acquires skills to perform by actually engaging in the process of legitimate peripheral participation, by participating in actual practice with an

49

expert" (p. 14).  The words *legitimate*, *peripheral*, and *participation* offer deeper insights into the process of developing competence in professional performance.  *Legitimate* means having access to actual work practice; therefore, newcomers as learners develop a view of what the entire context is and what is to be learned.  P*eripheral* denotes a way of gaining access to sources of understanding by engaging in and growing with involvement in practice.  *Participation* means absorbing and being absorbed in the culture of a practice.  By being engaged in a practice context, the new professional as a learner is developing competence, has opportunities to make the culture of the practice his or her own, including increased understanding of "how, when, and about what old timers collaborate, collude, collide, and about what they enjoy, dislike, respect, and admire" (Lave & Wenger, p. 95).

The key point in the legitimate peripheral participation process is access by the new professional to practice opportunities and "all that membership entails—the whole range of ongoing activities, old timers, other members, information, resources, and opportunities for participation" (Lave & Wenger, 2002, p. 81).  Three processes are important to legitimate peripheral participation:  cognitive apprenticeship, guided participation, and the zone of proximal development.

*Cognitive apprenticeship.*  The new professional learns through a process that Rogoff (1990) termed *cognitive apprenticeship*.  Rogoff defined cognitive apprenticeship as participation in activity with the guidance of more skilled people.  The less skilled person observes a person with more skills and participates with the more skilled person through involvement in work activities.  The goal of cognitive apprenticeship is to stretch the understanding and skills of the less-skilled person so that the person will be able to apply new abilities to new situations and problems.  The process involves active learning

50

efforts from observing and participating with peers and more skilled members of a community.  The more skilled person provides supportive structures for the new person's efforts:  the more skilled person supports, challenges, and guides the new person through collaborative participation in activities designed to increase the skills and abilities of the novice.  Ultimately, the new person will develop the cognitive skills and performance abilities that will develop the new person into a competent practicing professional.

*Guided participation.*  The development of a new person into a competent practicing professional occurs through the process of *guided participation*, defined by Rogoff (1990) as "people collaborat[ing] in arrangements and interactions that support learning" (p. 65).  Rogoff, in her studies on cognitive development, formulated the perspective that communication processes are the integral components of guided participation, entailing both verbal and nonverbal interpretations of thoughts and behaviors:  "Communication between social parties provides a medium for new members of the society to participate in more skilled problem solving with the guidance of partners. . . .It facilitates growing skills and participation in activities" (Rogoff, p. vii).

*Zone of proximal development.*  Vygotsky (1986) discussed an idea known as *the zone of proximal development*.  The zone of proximal development is a gap "between actual performance and the level achievable with the help of a competent peer" (Rogoff, p. 412).  A person participates in activities that are just out of the realm of his or her competence, and, with the assistance of more skilled people, advances his or her understanding of situations through shared problem solving opportunities (Rogoff, 1990; Rogoff & Gardner, 2000; Engestrom, 2003).  The process of mastery of a skill and development of competence involves modeling, coaching, and scaffolding (Rogoff &

Gardner, 2000; Rogoff, 2000). A novice observes an expert doing a task (modeling). The expert supports the novice (coaching) while the novice learns the skills needed for competent practice. Then, as the novice learns and becomes proficient (or competent) in his or her work processes, the expert provides less and less support. Finally, the novice is able to do the skill without supervision and support.

The new professional becomes a competent practicing professional during his or her interactions with more skilled members with whom he or she works during the activities of a performance period. During the development of his or her competent use of professional skills, the professional acquires expertise with and in practice. He or she has individual personal qualities that he or she brings with him or her to the practice activity. Through engagement and interaction with all the factors embedded in the social processes and communities of practice, the person develops competence and expertise through these situational influences.

*The Role of Expertise in Professional Performance*

Professional expertise, like competence, can be viewed through both individual and social lenses. Professionals are experts with the use of their personal qualities. They also become experts in their social/interactional relationships with co-workers and situations which are embedded in their environments.

*Individual expertise.* The Update and the Competence Models by Nowlen focus on the up-to-date knowledge, skills, characteristics, and abilities that are specific to individual practitioners. Such knowledge, skills, characteristics, and abilities have been identified as the essence of the competence of the individual professional. As with these two models that concentrate on individual personal qualities, others have discussed how individual professionals use their expertise with their personal qualities. For example,

according to Schmidt, Normal and Boshuizen (1990) and Dreyfus (1998), professionals use intuition, tacit knowing-in-action, and effective scripts based upon experiences more efficiently than do novices. Likewise, as viewed by Dreyfus, professionals, as experts, use intuition, analytic approaches, and tacit understandings in skillful performance more effectively and efficiently than do novices.

Eraut (1994) also discussed individual professional expertise when he stated ". . .the ability to cope with difficult, ill-defined problems rather than only routine matters . . .is often judged to be the essence of professional expertise" (p. 152). Under times of hot action, the professional engages and interacts in activities in which he or she must demonstrate the ability to correctly read a situation and resolve a client/patient's problem.

Eraut (1994) further discussed how professional expertise is related to performance through skills in collecting and interpreting information through a "rapid, non-analytical dimension, which is used in the majority of problems" (p. 135). These tasks must be performed skillfully, thoroughly, efficiently, and at appropriate times. If not, then the professional did not use any expert skills because he or she misinterpreted what was going on during a performance period.

*Social/interactional expertise*. On the other hand, just as the Performance Model suggests, a professional does not perform alone in solitary activities. According to Wertsch, Minick, and Arms (2003), people participate in social interactional settings, have experiences involved with the social settings as they take part, and internalize these experiences into cognitive processes as they take part in joint activities with other people. Such social contexts assist people in understanding meanings of information through a process of informational exchanges as people act as resources for each other and/or derive meaning from the information through a variety of social cues and messages

53

embedded within the environment (Brown & Duguid, 2002). Rogoff (1990) further added ideas about the social situatedness of developing competence/expertise in and with practice. Rogoff described the ideas that in social context people share experiences and collaborate with each other to find solutions to problems; in groups, people are able to put ideas together in ways that one individual would not be able to do.

Through interacting with other skilled professionals, professionals develop through interactions with each other the skills, decision making, problem solving, and behaviors to perform competently. Thus, expertise involves the ability and self-confidence to use one's individual personal qualities to perform interactively and successfully with others. Expertise entails the correct, efficient, and effective reading of information related to client situations and problems and the ability to problem solve in order to reach an effective treatment procedure for a client within appropriate time frames. Expertise also involves the ability to perform likewise with co-workers and environmental situations. Experts have more capabilities to perform these skills with efficiency, thoroughness, effectiveness, intuition, and timeliness than novices.

*Negotiated belief systems*. Walsh discussed the importance of negotiated belief systems in the development of the individual within group competence and expertise. Walsh and Charalambides (1990) asserted that professionals in practice contexts constantly encounter a "bewildering flow of information" (p. 517) that impacts complex decision and problem solving processes. Likewise, Daley (2000) stated that "recent research indicates that professionals construct their own knowledge-base for practice through the context of their practice, actively make[ing] decisions on how to incorporate new knowledge into the context of practice based on their interpretations of the environment" (p. 34). Walsh and Charalambides (2003) termed this skill "the creation of

belief structures," (p. 518) or "knowledge structures" (Walsh, 1995, p. 282).

Leonard, School, and Beauvais (1996) viewed decision making as being accomplished predominantly by group processes. Billet (1994) viewed this process as the acquisition of knowledge and skills learned through participation in authentic tasks (p. 54-55). Cunningham (1998) agreed with Billet that decision-making/problem-solving learning processes take place through social-interaction processes.

Within these social-interaction processes of decision-making and problem-solving, each individual brings to the situation his or her knowledge/belief structures about a specific information environment. As such, professionals as learners cope with the bombardment of information by chunking the information: "the more that learning tasks involve placing existing material in long-term memory, the more likely the information will be retained and available at a later time for access from this long-term memory storage depository" (Smith, 1998, p. 63). These knowledge structures form a "mental template consisting of organized knowledge about an information environment that enables interpretation and action in that environment" (Walsh, 1995). However, the interpretation of problems and associated solutions vary with the individuals involved in these processes (Walsh & Ungson, 1991) and influence how practitioners interact in social situations with other practitioners when making decisions and problem solving.

Walsh and Henderson (1996) discussed two views about group decision making processes. One view holds that as problems and decisions arise, the immediate pressures of the environment determine the criteria by which alternative solutions are made and executed; decisions are made in response to environmental forces and stimuli. On the other hand, individuals involved in the group decision making processes come together through coalitions and resolve differences based on the preferences of the most influential

55

or powerful members of the group. In any event, decisions are made as workers "construct knowledge bases for themselves in the context of their practice by obtaining information from multiple sources, processing information obtained by dialoguing with their co-workers, and then changing their practices based upon the revised [negotiated] meanings they have created" (Daley, 1999, p. 135). As Smith (2003) concluded: ". . .it is . . .understood that the communication between learners. . .and more expert workers is a legitimate method of meaning appropriation and understanding, of identifying relevant knowledge, and of testing knowledge" (p. 70).

Thus, decision making and problem solving processes take place through human interaction activities that provide opportunities to explore learning situations through asking questions, discussing situations with more expert workers, and being active in learning/work-related situations. Smith (2003) likewise concluded that professionals construct their own meaning perspectives from these learning activities. Through such social-interaction processes involved in group decision-making situations, individuals involved form a "negotiated belief structure" (Walsh, 1995, p. 291), in which the "shared knowledge structures develop from the social process marked by negotiation and arguments and triggers for change" (Walsh, p. 293).

*Competence of Physicians and Allied Health Professionals as Framed by Nowlen's Performance Model*

The Performance Model views professional practice in terms of the transactions that occur between professionals, activity/performance periods, and the environment. I will now provide a discussion of the competence of physicians and healthcare teams followed by a discussion of mental health workers as viewed through Nowlen's Performance Model.

Traditionally, patients have viewed their primary care physician as the key player when seeking treatment (Duff, 2005; Gardebring, 1996; Greenlick,1992):   the physician is responsible for health care interventions, and referrals to other professionals are made in delivering care to patients if additional assistance is needed.  Greenlick (1992) described this process as "the patient had something the matter with him [sic.]; the doctor was called in to cure it.  Payment of a fee ended the transaction" (p. 1645).  Physicians used their solitary knowledge and skills during patient-care interventions because they were the principal leaders of healthcare processes.  However, because of health care specialization, technological advances, knowledge explosion about health care needs and treatment, and issues of accountability and cost-effectiveness, "the direction of this change appears to be moving from hierarchy, and the related practice of paternalism, with the doctor at the top of the hierarchy and the patient at the bottom in terms of control and decision making power. . ." (Duff, 2005, p. 2) to that of teams and team/patient collaboration.   Two classifications of healthcare teams are commonly discussed in the literature:  multidisciplinary teams consist of healthcare professionals who work with the same patient but make independent recommendations for patient care whereas interdisciplinary teams consist of team members who collaborate to develop an integrated plan of treatment (The American Medical Student Association, 2005; Wiecha & Pollard, 2004; McCallin, 2001; Duff, 2005).

Treatment interventions now combine the activities and knowledge of physicians and allied healthcare practitioners from multiple disciplines because solving patient problems is beyond the scope of expertise and training of any one provider (Rafferty, Ball, Aken, & Fagin, 2001).  The overall goal of teamwork is to respond effectively and efficiently to the needs of the patients and their support systems (Duff, 2005).  These

activities are delivered in complex environments that involve ambiguous situations; information overload; patient idiosyncrasies (Salas, Sims, Klein, & Burke, 2003); and pressures related to time, performance, decisions, and consequences if errors are made.

There is considerable discussion in the literature on how to establish allied health care teams and manage them, but research explaining how team members work together and interact in everyday practice is minimal (McCallin, 2001; Wiecha & Polard, 2004). However, when it does address the performance and interactions of team members, the literature speaks of issues of communities of practices as professionals interact with each other through activities of coordination and cooperation, collaboration, negotiation and compromise, and shared awareness in problem solving/decision making. Attitudes and the environment also impact the interactions of team members.

Salas et al. (2003) defined teamwork as "a set of interrelated behaviors, cognitions, and attitudes that combine to facilitate coordinated, adaptive performance. . . .(p. 1). He further added that "[t]eamwork is not an automatic consequence of placing people together. Teamwork depends on a willingness to cooperate for a shared goal…. Teamwork is sustained by a shared set of teamwork skills. . ." (p. 1).

The healthcare team also functions in collaborative efforts to provide comprehensive and integrated care for patients (American Medical Student Association; 2005; Wagner 2000). McPherson, Headrick, and Moss (2001) concluded that "collaborative working between professions is the key to quality care for clients" (46). Through collaboration, team members provide feedback to each other and share their thoughts and feelings about work issues. They support each other and alternative ideas, listen to information presented, and attempt to gather relevant facts, clarify problems, and

discover alternative solutions until they arrive at the best treatment and care for clients. Collaborative processes happen through members' interactions via conversation and activity (University of Washington School of Medicine, 1999).

Team members have distinct disciplinary, educational, and training backgrounds (Dynamic Research Cooperation, 2005). Conflict exists because of this diversity and complexity of their preparations and experiences. Patient care involves team members' cooperation and abilities to compromise in conflicting discussions and situations (University of Washington School of Medicine, 1999); with effective interpersonal interactions, negotiation and conflict can encourage creative problem solving as team members work together in order to best utilize their knowledge, skills, and expertise concerning patient care. The result of such inter-professional compromises is a consensus about the best course of action for patients and their treatment.

The best course of action stems from shared awareness that results from joint activities of team members (University of Washington School of Medicine, 1999). "Teamwork depends on the ability of each team member to 1) anticipate the needs of others, 2) adjust to each other's actions and to the changing environment, and 3) have a shared understanding of how a procedure *should* happen in order to identify when errors are occurring—and how to correct for those errors" (Salas et al, 2003, p. 7): team members monitor each others' actions in order to catch mistakes before their occurrence. "This shared awareness allows team members to detect deficiencies or overloads and shift work responsibilities to others as it becomes necessary" (p. 7).

Shared awareness of team members also results in shared decision making and problem solving. Team members exchange information; deliberate about patients' treatment; and, through discussion and dialogue, agree on the treatment/care to

implement. Such processes include not only the members of the treatment team but patients and their support systems as well.

Team work also involves an affective component (Salas et al., 2003). Team members must feel motivated to achieve the team's mission, objectives, and tasks; to believe that the team can successfully meet its challenges; to be cohesive and trustful; and to be committed and attracted to working on and with the team.

Environmental factors also impact the interactions of practitioners who work in teams. According to Burke, Salas, Wilson-Donnell, and Priest (2004), "It's the result of members scanning of the environment and the perceiving of cues and patterns in a dynamic context. Information gained is then communicated and integrated into existing knowledge structures serving to update members' shared mental models" (p. 199). Team members are aware of the key activities of a situation within the environment that will impact the team's interpretation of a client problem; they then share the information. All team members then have access to the information needed in order to make a decision.

In addition, the environment of the facility or organization in which teams work must support the team: "the organizational environment must offer clear roles for each team member and direction from management via policies and procedures. The organizational climate must encourage teamwork, and management must also support the projects in which the team is engaged" (Wachs, 2005, p. 171). The organization must provide reinforcement for the goals and efforts of the team and acknowledge the work of the team as an important factor in the processes of allied healthcare teams (Wachs).

In summary: " Successful teamwork, say those who have participated in it, means learning to see the world through the eyes of other disciplines, and at the same time showing others what your skills and knowledge bring to the team. It means learning to

work through conflicts by keeping the goal of the team in mind. It means constant

communication among team members" (Domrose, 2003, p. 2). The literature about

healthcare teams discusses ideas of how effective functioning teams integrate group

effort, practice collaboratively through cooperation and interdependence, communicate

through dialogue and discussions, and negotiate and compromise in order to arrive at

effective and efficient client treatment that solve client problems. Salas et al. (2003)

provides a concluding comment about effective healthcare teams:

> Additionally, teams in complex environments must monitor their
> teammates and provide back-up behavior. . ., manage conflicts
> appropriately, make informed decisions, and promote coordinated
> action by synchronizing the team's task requirements, material
> resources, team members KSA's [knowledge, skills, attitudes],
> strategies, and responsibilities (p. 6).

*Competence of Mental Health Professionals as Framed by Nowlen's Performance Model*

The review of the literature concerning mental health practitioners' professional

learning and performance in interactions with co-workers is limited. Liberman, Hilty,

Drake, and Tsang's (2001) work on multidisciplinary teamwork in psychiatric

rehabilitation frames understanding of professional performance with-and-in mental

health professional environments. According to Liberman et al:

> Psychiatric rehabilitation by its very nature is multidisciplinary because of
> the many competencies required for its implementation. In promoting
> optimal levels of recovery from schizophrenia and other disabling mental
> conditions, teams must combine with expert contributions of professionals
> and paraprofessionals who can individualize a comprehensive array of
> evidence-based services with competency, consistency, coordination,
> collaboration, and fidelity (p. 1).

Issues of ambiguous and uncertain work environments, hot action, communities of

practice, guided participation, scaffolding, zone of proximal development, and cognitive

61

apprenticeship arise out of their work. As Liberman et al. (2001) concluded: "only a team can sustain an efficient and productive range of services (p. 2).

Within the work environment and context, "quality of care to clients is 'refractory' (Liberman et al., 2001, p. 5). Four phases exists with a person with mental disability: acute, stabilization, stability, and recovery; these phases do not take place in a linear fashion. For example, a client who has been stable for years may decompensate and experience acute symptoms of his or her mental illness. Therefore, the work environment is always uncertain. Liberman et al. stated: "Quality of care that teams provide is marked by plateaus, relapses, phase shifts, and overlapping loops of client needs and phases of their mental health" (p. 5). Therefore, teams as communities of practice are vital to the delivery of care and services to clients who suffer from severe and persistent mental illness:

> The team must bring together requisite expertise needed to deliver quality services, integrate the different areas of member expertise at the level of service delivery, and cultivate versatility among team members so flexible levels of interventions will be available to meet the needs of individualized clients (p. 6).

Teams deliver a full array of comprehensive and coordinated services to clients. Individual personal qualities interplay at the level of the individual practitioner, also: "each clinician must have the attitudes and abilities to work collaboratively and with respect for other team members" (Liberman, 2001, p. 2). In this way, effective quality services can be implemented that meet the needs of all clients served within the ambiguous work environments in which community support workers work and within their work contexts and interactions with each other as team members.

Liberman et al. (2001) also discussed issues of guided participation, scaffolding, zone of proximal development, and cognitive apprenticeship. They suggested that

effective case managers share responsibility and accountability in their areas of functioning, have trust and confidence in one another's clinical judgment and seek out technical assistance and supervision from team members with more specific areas of expertise or more clinical experience. They are always ready for mutual assistance, and they expect to learn from other case managers and professional colleagues throughout their career (pp. 11-12).

According to Liberman et al. (2001), work teams tend to function better when members have many opportunities for face-to-face interactions, and regular staff meetings provide the main context for effective communication about work contexts and client needs. Team members support each other at such meetings and exchange needed information about client needs, client care, and work-related issues. As such, within teams, members must "develop mechanisms that enable communication, collaboration, coordination, and problem solving among team members" (Liberman et al., p. 3).

Not only is support among team members important for work relationships, but team members need to be supported by supervisors and administration through resources, stressors, and other problematic areas that arise within the practice context, especially with empowerment for decision making about clinical decisions that relate to client care and the exchange of information and advocacy about obtaining and using needed community resources that are vital to client treatment and care (Liberman et al, 2001). Performance with-and-in the environment and among the various professionals and resources involved within the environment adds complexity to the practice context of mental health professionals. As Liberman et al. concluded: "The proliferation of effective services will place an even greater burden on mental health team members to learn diverse skills from each other and to share decision making and responsibility for reviewing, integrating, and implementing care plans" (p. 17).

My Perspectives Pertaining to Professional Competence

I have constructed a Situated Model of Professional Competence based upon the review of the literature that I conducted. I will now discuss my Situated Model of Professional Competence.

| Update Model: 'knows' | Competence Model: "knows how" "shows how" | Performance Model: "does" |
|---|---|---|

**"What must the professional know?"**    **"What is the professional best capable and able to do?"**    **" What is the professional all about?"**

**Background**

*Professional School/ education*

Minimal levels of competencies --keeping up-to-date skills, abilities, proficiencies

Environment of uncertain and ambiguous practice and performance context. Use of non-routine behaviors. Activities. Solutions to problems not well-defined. Situated.

**Personal Intangible Qualities:** Personal Experiences

Knowledge

Cognitive/ Reasoning

Skilled behaviors

Deliberative Processes

Relational skills

Meta-processes

Reflection of Practice

*influences the development of*

*provides frames of references*

Education = Prepositional Knowledge

*influences the ability to have*

**influences**

**Development of** Up-to-date skills and current knowledge

*factors impact*

time determine use

**Competent or not With skills/abilities**

OUTCOMES: Perform job skillfully, thoroughly, efficiently, correctly, and at appropriate times. If not, then mis-interpreted what was going on.

Figure 1: Relationship among the variables in the Situated Model of Professional Competence

*Discussion of the Situated Model of Professional Competence*

The Update Model and the Competence Model focus on the dimensions of competence that are specific to individual professionals. The Update Model asks, "What must the professional know?" The answers to this question are found in two different

stages of the professional's life:  as beginner and again as a professional who has practiced his or her profession.  Before a person becomes a novice professional, two activities have happened.  The person has studied in some type of a professional educational setting for several years in order to acquire the knowledge and background specific to his or her profession.  Upon completion of studies, the person undergoes some type of recognition activity that states that the person has acquired the knowledge base and skills to become a new practicing professional; such activities are finalized through the process of acquiring licensure, certification, or registration.  The novice professional becomes a practicing professional who must rely upon his or her propositional knowledge in order to have frames of references in how to practice his or her role as a professional:  the novice professional must begin the process of becoming competent and is therefore deemed qualified to practice as a professional.

The Update Model also focuses upon the need of the professional who has practiced for a while to stay up-to-date or current with knowledge and the skills of the profession.  The professional is mandated by his or her profession to participate in continuing educational programs, specializing in the professional knowledge base which includes the specific theories and concepts about the profession, the background of the profession, and related information that forms the basis for developing interventions to solve client problems.

The Competence Model asks, "What is the professional best capable and able to do?"  Both the beginning professional and the experienced professional bring skills to his or her professional practice; the professional "knows how" and "shows how" to do his or her job with up-to-date skills, abilities, and proficiencies that have been established by his or her profession.

The Performance Model focuses on the transactions of individual professionals with their social contexts and environments. *Professional competence* is the result of the individual-in-the-environment in conjunction with all related situated interactional factors of group and social influences.

*Individual factors used by the professional.* I have formed a multi-dimension approach to competence that is framed by Nowlen's Update, Competence, and Performance Models. The Update and Competence Models focus on the individual characteristics of what I will term "KAS" (knowledge, attitudes, and skills):
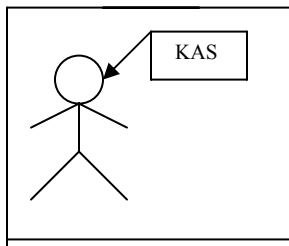


Figure 2: Personal "KAS" (Knowledge, Attitudes, and Skills)

Each professional brings to the practice situation his or her own individual knowledge (K), attitudes (A), and skills (S). "Knowledge" includes several dimensions. Propositional knowledge concerns the "de-contextualized" factual knowledge a person has acquired; knowledge acquired through educational endeavors, other formal learning processes, and informal learning processes; the formal theoretical/scientific base of a profession; and formal continuing developmental activities. Personal and/or experiential knowledge is acquired from the person's daily life experiences.

Practical intelligence involves the use of factual knowledge in performance and the direct application of performance. The professional stores information in long-term memory and then retrieves information as needed to assist in problem solving. Practical

66

intelligence often involves tacit knowledge when one practices his or her profession:  the professional can perform as needed but is unable to tell explicitly how he or she does his or her job.

Process/procedural knowledge is acquired as the professional works with clients. This type of knowledge involves the use of behaviors and processes to solve client problems and give/acquire information.  The professional is able to use processes and procedures that allow the professional to adequately do his or her job effectively and efficiently.  These deliberative processes form the essential part of professional practice as the professional plans, problem solves, analyzes, evaluates, makes decisions about clients' problems, designs interventions to solve these problems, and evaluates progress towards solving and resolving clients' problems.  Such process/procedural knowledge also tends to become tacit.

Professional judgment involves the use of intuition and tacit knowledge in a specific situation in order to find alternatives to solve client-related problems. Professional judgment involves the use of decision-making and problem-solving skills, critical thinking, and reflection about performance when practicing.  It also involves those meta-processes that are used in order to assist the professional in controlling his or her thinking about how to perform and use knowledge and skills in order to perform at his or her best levels.

"Attitude" includes the professional's personal qualities that are acquired from the daily life of the professional and from past, current, and future-oriented outlooks.  The professional has acquired his or her unique emotions, feelings, values, beliefs, convictions, ethics, motivation, self-initiative, professional identity, and meaning

perspectives.  Whether used consciously or unconsciously, these personal qualities will influence the professional when making decisions about client problems and related interventions.

"Skills" include the competencies and skilled behaviors of a professional when he or she engages in practice.  "Skills" encompass professional performance with minimal effectiveness, specific maneuvers required for effective interaction with clients, and the techniques of practice that assist a professional in effective and efficient work-related processes.  The professional has the mental and physical capabilities to perform his or her practice at standards established by the profession.  Such skills include effective communication, interpersonal relationships (with both clients and colleagues), problem-solving skills, and decision-making skills.  "Skills" involve a combination of propositional knowledge (how to do the job according to best practices), skilled behaviors (how to do the job with the most effective methods), and professional judgment (how to problem-solve in order to make the best and most effective decision when engaged in practice).

We know that the professional possesses propositional knowledge because he or she has graduated from a professional school and has obtained a license or certificate to practice.  These diplomas, licenses, and certifications inform both the public and private stakeholders that the new professional has the necessary "KAS" to begin to engage in practice.  There is a continual need on the part of the professional to stay current with his or her "KAS" throughout his or her lifetime of practice through involvement with informal/formal learning activities and continuing educational activities.

*Group factors used by the competent professional.*  The Situated Model of Professional Competence and its various components suggest that professional

competence contains three dimensions that are situated in the environment that intersect

with the client, a problem, and setting in which the practitioner works. First, the

practicing professional brings his or her unique background, experiences, propositional

knowledge, and scientific knowledge base to the environment in which he or she works.

Second, the professional brings up-to-date skills that have been acquired either from

professional studies or continuing education learning. Such skills are minimal levels of

competence or abilities, skills, and proficiencies that the professional is able to

demonstrate through practice opportunities. Personal background, experiences,

propositional knowledge, and competencies are common to all activity engagement in

which the professional demonstrates his or her practicing performance. Figure 3 provides

an overview of situated/group influences. Figure 4 provides an overview of the process

and outcomes of legitimate peripheral participation.

ENVIRONMENT

**COMMUNITY OF PRACTICE**

KAS

LIFELONG

LEARNING

Formal Learning
Activities

**Situated Learning**

Informal Learning
Activities

Situated Activity
Engagement

KAS

KAS

Group Interactions

SELF-DIRECTED
LEARNING

KAS

**LEGITIMATE PERIPHERAL PARTICIPATION PROCESS**

WATCHES/OBSERVES

**ENVIRONMENT**

KAS

MODELS/SUPPORTS
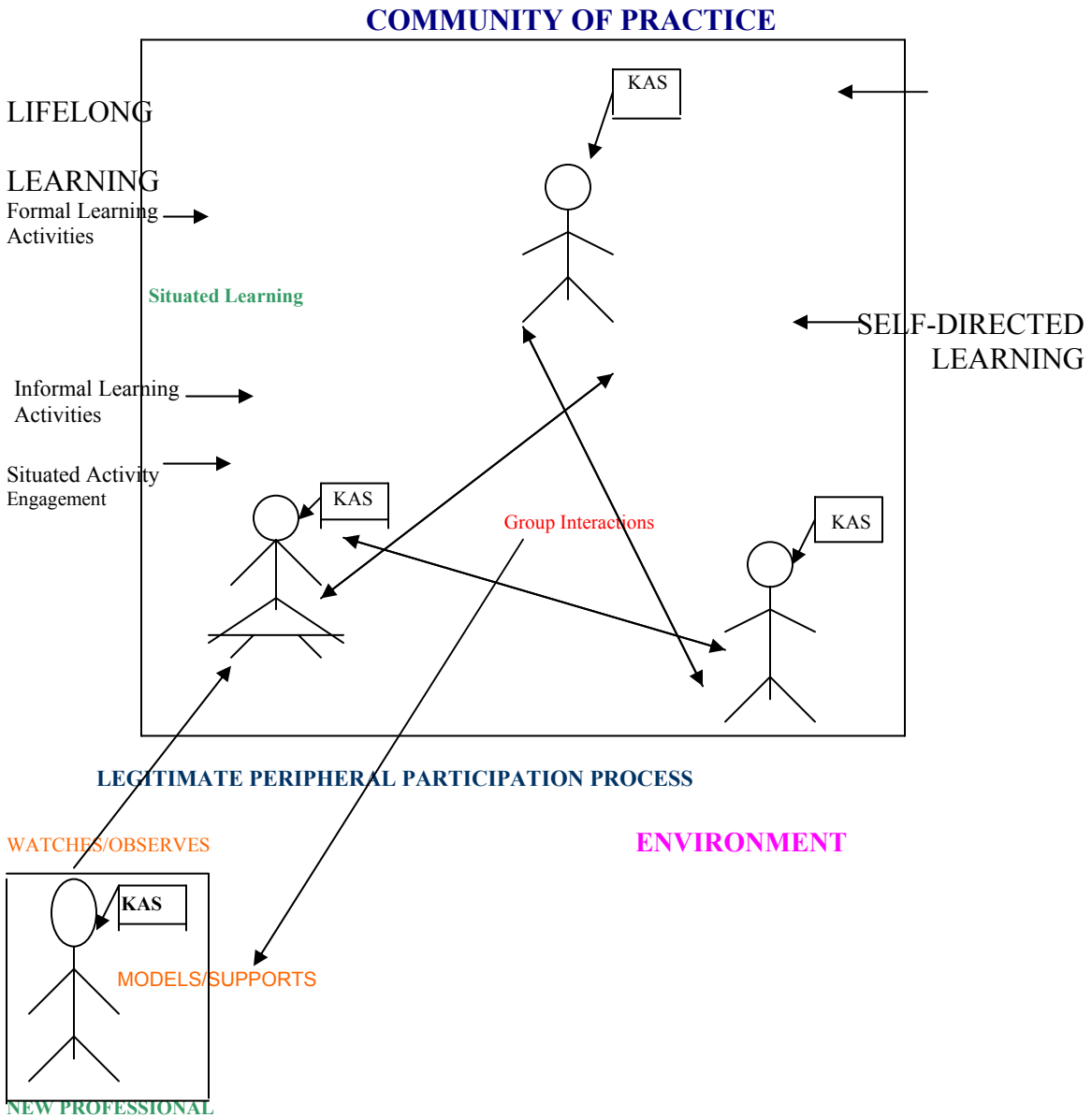
NEW PROFESSIONAL

Figure 3: Situated Model of Professional Development of Competence: Performance

Period

AMBIGUOUS/COMPLEX
ENVIRONMENT

I/C-interprets, compares,
creates, plans, judges

ROUTINE/PREDICTABLE
PROBLEM WITH STABLE
SOLUTIONS

develops competence

COMPLEX/UNCERTAIN
PROBLEMS WITH
MULTIPLE SOLUTIONS

D/B-observes, participates

STABLE/CERTAIN
ENVIRONMENT

D/U = DEPENDENT/BEGINNING TO LEARN TO BE CAPABLE/INDEPENDENT
I/C = INDEPENDENT/CAPABLE

NEW PROFESSIONAL and the process of legitimate peripheral participation

KAS

Figure 4:  Process and Outcomes of Legitimate Peripheral Participation

*Discussion of the Situated Model of Professional Development of Competence:*

*Performance Period*

Groups of professionals work together in conjunction with the activities of a

performance period.   They form a community of practice as they constantly engage in

transactions with others involved in the activity, job performance, and on-going

interactions with the environment in which they work.  (See Figure 3.)  The people

involved in the performance period's activity work together, learn from each other, and

exchange ideas and information.  Through the process of constructing such a shared

knowledge base, each of the professionals involved with and in these interactions

retrieves from long-term memory what each person knows and contributes and shares

with each other the information and perspectives retrieved.  The professionals involved in

these interactions of the group practices compare and contrast their views and meaning

perspectives, thus devising shared insights and ideas for solutions to client problems that could not have been comprehended and completed by working alone and in solitary situations with one's own private store of knowledge, attitudes, and skills.

New professionals enter the community of practice. Each one brings his or her "KAS" to the performance period within a community of practice (See Figure 4). He or she has a propositional base of knowledge upon which to rely but must start the process of learning the tacit knowledge, the deliberative processes, and the skilled behaviors of the group in which he or she will perform. The new professional will learn the processes, knowledge, and behaviors of the group as he or she watches and learns from the experienced professionals who, in turn, model and support the new professional in his or her learning situation.

On-the-job experiences, formal and informal opportunities to engage in practice and learn from others' experiences, and maintaining the motivation and initiative to interact with the experienced professionals provide the mechanisms to develop the new professional into a "competent" professional practitioner. Through such learning activities and processes, the new professional will develop competence as he or she learns to make quick decisions under hot action and use intuition and judgment to safely, effectively, efficiently, and skillfully solve client problems.

For me, many performance periods have to be viewed when considering professional competence from the perspective of group influences. Questions arise. Is the professional able to successfully work with others in collaborative processes and intervention strategies that will meet client needs on a consistent basis? Will group processes maintain the structure and essence needed to stay focused in order to resolve client problems?

Within this "community of practice," colleagues work and interact together in performance periods in order to perform their jobs. They engage in formal and informal learning activities and in situated activities located in the environment. Experienced professionals mentor, model, and support new professionals in the process of becoming an experienced professional. The process continues throughout the lifetime of practice and is enhanced if such learning is self-directed.

I think that professionals must be "competent" in their interaction processes with their colleagues and in their work activities. This means that the group must be able to interact in ways to resolve client problems in the most efficient and effective manner while using members' personal qualities of judgment, attitudes, intuition, and other related skills and capacities in such ways as to be able to perform. Other criteria to include in competent professional work processes consist of performing while making minimal errors, using effective teamwork skills, and using their individual qualities in ways to resolve client problems.

CHAPTER 3

METHODS


The goal of this study was to identify and describe patterns in learning activities

which caseworkers in a community mental health center experienced in order to develop

and maintain professional competence with-and-in practice.  These practitioners provided

direct psychosocial care for the treatment of clients who suffer from a severe and

persistent mental illness.  The central question in this study was:  From the perspectives

of the study participants, what are the learning activities that caseworkers use in order to

develop and/or maintain competence with-and-in professional practice?  Two sub-

questions lent understanding to the central question.  According to the perspectives of the

study participants:

1. What different learning activities do caseworkers use in their professional

   development?

2. How do these learning activities contribute to their professional competence

   development?

 This chapter provides a rationale for using qualitative research and for using

inductive data analysis.  A combination of unstructured interviews was used to collect the

data.  This study's method is described in terms of the setting, the participants, research

data collection procedures, data analysis processes, and the establishment of

trustworthiness and consistency in research findings.

The Use of Qualitative Research

By the term "qualitative research," we mean any type of research that
produces findings not arrived at by statistical procedures or other means of
quantification.  It can refer to research about persons' lives, lived

74

experiences, behaviors, emotions, and feelings as well as about organizational functioning, social movements, cultural phenomena, and interactions between nations. . . [T]he bulk of the analysis is interpretative. . . .carried out for the purpose of discovering concepts and relationships in raw data. . . (Strauss & Corbin, 1998, pp. 10-11).

Qualitative research can be used to better understand any phenomenon when little is known about it (Hoepfl, 1997). New perspectives and/or in-depth information can be more effectively revealed through the use of qualitative research than through the use of statistics (Hoepfl). Qualitative research provides "rich description and insights" (Hoepfl, p. 2) into participants' experiences pertaining to the focus of the research. Qualitative research can bring forth the "complex and dynamic quality of the social world" (Hoepfl, p. 2). Creswell (1998) offered his own definition of qualitative research: "Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of information, and conducts the study in a natural setting," taking the reader into the "multiple dimensions of a problem or issues and displays it in all of its complexity" (p. 2). A principal reason for conducting a qualitative study is to obtain details about the subject under investigation that otherwise would be difficult to obtain using quantitative research methods. By conducting this study using qualitative research, I gained an in-depth understanding of the learning activities that contributed to the development of caseworkers' competence with-and-during their professional practice.

According to Strauss and Corbin (1998), qualitative research is important for several reasons. Through qualitative research, the researcher discovers concepts and relationships in raw data and then organizes these concepts and relationships, through interpretation, into "exploratory schemes" (p. 11). The qualitative researcher attempts to

understand the lived experiences of people by allowing the participants' voices and perspectives to be known in order to obtain the "intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods" (Strauss and Corbin, p. 11). As Creswell (1998) concluded, through qualitative research, the researcher attempts "to interpret phenomenon in terms of the meaning people bring to natural settings" (p. 15).

Qualitative research, therefore, was important to my study. By using qualitative research processes, I understood the experiences of mental health caseworkers as they voiced how they stayed current with professional knowledge and skills and applied such knowledge and skills while working with others in environments that are ambiguous, uncertain, and chaotic. Qualitative research contributed to understanding the specific details and activities that assisted caseworkers in obtaining and maintaining professional competence with-and-in practice settings.

The Use of Inductive Data Analysis

The common tools used to discover the lived experiences of the research participants include the qualitative method of unstructured interviews. The main purpose for using such a tool is to let the voices of the research participants be heard.

This research study used unstructured interviews in order to understand the learning activities that caseworkers used in their clinical work processes as they cared for people with severe and persistent mental illness. Listening to the voices of caseworkers and understanding their learning activities as used in the context of their work assisted me in obtaining more insight into how they became more competent practitioners. These results, in turn, may help other mental health professionals improve their competence and

mental health organizations improve their accountability with clients and support systems.

<div align="center">Setting</div>

Community mental health centers are those patient service facilities that provide treatment and medical services in the community for people who suffer from severe and persistent mental illness. These centers were established by the 1963 Community Mental Health Act.

In 1978, the National Institute of Mental Health defined these community mental health services as a "community support system" which was an alternative to hospitalization (Martini, 1996). The goal was to "treat the patient as close to his [sic] familiar environment as possible (Anthony & Liberman, 1986, p. 542). The principal treatment modality is termed psychiatric (psychosocial) rehabilitation; caseworkers provide the treatment interventions to the clients of the local community mental health centers. Clients of mental health centers are those individuals who have a diagnosis of a major affective disorder, the impairment of which lasts six months or longer. Clients experience repeated periods of remission and relapse, flare-ups of acute symptoms, and disabilities severe enough to interfere in many of life's domains.

The two primary purposes of community mental health centers are rehabilitation and stability of their clients. Emphasis is on improving functioning, on remediation of the disability of the person, on developing compensations for the disability, on assisting in the re-adaptation to society, on overcoming the social practices that prevent the re-adaptation (such as stigma, discrimination, inadequate income, and housing), and on overcoming a sense of powerlessness (Brink, 1994).

Because this study focused on understanding the learning activities of caseworkers, the settings were two community mental health centers located in a mid-western metropolitan area within the United States.  The first community mental health center was referred to as Western Community Mental Health because it was situated on the western side of the metropolitan geographical area.  The second community mental health center was referred to as Eastern Community Mental Health because it was situated on the eastern side of the metropolitan geographical area.  Because the metropolitan area crossed state boundaries, the mental health centers were each located in a different state.

*Western Community Mental Health*

Those community mental health centers located in the state west of the metropolitan area are granted licensure to operate through the state's Department of Social and Rehabilitation Services.  Such mental health centers must qualify according to the Department's policy and procedure requirements, and periodic re-certification processes are conducted in order to ensure that the centers remain compliant with the requirements for licensure.  The board of county commissioners in each county acts as the governing board of these centers located within the respective county.  The board of county commissioners appoints an advisory board of at least seven members; the advisory board is empowered to establish the center's policies and procedures, set goals, formulate a budget, and hire/evaluate and/or fire the executive director.  The executive director is appointed by and is responsible to the board of county commissioners and has the responsibilities for the center's daily operations, quality of service provision, and the effective and efficient management of resources.

Case management services are provided to any adult client who has a severe and persistent mental illness and who is determined to be in need of case management services. Case management services are provided by one individual or by a team. Each person working as a case manager must be qualified to perform case management duties as prescribed by the Department of Social and Rehabilitation Services either through education and experience (however, the Department of Social and Rehabilitation Services does not clearly specify the details or procedures for obtaining such qualifications) or through the completion of a community services training program approved by the Department of Social and Rehabilitation Services. Case managers are supervised by sufficiently qualified personnel (again, the Department does not provide specific details); these supervisors will either have the necessary experience and education or will have completed a supervisory training program approved by the Department.

Western Community Mental Health Center was one of the community mental health centers licensed by the Department of Social and Rehabilitation Services. It is governed by a seven-member governing board that is responsible to the county board of commissioners. Western Community Mental Health Center began operations in 1962 by providing outpatient services in one location; today, the mental health center provides services in four separate facilities located throughout the county it serves. Twenty-four hour emergency services are also provided to help meet the needs of the persons living within the county who experience a mental health crisis. The mission of Western Community Mental Health is to improve the mental health and life quality of the Center's clients. Its staff accomplishes this mission by providing mental health services tailored to the needs of those the center serves; these services are individualized per client and are easily accessible to all residents.

Case management services provided by Western Community Mental Health Center include a comprehensive range of services to adults who suffer from a severe and persistent mental illness, including residential resources, medical services, attendant care, resource/community development, vocational services, mobile crisis response services, and consumer advocacy   Services also include assistance with benefits, housing, employment, accessing community resources, and ongoing education and support.  Each client is assigned a case manager who is usually the client's most important link with the community.  Case management services also include a respite/partial outpatient hospital program designed to provide clients with support for crisis that is an alternative to hospitalization and that provides needed care 24/7 for up to thirty days.  Attendant care workers provide companionship and oversight to clients who need additional support in living independently.  Services are based on individual needs and may range from a few hours at a time in the client's residence to 24-hours a day in some group living settings.

The focus of these services is to help the clients stabilize and successfully remain in the community, even during times of intense crisis.  The Center has six case management teams that have the primary responsibility for delivery of these services. Each team consists of 7-8 caseworkers; therefore, Western Mental Health Center employs between 42 and 56 people who deliver services to people suffering from severe and persistent mental illness.

*Eastern Community Mental Health*

Those community mental health centers located in the state east of the metropolitan area are granted licensure to operate through the state's Department of Mental Health.  The Department of Mental Health oversees and certifies the state's

community mental health centers, establishes the qualifications for the personnel who hold positions within the centers, and conducts periodic audits to ensure compliance with licensure to operate.

The State Department of Mental Health defines case management as those activities aimed at linking the client to the service system and coordinating the various services that the client needs. Such services include developing a treatment plan for the client, identifying and establishing the needed services, regularly reviewing the client's case, documenting progress on treatment, and advocating for the client.

The Department of Mental Health specifies who qualifies as professionals or those who are legally able to work for the community mental health agencies. Specifically, the Department of Mental Health mandates that case managers (called community support workers) be part of the team that delivers treatment services and work under the supervision of a qualified mental health professional. Community support workers must have at least a bachelor's degree in social work, psychology, nursing, or a related field in order to be hired by a mental health agency. However, equivalent experience may be substituted on the basis of one year of experience for each year of required training.

Supervision of community support workers is conducted by qualified mental health professionals. A person is determined to be a qualified mental health professional by possessing a master's or a doctoral degree in counseling, psychology, family therapy, or a related field and having one year of treating problems related to mental illness while under the supervision of a qualified mental health professional. Other qualifications include having a master's degree in pastoral counseling; or being a licensed physician, a licensed psychologist, a psychiatric nurse, or a social worker at the master's level.

81

Community mental health organizational staff must undergo a clinical privileging process: the agency for which the staff personnel work provides authorization to render services limited to those that the staff person is trained to do or to the possession of the experience and qualifications to perform his or her duties. Clinical privileges are approved both by the agency's governing body and the Department of Mental Health. This process includes periodic reviews of the professional's credentials, performance, and education. Renewal or revision of the clinical privileging process takes place, at a minimum, every two years.

Eastern Community Mental Health Center is one of the community mental health centers licensed by the Department of Mental Health. It is governed by a nine-member board that is responsible to the Department of Mental Health. Eastern Community Mental Health Center began operations in 1970 by providing outpatient services in two facilities which are still currently operating. Twenty-four hour emergency services are also provided throughout the eastern part of the metropolitan area. The mission of Eastern Community Mental Health is to continuously strive to improve the quality of mental health services provided by the Center.

Eastern Community Mental Health Center provides a comprehensive array of treatment and rehabilitation services. Clinical case managers assist clients in establishing goals and accessing the needed resources in order to achieve their goals. Group and individual counseling helps clients learn to cope with their illness. Through medication services, psychiatrists prescribe and monitor medications that clients take in order to stabilize the symptoms of their mental illness. Job development and supports assist clients in obtaining and maintaining employment. Independent living skills training provides clients with the necessary skills they need in order to live as independently as

possible in the least restrictive environments.  Recreation activities connect clients with

other people and activities in the community.  Twenty-four hour crisis interventions,

partial hospitalization facilities, and relapse prevention programs are available to help

clients who are in crisis so that the clients do not need to be hospitalized.  Throughout the

eastern edge of the metropolitan area, 8 teams of caseworkers provide the majority of

these services.  With approximately five people per team, Eastern Mental Health Center

employs around 40-50 caseworkers.

<p align="center">Participants</p>

Caseworkers assist clients with "perform[ing] those physical, emotional, social,

and intellectual skills needed to live, learn, and work in the community with the least

amount of support from agents in the helping professions" (Anthony & Liberman, 1986,

p. 542).  The professional either teaches the specific skills needed to function in the

community or arranges the necessary environmental supports that will compensate for

deficits in skills (Anthony & Liberman).  The principal goal of a caseworker's job is the

prevention of unnecessary hospitalization through symptom stability and functional skills

development (Cook, Graham, & Rassano, 1993).  Stability for people with a mental

illness includes three dimensions:  (a) absence of re-hospitalization, thus remaining in the

community longer; (b) effective use of functional ability and/or environmental supports

to compensate for deficiencies; and (c) the ability to live "as normally" in the community

as possible.   The care and treatment of clients are vital concerns and components of

caseworkers' professional jobs.  Keeping clients out of the hospital and stable are two

accountability or outcome measures for caseworkers.

Caseworkers are considered to be professionals who must have obtained at least a

four year degree in a human-service related field from a recognized institution of higher

<p align="center">83</p>

education; the majority of the degrees earned come from the disciplines of psychology, sociology, social work, therapeutic recreation, and social gerontology. Caseworkers work for the community mental health center in teams that provide direct care-treatment service interventions to clients with severe and persistent mental illness.

In order to collect the data, participants must be selected, and the participants "need to be individuals who have taken an action or part in a process that is central to the study" (Creswell, 1998, p. 117). Since this project focused on the learning activities of caseworkers who worked in psychiatric rehabilitation community mental health centers, caseworkers were the participants in this research study.

I met with supervisors of the casework teams. All six supervisors at Western Mental Health Center nominated caseworkers to participate in this study; five of the seven supervisors at Eastern Mental Health Center nominated caseworkers. Supervisors nominated caseworkers that they identified as being competent because an assumption was made that direct-line supervisors knew their caseworkers sufficiently in order to inform me of the workers who displayed professional competence. The caseworkers who were nominated to participate in this study were considered by their supervisors as representing "the best of professional competence" among the team members who worked at the two mental health facilities. Six caseworkers were interviewed from Western Mental Health and five from Eastern Mental Health.

Supervisors also asked co-workers of each of the caseworkers who were participants in this study to volunteer to be interviewed concerning their perceptions of the caseworkers' professional competence and abilities. These co-workers were identified and asked to volunteer to participate in this study because they knew the caseworkers sufficiently enough to discuss the caseworkers' involvements with learning

84

activities and to describe their perspectives of the caseworkers' professional growth and development.  Each co-worker had the same job role and function, background, and educational level as the caseworkers who participated in this study.

Data Collection

Collecting data from participants involved in the social context under study allowed their voices to be heard and their perspectives to be revealed.  This outcome was an important result of data collection strategies.  In this study, I used interviews as the method to obtain my data.

*Interviews*.  Interviews play an important role in data collection in qualitative research.  This type of interviewing gathers data from the interviewee's point of view. The researcher asks open-ended questions and uses probes to obtain further information. Silverman (2001) captured the essence of interviewing within qualitative research: "Interviews. . .offer  rich sources of data which provide access to how people account for both their troubles and their good fortune" (p. 114).  And, as Bowers (1993a) further explained:  "We are asking the people we interview to inform us (the researcher) about their perspectives. . .how they define and act toward the phenomena in question. Research informants are the experts about the phenomena in question. . .when we are trying to understand the lived experience. . . .They are the ones living day-to-day with [their] work. . .and its consequences" (p. 2).

I used unstructured interviews as sources of data for this study in order to gather perspectives of caseworkers about their learning activities that have increased their professional competence.  I used an unstructured interview guide (see Appendix 5) to frame my interview questions.  I interviewed 11 caseworkers, and each interview lasted from 1 to 11/2 hours per caseworker.  I also interviewed eleven supervisors and eleven

co-workers, one for each of the caseworkers interviewed.  I used unstructured interview guides for the supervisors and co-workers (see Appendices 6 and 7); each of these interviews lasted between thirty and forty-five minutes.  Supervisors and co-workers where interviewed in order to collect multi perspectives pertaining to the caseworkers' abilities and professional competent practices.

<div align="center">Data Analysis</div>

Strauss and Corbin (1998) discussed the need to analyze data from the beginning of a project "to generate initial categories (with their properties and dimensions) and to discover the relationships among concepts" (p. 57).  The first case will teach the researcher about other cases, moving the researcher from "the specific to the more general" (p. 88).   Strauss and Corbin added that ". . .we use a case to open up our minds to the range of possible meanings, properties, dimensions, and relationships inherent in any bit of information" (p. 88).  Thus, through the use of inductive data analysis, the researcher begins with raw data consisting of multiple sources of information, and then broadens to specific themes represented by the research participants' perspectives (Creswell, 1998).  The researcher attempts to discover the multiple realities of the participants, describe them, and analyze their similarities and differences.

An important approach to analyzing data is to develop codes and/or categories (Strauss & Corbin, 1998; Creswell, 1998).  Strauss and Corbin defined coding as "the analytic processes through which data are fractured, conceptualized, and integrated. . ." (p. 3).  Wolcott (1994) described this process as "identifying bits and pieces of information. . .and linking these concepts and themes around which the final report is organized" (p. 76).  The goal is to saturate the data (continue looking for categories until there is no more new information to categorize).  Creswell explained this process as

<div align="center">86</div>

"reducing the database to a small set of themes or categories that characterize the process or action being explored. . . ."(p. 151). Miles and Huberman (1994) summarized coding by stating that coding reduces the data and combines data for easier analysis.

Data were analyzed by reading the transcriptions the first time and coding for "labels" which were used for categories of information. The data were then read a second time in order to establish the interrelationships between the categories. Then the first interview was re-read in order to frame the information from the data into a concept map. The second interview was re-read for the same purpose; then the two concepts maps were merged into a bigger concept map in order to have a model that established the connections and interrelationships among the data. All interview data were thus re-read and concept maps merged until one concept map containing all the relationships and connections of all the data was constructed.

Each of the community mental health participants' interviews was thus coded and analyzed. Two main concepts maps were completed, one for each of the community mental health facilities. Upon further analysis, both concepts maps were so similar in structure that they were merged into one concept map that formed the basis for the categories and relationships that emerged from the data.

Whereas caseworkers' interviews were analyzed individually for data because the caseworkers' provided the primary source of data collection for this project, I merged the interviews from supervisors and co-workers into groups. The findings that emerged from these interview data were grouped in order to provide confidentiality about what supervisors and co-workers said about each specific caseworker. This analytical approach served the purpose of triangulation of data concerning the activities that were

used in the caseworkers' professional development and how these activities contributed to their professional development of competence.

<div style="text-align: center;">Trustworthiness, Consistency, and Transferability</div>

Qualitative research is influenced by interpretation which means that "both the research design and the analysis of the data are informed by assumptions that the world is socially constructed, that we are all meaning makers, and that reality is dependent on context" (Bowers, 1993b, p. 11). Reality becomes "a multiple set of mental constructions" (Lincoln & Guba, 1985, p. 295) which is made by humans. In order to demonstrate trustworthiness (or, as Lincoln and Guba have termed the idea, *truth value*), the researcher must show that he or she has "*represented those multiple constructions* [of reality] *adequately*" (Lincoln & Guba, p. 296). The research study must be "credible" (p. 296); the researcher must demonstrate the credibility of the findings by "having them approved by the constructors of the multiple realities being studied" (p. 296).

Silverman (2001) also described the rationale for establishing trustworthiness. As he stated, "once we treat social reality as always in flux, then it makes no sense to worry about whether our research instruments measure accurately" (p. 226) as "'truth' is interpreted as the extent to which an account accurately represents the social phenomena to which it refers" (Silverman, p. 232). The job of the researcher is to adequately represent the experiences, perceptions, and/or perspectives of the research participants.

Several processes ensure that trustworthiness is established in a research project. Triangulation of data compares different kinds of data such as documents and interviews "to see whether they corroborate one another" (Silverman, 2001, p. 233). Member checks is defined as "taking one's findings back to the subjects being studied. . .[w]here these people verify [the researcher's] findings" (Silverman, p. 233). A peer

<div style="text-align: center;">88</div>

debriefer/coder examines a certain percentage of the researcher's data in order to find consistency in the researcher's results and conclusions. The audit trail involves keeping detailed written records of the research project, including transcripts, memos, a research journal and notes, and any other records pertaining to the research project (Creswell, 1998, p. 203).

Such processes ensure that consistency in the findings exist, thus increasing the project's trustworthiness. The idea is that given the data collected, the results make sense—they are consistent and dependable (Lincoln & Guba, 1985). Consistency means that the perspectives of the participants are conveyed as "truthfully" (Lincoln & Guba, p. 290) as possible by the researcher, that the interpretations of the data are plausible, and that the findings of the investigation reflect the data collected.

The ultimate goal of the research study is to ensure transferability so that the reader seeking to "make application elsewhere" (Lincoln & Guba, 1985, p. 296) can decide if a match exists between the context of the original research findings and the reader's. The researcher describes through "rich and thick description" (Creswell, 1998, p. 203) the details of the settings and the participants of the study. This, in turn, will allow readers to determine whether the information can be transferred to other settings.

In order to maintain trustworthiness and consistency in findings, I used several processes. I used multiple sources of data and triangulated data by interviewing 11 caseworkers, their supervisors, and 11 of their co-workers. I also conducted two member checks. The first member check consisted of constructing conclusions from each interview (see Appendix 8). Each summary conclusion was reviewed and verified by individual participants. I telephoned each caseworker and read each caseworker the summary conclusions. Ten of the eleven caseworkers were available to hear the

conclusions, and all ten of these study participants agreed that the summary conclusions were "reasonable" and "truthful."

The second member check occurred after the research conclusions were finished. I contacted the caseworkers who participated in the study again. Nine caseworkers agreed to review the conclusions, so I met with these research participants, two individually and seven as a group. After reviewing the conclusions, the participants agreed that the research conclusions were "truthful."

A supervisor from the organization in which I work served as a peer debriefer/coder. This supervisor independently analyzed and interpreted 10% of my data. The independent coding of my colleague and myself were then compared to compute 100 percent of agreement. If a discrepancy existed, we discussed the data until we agreed upon the codes. The peer debriefer/coder and I also met monthly in order to compare notes and determine if the findings of this peer debriefer/coder and myself were consistent in meanings. The meetings were also used to verify the categories, the interrelationships and connections among the categories, and the themes that emerged from the categories.

I also maintained an audit trail by keeping a journal throughout the data collection/analysis phases; this journal contained detailed accounts of what I did well as memos concerning my thoughts, perceptions, and perspectives. I also kept all notes and rough drafts of my chapters as further examples of my thought processes and perceptions of how professional development occurred in relation to learning activities.

In order to ensure transferability, I provided a rich and thick description of the context of the setting and the participants' perspectives. Through such descriptions, the readers can decide if the findings can be transferred to other contexts.

In the next chapter I will present the findings of my study.  I will describe the participants, themes about competence, and the findings in terms of the major research question and two research sub-questions.

CHAPTER 4

FINDINGS

This chapter presents the findings of this qualitative study about the learning activities of caseworkers for the development of professional competence. Four sections are presented. The first section describes the participants in terms of their educational levels and years of experience within the mental health profession. The second section describes the themes about competence that emerged from the data from the perspectives of the participating caseworkers, supervisors, and peer/co-workers. The third and fourth sections provide answers to the central research question: from the perspectives of the research study participants, what are the learning activities that caseworkers use in order to develop and/or maintain competence with-and-in professional practice? The third section provides answers to the first research sub-question: from the perspectives of the research study participants, what different learning activities do caseworkers use in their professional development? The fourth section provides answers to the second research sub-question: from the perspectives of the research study participants, how do these learning activities contribute to their professional development? This chapter ends with a summary of the findings.

Participants

The participants interviewed for this study were eleven mental health caseworkers. The interviews were completed over a two-month period. Six of the participants worked in Western Mental Health Center; five worked in Eastern Mental Health Center. The two community mental health facilities were located in a mid-

western metropolitan city within the United States.  Because the metropolitan area crossed state boundaries, the mental health centers were each located in a different state.

Seven of the caseworkers were female; four were male.  The education backgrounds and levels of the participants varied.  All of the participants had obtained bachelor's degrees, consisting of degrees in social science, sociology, rehabilitation psychology, psychology, clinical psychology, social work, and criminal justice.  Four of the caseworkers had master's degrees, two in social work, one in telecommunications, and one in counseling psychology.  Two caseworkers were working on their master's degrees, one in counseling and the other in psychology.  Two caseworkers were planning to start working on their master's degree within the following year; one was going to pursue an advanced degree in social work and the other caseworker an advanced degree in family and marriage counseling.

The participants' experiences also differed in terms of years of practice within the field of mental health.  Their experiences within the field ranged from seven to seventeen years.  Only one caseworker had been at the same facility where she had started; the other ten caseworkers had worked at several facilities but had stayed with case management-type work in all the different work settings.

Additional information on individual participants can be found in Appendix 8 which contains summary conclusions of the learning processes that emerged from their interviews.  Pseudonyms were assigned to participants in order to preserve confidentiality.  Supervisors and co-workers were also interviewed and referred to only as "he" or "she" in the written content of the data interpretations in order to further maintain confidentiality of the participants as well as supervisors and co-workers.

Four major areas of competence emerged from the data: personal competence, work competence, tools competence, and learning competence. (Refer to Figures 5, 6, and 7). By reviewing Figures 5, 6, and 7, comparisons and contrasts can be made between the caseworkers', supervisors', and co-workers' perceptions about competence. In these tables that follow, I have indicated with an "x" when a caseworker, supervisor, or co-worker mentioned during the interview information concerning the competence areas.

Three areas of caseworker personal competence emerged from the data: emotional maturity, cognitive abilities, and personal values about clients. Emotional maturity included having the ability to offset burnout, handle change, and separate professional life from personal life. Cognitive abilities included the use of memory processes, intuition, and clinical judgment. Values about clients included compassion, empathy and support, client empowerment, overcoming stigmas, boundary setting, recognizing individual factors about clients, not working harder than clients, and not taking clients' remarks personally.

Caseworkers focused on personal competence in all three areas of emotional maturity, cognitive abilities, and values about clients. Supervisors focused less on personal competence than caseworkers but more so than co-workers; supervisors' primary focus was in the dimension of values about clients. Co-workers did not focus very much on personal competence; what focus they did have was in the dimension of values about clients.

Work competence included basic job duties, decision making, problem solving, locating resources, information literacy, time management, documentation, and multi-tasking. Caseworkers focused heavily on work competence. Caseworkers were 100% in

agreement that locating resources and information literacy were important aspects of work competencies and almost 90% in agreement that problem solving was an important competency. Supervisors focused almost as much as caseworkers did on work competence and also were almost in total agreement about locating resources and information literacy as important competencies. Co-workers focused less on work competence than did caseworkers and supervisors; co-workers were primarily in agreement that information literacy was an important competency.

Tools competence included communication channels, making connections, positive attitude about working with others, shared knowledge, networking, and effectively interacting with supervisors and team members. Caseworkers, supervisors, and co-workers concentrated heavily in the area of tools competence. All three groups of participants agreed that communication channels, establishing relationships, and networking were important competencies, with less but still much emphasis on effectively interacting with supervisor and team members.

Within the area of learning competence, all three groups identified that solving work-related challenges and obtaining needed resources were important competency areas. Caseworkers also identified that solving client needs was an important competency.

In the next sections following Figures 5, 6 and 7, each area will be defined and supported by the research participants' data. Data collected from the supervisors and co-workers will also be presented.

| COMPETENCE AREAS --caseworkers | Alex | Bo | CJ | Dot | Fran | Gale | Huie | Ira | Jo | Len | Pat |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Personal Competence** | | | | | | | | | | | |
| a. Emotional Maturity | X | X | X | X | | | X | X | | | |
|    Offset Burnout | X | X | | X | | | X | | X | | |
|    Handle Change | | | X | | | | X | X | | | |
|    Separate Job from Personal Life | | X | | | X | | X | | X | | |
| b. Cognitive Abilities | | | | | | | | | | | |
|    Memory Process | X | | X | | X | | X | | | | |
|    Intuition | | X | | X | X | | X | X | X | X | X |
|    Clinical Judgment | X | | X | X | X | | | | | | |
| c. Values about Clients | | | | | | | | | | | |
|    Compassion | | | X | | X | X | | | X | X | |
|    Empathy and Support | | X | | X | X | | | | X | X | |
|    Client Empowerment | X | | X | X | | X | X | X | X | X | X |
|    Overcoming Stigmas | X | | X | | X | | | | X | | |
|    Boundary Setting | X | X | | X | | | X | | X | X | |
|    Individualization | X | X | | X | X | | | | X | X | X |
|    Not work harder than clients | X | | | | | | X | | | | |
|    Don't take client's remarks personally | | X | | | | X | X | | | | |
| **Work Competence** | | | | | | | | | | | |
| a. Basic Job Duties | X | X | X | X | | X | X | | | | |
| b. Decision Making | X | | X | | X | X | | | | | |
| c. Problem Solving | X | | X | X | X | X | X | X | X | | |
| d. Locating Resources | X | X | X | X | X | X | X | X | X | X | X |
| e. Information Literacy | X | X | X | X | X | X | X | X | X | X | X |
| f. Time Management | X | | | | X | | | | | X | |
| g. Documentation | | X | | X | | | | | X | | X |
| h. Multi-Tasking | X | X | X | | | | | X | X | | |
| **Tools Competence** | | | | | | | | | | | |
| a. Comm. Channels | X | X | | X | X | X | X | | X | X | X |
| b. Making Connections | | | X | X | X | X | X | X | | X | |
| c. Positive Attitude | | | X | X | | X | X | X | X | X | X |
| d. Shared Knowledge | X | | | | | X | X | X | | | |
| e. Networking | X | X | X | X | X | X | X | | | X | |
| e. Supervisor | | | X | X | X | X | X | X | X | | X |
| f. Team | X | X | X | | X | X | X | X | X | | X |
| **Learning Competence** | | | | | | | | | | | |
| a. Solving Client Needs | X | | X | | | X | X | X | | X | |
| b. Solving Work-Related Challenges | | X | | X | X | X | X | X | X | X | |
| c. Obtaining Needed Resources | X | X | X | X | X | X | X | X | X | X | |

Figure 5: Competence Areas as Viewed by Caseworkers

96

| COMPETENCE AREAS --supervisors | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Personal Competence** | | | | | | | | | | | |
| a. Emotional Maturity | | | | | | | | | | | |
| Offset burnout | | | | X | | | X | | | | |
| Handle change | | | | X | | | | | | | X |
| Separate Job from Personal Life | | | | X | | | | | | | |
| b. Cognitive Abilities | | | | | | | | | | | |
| Memory Process | | | | | | | | | | | |
| Intuition | | | | | | | | | X | | |
| Clinical Judgment | X | | | | | | | | X | | X |
| c. Values about Clients | | | | | | | | | | | |
| Compassion | | | | | X | X | X | X | X | | X |
| Empathy and Support | | | X | | | | | X | | | X |
| Client Empowerment | X | | X | | X | X | X | X | | | X |
| Overcoming Stigmas | | | | | | | | | | | |
| Boundary Setting | | | | | X | | | | | | |
| Individualization | | | | | | | | | | | |
| Not work harder than clients | | | | | | | | | | | |
| Don't take client's remarks personally | | | | | | | | | | | |
| **Work Competence** | | | | | | | | | | | |
| a.  Basic Job Duties | X | X | | | | | | X | X | | |
| b.  Decision Making | | | | | | | | | | | |
| c.  Problem Solving | | | | | | | | X | | | |
| d.  Locating Resources | X | X | X | X | | X | X | X | X | X | X |
| e.  Information Literacy | X | X | X | X | | X | X | X | X | X | X |
| f.  Time Management | | X | X | | X | X | | X | X | | |
| g.  Documentation | | | | | X | | | | | | |
| h.  Multi-Tasking | | X | | | X | X | | X | X | | |
| **Tools Competence** | | | | | | | | | | | |
| a.  Comm. Channels | | | X | | | | X | | X | | X |
| b.  Making Connections | X | X | X | X | | X | X | X | X | | X |
| c.  Positive Attitude | | | X | | X | X | X | | | | X |
| d.  Shared Knowledge | | | X | | | | | X | | | |
| e.  Networking | | X | X | X | X | X | X | X | X | X | |
| e.  Supervisor | | | | X | X | | X | X | X | X | X |
| f.  Team | | | | X | X | | X | X | X | X | X |
| **Learning Competence** | | | | | | | | | | | |
| a.  Solving Client Needs | | | | | X | | X | | | | |
| b.  Solving Work-Related Challenges | | | X | | X | | X | | X | | X |
| c.  Obtaining Needed Resources | | | X | | X | | X | | X | | X |

Figure 6:  Competence Areas as Viewed by Supervisors

| COMPETENCE AREAS --co-workers | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Personal Competence** | | | | | | | | | | | |
| a. Emotional Maturity | | | | | | | | | | | |
|    Offset Burnout | | | | | | | | | | | |
|    Handle Change | | | X | | | X | | | | | X |
|    Separate Job from Personal Life | | | | | | | | | | | |
| b. Cognitive Abilities | | | | | | | | | | | |
|    Memory Process | | | | | | | | | | | |
|    Intuition | | | X | | | | | | | | |
|    Clinical Judgment | | | | | | | | | | | |
| c. Values about Clients | | | | | | | | | | | |
|    Compassion | | | X | | | | | | | X | X |
|    Empathy and Support | | | | | | | | | | | X |
|    Client Empowerment | | | X | | | | | | | X | X |
|    Overcoming Stigmas | | | | | | | | | | | |
|    Boundary Setting | | | | | | X | | | | | |
|    Individualization | | | | | | | | | | | X |
|    Not work harder than clients | | | | | | | | | | | |
|    Don't take client's remarks personally | | | | | | | | | | | |
| **Work Competence** | | | | | | | | | | | |
| a. Basic Job Duties | | | | | | | | | | | |
| b. Decision Making | | | | | | | | | | | |
| c. Problem Solving | | | | | | | | | | | |
| d. Locating Resources | X | X | X | X | | | | | X | X | X |
| e. Information Literacy | X | X | X | X | | X | X | X | X | X | X |
| f. Time Management | | | | | | X | | | | | |
| g. Documentation | | | | | | | | | | | |
| h. Multi-tasking | | | | | | | | | | | |
| **Tools Competence** | | | | | | | | | | | |
| a. Comm. Channels | X | | X | | X | X | | | | | X |
| b. Making Connections | | | X | | X | X | | | X | | X |
| c. Positive Attitude | | | X | | X | | | | X | | X |
| d. Shared Knowledge | | | X | | | X | | | X | | |
| e. Networking | X | X | X | | X | X | X | X | | | |
| e. Supervisor | | | X | X | | | X | X | X | | X |
| f. Team | | | X | | | | X | | X | X | X |
| **Learning Competence** | | | | | | | | | | | |
| a. Solving Client Needs | | | | | | | | | | | |
| b. Solving Work-Related Challenges | | | X | X | X | | | | X | X | X | X |
| c. Obtaining Needed Resources | | | X | X | X | | | | X | X | X | X |

Figure 7:  Competence Areas as Viewed by Co-Workers

*Personal Competence*

Three areas of caseworker's personal competence emerged from the data: emotional maturity, cognitive abilities, and personal values about clients. Emotional maturity included having the ability to offset burnout, handle change, and separate professional life from personal life. Cognitive abilities included the use of memory processes, intuition, and clinical judgment. Values about clients included compassion, empathy and support, client empowerment, overcoming stigmas, boundary setting, recognizing individual factors about clients, not working harder than clients, and not taking clients' remarks personally.

*Emotional maturity.* Caseworkers discussed how they balanced their professional and personal lives, therefore avoiding job burnout. Caseworkers were "flexible" and "adaptable" when dealing with a work environment that constantly changed. Huie stated that "adapting to change is big" because "things always change" and caseworkers should see "change as exciting." Fran discussed how she avoided job burnout when she stated "I do socialize here at work. With my office mate and a couple of other caseworkers—and we always find time to get together at least once a week. To try to kind of decompress." Alexis discussed how she avoided burnout when she concluded that "One of the things I've learned from past experiences is that I have to let some things go, and then to understand that what I can't do I need to find somebody else to do. Otherwise, I'm going to be burned out." Bo pointed out that she did not "take work home with her" and that she "had friends and interests outside of work."

Supervisors identified that their caseworkers were "positive" in their attitudes and handled change effectively and did not let the stress of the job burn them out. Supervisors also stated that many of the caseworkers understood how to separate their

professional and personal lives.  One supervisor stated that his caseworker was "very non-reactive.  He rarely gets ruffled or upset.  He's able to handle crisis in a calm manner. . . .He's just a very patient person."  Yet another supervisor described how her caseworker "takes care of herself and is able to balance her work and personal life and avoid burnout."  Another supervisor commented that his caseworker had a "passion in her that I very much appreciate and I think it gives her the drive to do the work she does."

Co-workers reported that their team members, with time and experience, developed emotional competence which included the skills to offset burnout and handle change.  Co-workers described their team members in such terms as being "stable," "knowing how to handle frustration," and "taking care of themselves by balancing private and personal lives."  One co-worker commented that he thought his team mate was "pretty stable all the time."  Another co-worker stated that her team mate "knows when she needs some time to herself.  She has a good balance and I think that helps her stay competent."

*Cognitive abilities.*  Caseworkers discussed their cognitive skills and abilities, which consisted of memory processes, intuition, and clinical judgment.  They had in their long term memories scenarios of situations encountered with clients that they used as reference points when dealing with similar situations in the present.  They developed intuitive use of decision making and judgment in order to solve problems "because they just know" how to do so.  Caseworkers felt that they had the experiential background that assisted with "making sense" and "meaning" of their jobs and use of "skill sets." Pat explained the use of intuition as "They [clients] may not be saying it that they're really depressed but when you look at them, you know something's going on here."  Fran explained the use of her cognitive abilities in this way:  "The information on different

100

symptoms, community resources that are out there, it's kind of like a roll-a-dex in your mind." Bo had no idea how she developed her intuition or clinical judgment skills but described how she thought that her intuitive development was through "habit. If I listen to it, it's never led me astray. I trust my gut feeling. I've learned to say, "OK, if it doesn't feel right, then, something's wrong."

Supervisors reported that they felt that their caseworkers had "common-sense understandings" about how to work with their clients and perform their jobs. One supervisor stated that his caseworker was "forward thinking." Another supervisor stated that his caseworker "was very level headed" and had "sound judgment."

Co-workers viewed their team members as "being able to "use" what was in their memories and "intuitive." One co-worker stated that her team mate was "very decisive. She pays a lot of attention to what she's saying, she's very intuitive." Another co-worker commented on how her team member was "able to use what she had learned and pass that along to me because that heightened my understanding of the situation[s] encountered."

*Values about clients.* Caseworkers identified that they effectively used personal values with clients. Caseworkers saw "beyond the symptoms and the disability" and understood that clients are individual human beings with the same emotions, desires, and needs as "you and me," worthy of "compassion," "understanding," "empathy," and "social worth." In addition, caseworkers understood that clients were not going to be "their friends," and thus acquired the knowledge and "know how" to establish professional roles and boundaries while being able to "step back" from taking control of clients' lives and trying to solve all their problems. Caseworkers empowered clients to make their own decisions and to live with related consequences, educating clients with the "know how" to "recover." Caseworkers realized that they could not "be all things to

101

all clients" or be the "superhero of every moment."  Fran described her values about her clients as "trying to instill those coping skills, about trying to provide as much support as I can, and encouragement to help motivate them, to get them back to where they [clients] want to be."  Dot explained that she knew when to back away from client problems when she did "what I can but it's still my client's problem and I just have to just sometimes say, "OK, I've done what I can."  Caseworkers also understood that they should not work harder than their clients and not take clients' remarks personally.

Supervisors remarked that their caseworkers focused on client safety when working with clients and treated their clients with respect.  Caseworkers also had "compassion" towards their clients, desiring to help clients obtain their goals and be independent with daily living skills so that they would not have to rely upon professionals for the rest of their lives for assistance and support.  Supervisors even reported that they thought that their caseworkers enjoyed working with clients.  One supervisor stated that his caseworker was "laid back. . .her personality alone is really great with her not getting flustered with clients."

Co-workers described their team members in terms of having "empathy and support for clients," having the patience to meet with clients and provide treatment interventions, and "providing assistance" to clients to help them learn to meet their needs. One co-worker stated that his team member "gets to know the client pretty well, cognitively and with whatever better will help them get through situations."  Another co-worker stated that he knew "that my clients that have interacted with him [team member] or had him in group always have great reports of the way that he interacts."

*Work Competence*

        Caseworkers identified that work competence included skillful processes of their basic job duties, decision making, problem solving, locating resources, information literacy, time management, documentation, and multi-tasking. They were able to juggle the multiple demands of their jobs in order to resolve client problems and satisfy client needs. They had the "knowledge" to do their jobs and treat clients and performed at many demanding and different professional roles. ." Dot thought that "a big chunk of my responsibility as a case manager—is to make sure that they [clients] are keeping on with what they need to do, especially if they have limited cognitive ability." Fran described her professional expectations as "Time management! You're expected to bill a certain amount. But your time is flexible and you're about trying to balance family and work and upholding your expectations within your job."

        Supervisors identified that competent caseworkers could find, locate, access, and use needed resources and information in order to resolve clients' problems and issues. Competent caseworkers also understood how the processes associated with each resource worked and could share that information with co-workers. Competent caseworkers were also identified as being able to "do a well-rounded job of getting their own information," of being able to "disseminate information," being "organized" about accessing and using information, and being "resourceful" for finding information independently. Competent caseworkers were also seen as being "organized" and "able to multi task" when looking for resources and information.

        Co-workers discussed how they thought that their team members were "prepared," "organized," and "good at locating and finding resources." One co-worker described how his team mate "was so knowledgeable about what goes on and that's to

my benefit because then I don't have to act like 'what the heck am I suppose to be doing?" Another co-worker stated that he thought that his team mate did "a good job with figuring out what we can utilize for our clients."

*Tools Competence*

Caseworkers also had tools competence which consisted of working with physical and social tools. Physical tools consisted of technology (such as computers, telephones, and fax machines) and non-human resources (such as libraries and newspapers). Social tools consisted of human resources such as co-workers, community resource personnel, and subject matter experts. Caseworkers identified that they had "skill sets" that assisted with the effective and efficient use of treatment protocols with clients and interactions and relationship skills with co-workers, supervisor, team members, and community resource personnel. Caseworkers discussed how important effective communication channels, making connections, networking, and building a shared knowledge base were. Alexis described how important teams were for her situations:

> you're talking about the team situation. Teams are very important to
> work. It's very important to work as a team—because to do a job like this
> you have to have a team, you know, because I don't know everything. But
> maybe my co-worker does. And they [team members] can give me the
> most up-to-date information. Where to begin, that search, or where to
> start in the process. There is no way you could—I just don't see anyway
> you could do—be a caseworker without having a team.

Supervisors identified competent caseworkers as using effective skills with physical and social tools. Caseworkers networked in order to find information and resources to share with each other and use in order to resolve client issues. As team members, competent caseworkers provided their colleagues with suggestions, ideas, and feedback about handling situations; they cared about each other without becoming enmeshed in personal situations; they were positive and willing to assist their team mates

104

within the limits of their qualifications and job responsibilities; and they respected the boundaries and quality of each other's work.

Co-workers identified their team members as being adept at interacting with social tools by being "team players." They were viewed as being well-prepared, organized, being available to be contacted easily, being "easy to talk to," and having a "good reputation" because of the establishment of "good relationships" with everyone. Co-workers also noted that their team members were "honest," "supportive," "understanding," "positive," and "professional." They "networked" and "collaborated" with their team members by sharing information and resources. One co-worker stated that "it was just a nice collaboration" working with her team mate and that she "really liked working with her."

*Learning Competence*

Caseworkers identified that learning competence included maintaining a positive attitude and openness about learning in order to solve client needs and work-related challenges and obtain needed resources. Gale reported that "obviously as you continue to work, you just learn so much everyday. I would say just continuing to learn [is important]." She added that "I'm always willing to learn and I always want to learn and I always want to know what I can be doing better." She also offered that "there are always things that come up that I can learn about." And Pat added "That's everyday, you kind of learn something new." Fran concluded that "because I think there are a lot of resources out there that I don't even know about, and so I am learning about them and remembering them."

The majority of the supervisors noticed that their caseworkers were self-directed with learning. One supervisor commented that his caseworker "seeks out training, wants

105

to learn.  She's very humble, she doesn't let ego get in the way, there's always room for her to grow."  Another supervisor stated that his caseworker "will attend a workshop if he thinks there is really something to learn."  Further comments about caseworkers' continuing to learn included:  "he really looks for those workshops that are clinically going to improve his skills and his level of knowledge" and "he's kind of picky and choosey about what he really wants to, what he thinks is really going to be beneficial and chooses to go to those [kinds of trainings]."

Co-workers viewed their team members as having the attitude for continuous learning.  Because clients always have new needs and issues, competent caseworkers were perceived by their co-workers as being open to learn about the necessary resources and information that would resolve client concerns.  Co-workers also viewed their team members as having the desire to continue to learn new techniques and skills in order to be the "best caseworker possible."

Four major areas of competence emerged from the data.  Caseworkers developed personal, work, tools, and learning competence.  The next two sections provide answers to the major research question:  from the perspectives of the research study participants, what are the learning activities that caseworkers use in order to develop and/or maintain competence with-and-in professional practice.  Section three addresses and provides answers to the first research sub-question:  from the perspectives of the research study participants, what different learning activities do caseworkers use in their professional development?  The fourth section addresses and provides answers to the second research sub-question:  from the perspectives of the research study participants, how do these learning activities contribute to their professional competence development.

First Sub-Research Question:  Two Major Learning Categories

This section reports on the findings that emerged from the interviews concerning the first sub-question:  From the perspectives of the research study participants, what different learning activities do caseworkers use in their professional development?  Two major learning categories emerged from the interviews.  Caseworkers learned through formal learning activities that consisted of attendance at educational institutions, training/seminars/in-service sessions, and subject matter expert presentations.

Caseworkers also learned from experiences and situations encountered in the environment in which they work.  They engaged in authentic work activities and learned by doing the job, interacting with situations, trial-and-error, assessing situations, and by making mistakes.  Caseworkers learned through mentorship activities as they observed, imitated, and received feedback from co-workers.  Caseworkers also learned from interacting with physical and social tools.  Physical tools consisted of technology (such as computers, telephones, and fax machines) and non-human resources (such as libraries and newspapers) available to help carry out the caseworkers' jobs as efficiently and effectively as possible; social tools consisted of working with people.  Caseworkers learned by actively networking, dialoguing, asking questions, reading printed information, and interacting with the tools during team meetings.

Figures 8, 9, and 10 compare and contrast caseworkers' supervisors', and co-workers' perceptions of learning activities.  I have indicated with an "x" when caseworkers, supervisors, or co-workers discussed related information concerning a learning activity.

Caseworkers did not focus very much on learning from formal opportunities. This is the area of learning that both supervisors and co-workers focused on, especially with educational institutions and trainings/seminars/in-service sessions.

Caseworkers also focused on learning from engagement in authentic work activities. They were 100% in agreement on situational interactions, followed closely by learning by doing. Supervisors did not focus on learning by engagement in authentic work activities except for the activity of learning by doing. Co-workers, like supervisors, did not focus on learning from engagement in authentic work activities except for the activity of learning by doing.

Caseworkers focused heavily on learning through mentorship. Observing, imitating, and feedback were identified as very important learning activities. Supervisors did not focus on learning through mentorship except with minimal attention to the importance of feedback. A few of the co-workers identified observing and feedback as useful learning activities.

Caseworkers focused heavily on learning from physical and social tools. Caseworkers were 100% in agreement about the importance of dialoguing and asking questions. They were in agreement almost 90% about the importance of actively networking. Reading was not as important. Supervisors also focused on learning from physical and social tools, especially in the areas of asking questions and actively networking. Co-workers focused on physical and social tools in the areas of dialoguing and asking questions. They were somewhat focused on actively networking.

Following the pages containing Figures 8, 9, and 10, the caseworkers' perspectives are presented concerning each specific learning activity. The perspectives of co-workers and supervisors follow.

| CASEWORK LEARNING ACTIVITIES--from caseworkers | Alex | Bo | CJ | Dot | Fran | Gale | Huie | Ira | Jo | Len | Pat |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Years of experience | 7 | 17 | 14 | 10 | 14 | 7 | 6 | 7 | 7 | 9 | 9 |
| Education level | MA | BA | MA | BA | BS | MSW | BS | BS | BS | BS | MSW |
| | | | | | | | | | | | |
| **Learning from Formal Opportunities** | | | | | | | | | | | |
| | | | | | | | | | | | |
| a. Educational Institutions | | | | | | | X | | | | X |
| b. Trainings/Seminars/In-Service Sessions | X | | | X | | | X | | | X | X |
| c. Subject Matter Expert Presentations | | | | | X | | | | | | |
| | | | | | | | | | | | |
| **Learning from Experiences/Situations** Co-occurs with integrated learning and is interwoven with interactions with physical and social tools and search and research activities. Is planned/purposeful or unplanned, spontaneous, informal, and incidental. | | | | | | | | | | | |
| | | | | | | | | | | | |
| 1. Engagement in Authentic Work Activities | | | | | | | | | | | |
| a. Learning by Doing | X | | X | | X | X | X | X | | X | X |
| b. Situational Interactions | X | X | X | X | X | X | X | X | X | X | X |
| c. Trial-and-Error | X | | X | X | | | | | | | |
| d. Assessing Situations | X | X | | | X | | X | | X | | |
| e. Making Mistakes | | | X | X | | | | X | | | |
| 2. Mentorship | | | | | | | | | | | |
| a. Observing | X | X | X | X | X | X | X | X | | | |
| b. Imitating | X | X | X | X | X | X | X | X | | | |
| c. Feedback | X | X | X | X | X | X | X | | X | | |
| 3. Physical and Social Tools Interactions | | | | | | | | | | | |
| a. Actively Networking | X | X | X | X | X | X | X | X | X | X | X |
| b. Dialoguing | X | X | X | X | X | X | X | X | X | X | X |
| c. Asking Questions | X | X | X | X | X | X | X | X | X | X | X |
| d. Team Meetings | | | | X | | X | X | X | X | | |
| e. Reading | X | X | X | | | | | | | | |
| | | | | | | | | | | | |

Figure 8: Learning Activities as Viewed by Caseworkers

| CASEWORK LEARNING ACTIVITIES--from Supervisors | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| **Learning from Formal Opportunities** | | | | | | | | | | | |
| | | | | | | | | | | | |
| a.  Educational Institutions | X | X | X | | X | X | X | X | X | X | X |
| b.  Trainings/Seminars/In-Service Sessions | X | X | X | X | X | X | X | X | X | X | X |
| c.  Subject Matter Expert Presentations | X | X | | X | | | | | | | |
| | | | | | | | | | | | |
| **Learning from Experiences/Situations Co-occurs with integrated learning and is interwoven with interactions with physical and social tools and search and research activities.  Is planned/purposeful or unplanned, spontaneous, informal, and incidental.** | | | | | | | | | | | |
| | | | | | | | | | | | |
| 1.  Engagement in Authentic Work Activities | | | | | | | | | | | |
| a.  Learning by Doing | X | X | X | X | X | X | X | X | X | X | X |
| b.  Situational Interactions | | | | | | | | | | | |
| c.  Trial-and-Error | | | | | | | | | | | |
| d.  Assessing Situations | | | | | | | | | X | X | | |
| e.  Making Mistakes | | | | | | | | | | | |
| 2.  Mentorship | | | | | | | | | | | |
| a.  Observing | | | | | | | | | | | |
| b.  Imitating | | | | | | | | | | | |
| c.  Feedback | | | | | X | | X | | X | | X |
| 3.  Physical and Social Tools Interactions | | | | | | | | | | | |
| a.  Actively Networking | X | X | X | X | X | X | X | X | X | | X |
| b.  Dialoguing | X | X | X | | | | X | X | X | X | X |
| c.  Asking Questions | X | X | X | X | X | | | X | X | X | | X |
| d.  Team Meetings | | | | | X | | | | | | X |
| e.  Reading | | | | | X | | X | X | | | |
| | | | | | | | | | | | |

Figure 9:  Learning Activities as Viewed by Supervisors

110

| CASEWORK LEARNING ACTIVITIES--from Co-Workers | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Learning from Formal Opportunities** | | | | | | | | | | | |
| a.  Educational Institutions | X | X | X | X | X | | X | X | X | X | X |
| b.  Trainings/Seminars/In-Service Sessions | X | X | X | X | X | X | X | X | X | X | X |
| c.  Subject Matter Expert Presentations | X | | X | X | | | | | | X | |
| **Learning from Experiences/Situations Co-occurs with integrated learning and is interwoven with interactions with physical and social tools and search and research activities.  Is planned/purposeful or unplanned, spontaneous, informal, and incidental.** | | | | | | | | | | | |
| 1.  Engagement in Authentic Work Activities | | | | | | | | | | | |
|     a.  Learning by Doing | X | X | X | | X | | | | X | X | X |
|     b.  Situational Interactions | | | | | | | | | | | |
|     c.  Trial-and-Error | | | | | | | | | X | | |
|     d.  Assessing Situations | | | X | | | X | | | | X | |
|     e.  Making Mistakes | | | | | | | | | | | |
| 2.  Mentorship | | | | | | | | | | | |
|     a.  Observing | | | X | | | X | | | | | X |
|     b.  Imitating | | | | | | | | | | | X |
|     c.  Feedback | | | X | | | X | | | | | |
| 3.  Physical and Social Tools Interactions | | | | | | | | | | | |
|     a.  Actively Networking | X | X | X | | X | | | | X | X | X |
|     b.  Dialoguing | X | | X | | X | X | X | X | X | X | X |
|     c.  Asking Questions | X | | X | X | | | X | X | X | X | X |
|     d.  Team Meetings | | X | | | X | X | | | X | | |
|     e.  Reading | | | X | | | X | | | | | |

Figure 10:  Learning Activities as Viewed by Co-Workers

*Learning from Formal Opportunities*

Formal learning consists of actually attending a structured "learning" or "educational" institution or program. Having at minimum a bachelor's degree in a human service field is a requirement for being hired as a caseworker. Once hired, caseworkers are expected to continue their education. Both mental health centers required a minimum number of hours of attendance at seminars, in-service sessions, and trainings. Agencies also encouraged caseworkers to continue their education by working on their master's degrees. Two of the caseworkers were pursuing their master's degree while working; two other caseworkers were considering starting their masters' degrees. In-service sessions, trainings, seminars, and subject matter expert presentations were activities that were considered to be formal learning.

Figure 11 is presented on the next page. It illustrates the category of learning from formal opportunities. Formal learning occurs when caseworkers attend educational classes, listen to subject matter experts, and attend seminars/training s/in-service sessions.

EDUCATION

learning occurs

attendance at

learning occurs

attendance at

SUBJECT MATTER
EXPERT
PRESENTATIONS

learning occurs

attendance at

SEMINARS
TRAININGS
IN-SERVICE SESSIONS
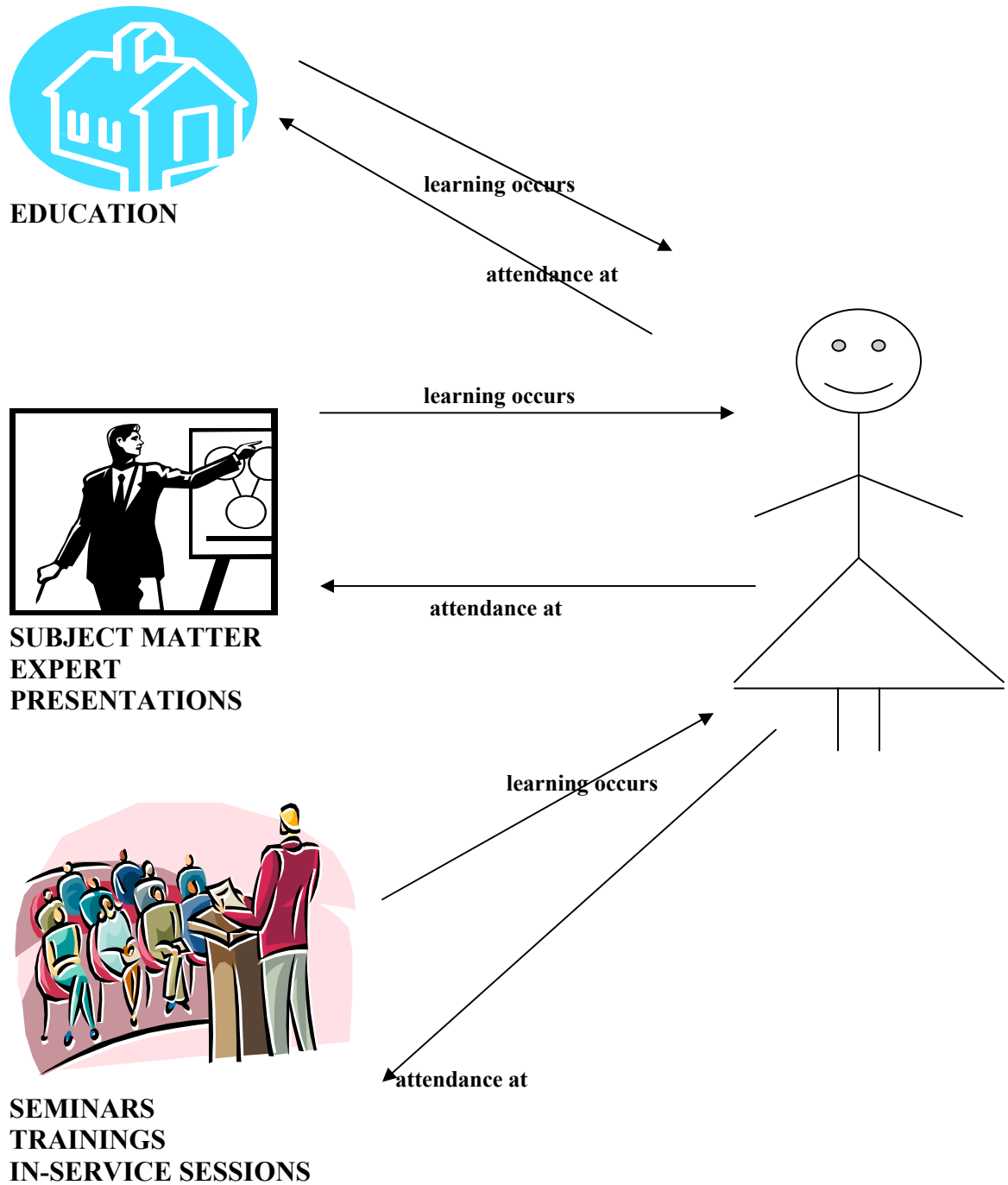
Figure 11:  Learning from Formal Opportunities

*Formal institutions.*    Caseworkers identified that formal education taught them

skills they could use in doing their jobs but not how to do their jobs.  Classes in college

taught them how to problem solve, make decisions, use ethical practices; but on-the-job

learning was the best educator.  Ira's statements are applicable to this situation:  "Um, I mean, I think that the education that I received I think it was important but to be honest with you when you're in the field I think that the best education you can get is from your co-workers and from the professionals that are in the field that have been doing this job for 20 years."  Bo also thought that "this job, you can't learn in college or school."  She did, however, think that the formal education helped caseworkers "with your thinking processes, you know, to be able to problem solve, and stuff. . .and just dealing with people in general."  She also discussed how the "core classes" taught caseworkers how to do research, write, and look for information.  Pat was in agreement with Bo because he also thought that formal education "teaches you different skills and techniques about how to work with clients."

Supervisors and co-workers discussed how all co-workers had a formal college degree.  Supervisors identified that formal education was a primary learning tool for being a caseworker.  One supervisor identified that her caseworker was working on her master's and thought that, because of her participation in college, she would "pick up different pieces—and they may not be directly related to what she does here—but I think it just makes you more polished or rounded. . . ."  Another supervisor stated that her caseworker "had a very good knowledge and background in education that gives him some basic information on dealing with adults with severe and persistent mental illness."  All the co-workers interviewed stated that their teammate had "a degree" or "education" but they did not describe how the formal education influenced their teammates' learning about how to do their jobs.

*Trainings/ seminars/in-service sessions.*  Caseworkers also attended trainings, seminars and in-service sessions from which they were able to learn.  Caseworkers were

114

divided in their assessment of the usefulness of the learning opportunities that came out of these sessions. Alexis took the position that "There's not a lot of training for a person who is doing case management." She viewed formal learning opportunities as not being very helpful to caseworkers because, unless the caseworker was in school, the trainings did not "add to their knowledge because the training has nothing to do with their job. And they [caseworkers] don't understand what's being presented in the meetings."

Those trainings that did offer specific skills about which caseworkers were especially interested were viewed as worthwhile to attend. Huie found that some formal training was beneficial to him when he stated that "I've had to go to some formal trainings that have helped [me learn about diagnosis]." Like Huie, Gale found trainings and seminars to be very beneficial to her learning:

> Um, I try to attend as many different trainings that I can. Because I don't know, I still don't feel like I know a ton about [things] and I'm always learning. So whenever I see different things that become available for training and stuff I will do that.

Supervisors identified attendance at trainings, seminars and in-service sessions as very important. According to supervisors, attendance at formal learning opportunities was a major source of learning for caseworkers; this is different from what caseworkers said about their formal learning opportunities. One supervisor reported that his caseworker

> keeps abreast of the training opportunities. We have a board—a bulletin board where we post fliers that everybody receives throughout the agency. And then people look at that and see if there's something that catches their eye that they want to learn more about. He keeps abreast of that and then picks out workshops that are—where he has some learning needs and then asks to go to those workshops.

Another supervisor noted that her caseworker was "probably one of the most diligent about training. She comes to our in-service trainings, she makes sure she gets

enough information about what to do, and then she does it." A third supervisor reported that her caseworker "seeks out the specialized trainings" because "she likes to develop those clinical skills that way." A fourth supervisor discussed how her caseworker took "advantage of any educational opportunity that's provided. She really keeps her eyes open for training possibilities and she is really good at taking advantage of them."

The majority of the co-workers reported that their team mates "had gone to various trainings," "went to trainings that are out there," and "were good about going to seminars." One co-worker thought her team mate learned because she went "to the meetings she's supposed to, and because at those meetings they'll say how things are changing, and she will give warnings about changes in processes." Another co-worker identified that "the seminars are resources to her [team mate] to her acquiring her skills."

*Subject matter expert presentations.* Subject matter experts are defined, for purposes of this research project, in two ways. Experts are defined as people who are affiliated with the organizations in this study and who have knowledge about the organization and/or are above entry-level positions within the organizations. They are thoroughly knowledgeable about the services and activities of the organization. The experts are also people who have advanced degrees and work within specialized areas of practice. Both types of subject matter experts are able to pass along information through formal presentations. Caseworkers noted that they learned through presentations provided by medical staff, other therapists, and community resource staff personnel.

Supervisors recognized that caseworkers learned through contact with other people who have knowledge related to the job of being a case manager. Supervisors identified medical experts as sources of learning. Meeting with medical staff such as the psychiatrist were planned formal meetings in which learning about mental health

116

symptoms and basic related scientific information took place. One supervisor discussed how caseworkers learned from the psychiatrists at these clinical meetings and how the psychiatrist partnered with the caseworkers:

> And then we meet with our psychiatrist for the clinical meetings and that's several times a month, and he's always bringing in situations, getting updates to the doctor about people and issues, and getting feedback. Our doctors here are really good and they pretty much see the case managers as partners.

One supervisor summed up the learning the caseworkers receive from subject matter experts in general: "So I think it's a combination of gathering written and verbal and other knowledge [from] the doctors and outside providers."

Co-workers identified learning from medical experts as the main source of formal learning in which they saw their team members engage. Co-workers focused on how their team members used the pharmaceutical representatives as sources to assist in their learning processes. One co-worker identified that his team member often "goes to the luncheon—the drug rep lunches that we have so we learn quite a bit about medications." Another co-worker stated that he "knew" that his team member "goes to some of our 'lunch and learns' that the pharmaceutical companies have where they come in and talk about their pharmaceuticals."

*Learning from Experiential/Situational Contexts*

Caseworkers also learned from their experiences and situations encountered within the contexts of their jobs. Learning from experiential/situational contexts means that professionals actively participate in the activities and situations that take place while at work. The professionals learn-by-doing through personal interactions with the social work environment, the activity, tools, and people involved in the activities or situations. Caseworkers discussed how they acquired knowledge through their job activities as they

117

gained experience as they performed their jobs. Sources for their learning stemmed from resolving client needs and issues. The activities and situations were "authentic" because they were real, occurring in the actual work-routines of the caseworkers.

Caseworkers identified that most of their learning occurred while they actually were engaged in their work experiences and situations. Many of the activities are conducted by having direct practical experiences in the operation and functioning of job processes. Learning co-occurred with the experiences and situations located within the context of the job. Therefore learning was integrated and self-directed, informal, purposeful and unplanned, latent, and/or spontaneous and incidental, depending upon the contexts of the experiences and situations. Search and research activities were also interwoven and co-occurred simultaneously throughout the experiences and situations.

Learning "how" and "about doing" casework is a constant, daily process—"it's just every day, I mean you have an opportunity to learn," as Pat explained, "that's everyday, you kind of learn something new." Dot understood that learning is an ever-evolving process when she stated, "just to be open to looking at things in different ways. And to keep learning, you know, there's a lot of new things that come out." Associated learning activities included learning by doing, situational interactions, trial and error, assessing situations, and making mistakes.

Caseworkers also learned from each other when they gained knowledge from co-workers who had expertise with situations or when they received feedback. Caseworkers learned from each other as they also observed and imitated what the others did.

Another way caseworkers learned from their job experiences and situations was through their interactions with physical and social tools. Physical tools consisted of

technology such as computers and cell phones and other non-human resources such as

buildings and printed materials.  Social tools consisted of co-workers, supervisors,

agency staff personnel, subject matter experts, and community resource personnel.

On the page after the next one, Figure 12 addresses learning from experiences and

situations.  Following the page containing Figure 12, the caseworkers' perspectives are

presented concerning each specific learning activity.   The perspectives of supervisors

and co-workers follow.

**Performance Period
and
Activity Setting**

Self-Directed

Formal

Informal

Latent

Purposeful

Unplanned

*AUTHENTIC WORK ACTIVITY*        *MENTORSHIP*

S E A R C H   A N D   R E S E A R C H

I N T E G R A T E D   L E A R N I N G

learning by doing

situational interactions

trial and error

assessing situations

mistakes

E X P E R I E N C E S

AND

S I T U A T I O N S

observing

imitating

feedback

S O C I A L   T O O L S

P H Y S I C A L   T O O L S

Networking
Dialoguing
Asking questions
Team Meetings
Reading

spontaneous                                incidental

**Contributions to Professional Development
Active
Networking**

**Social Tools**
Clients
Co-Workers
Supervisors
Subject Matter
 Experts
Community
  Resource
  Personnel

Time  engaged in professional development

**Physical Tools**
Buildings
Community Resources
Printed Materials
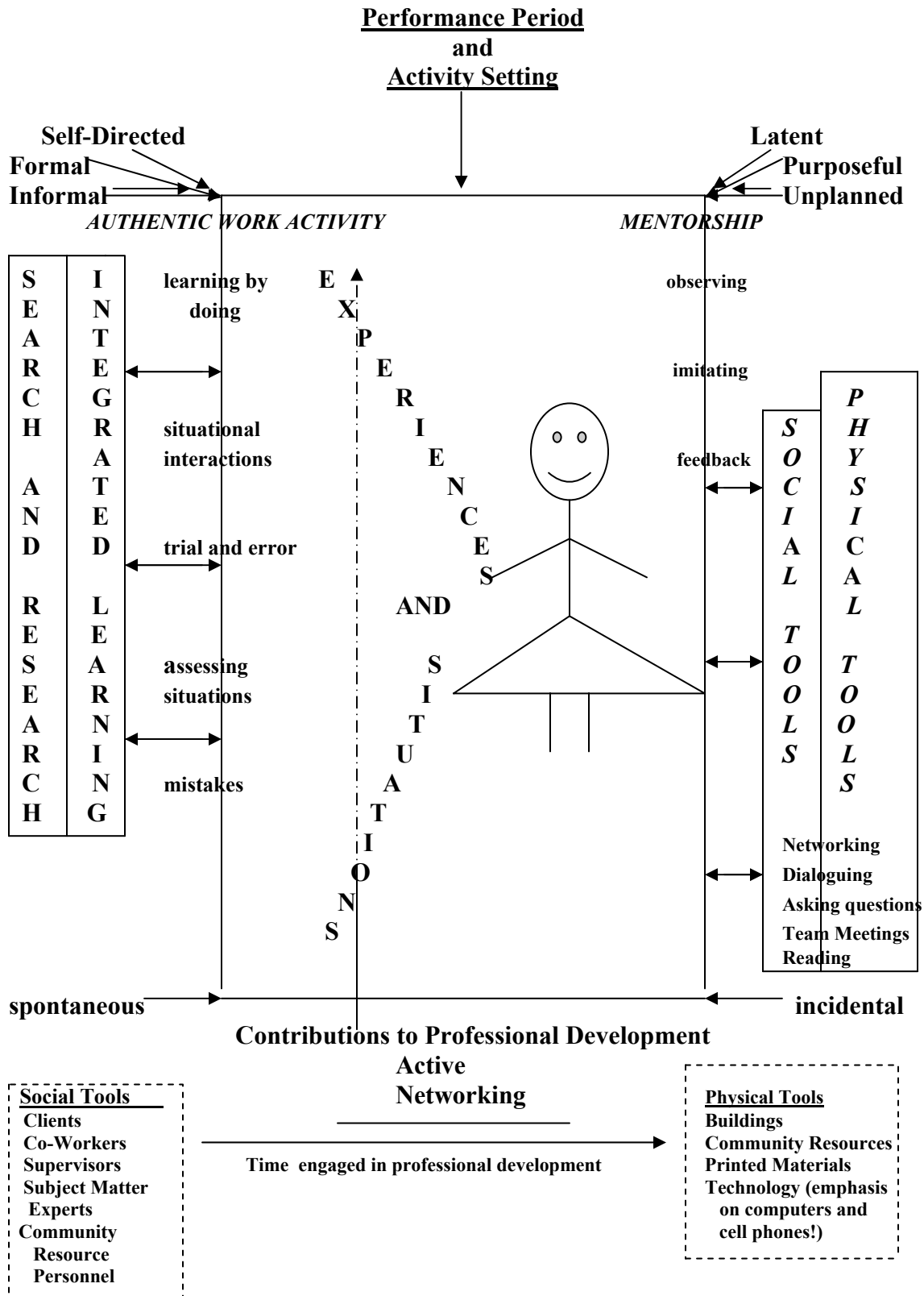Technology (emphasis
  on computers and
  cell phones!)

Figure 12:  Learning from Experiences/Situations

*Learning from Experiences/Situations*

Caseworkers learned from engagement in authentic work activities. They learned by doing their jobs, through interacting with situations, trial-and-error, assessing situations, and making mistakes.

*Learning by doing.* On-the-job learning involved being engaged in the activities of the job and learning "what works" and "what does not work" as one moves through the processes associated with the performance aspects of "doing" the job. Caseworkers reported that their most valuable learning processes were through direct experiences with job activities that occurred over a length of time. Jo's remarks are a sample of how caseworkers thought that learning through experiences was a more effective way to learn how to be a caseworker: "you know, learning kind of as you go, day to day, what's effective, what works for certain individuals, and what's not. I mean I feel that everything's on an individual basis. But I mean experience is definitely the key." Francis thought that she gained much knowledge about how to do her job through interactions with her clients: "just trying. . .You know, the textbook did not really talk too much about that, you know. So, what I—learned on the job. . . And you know, again, gaining knowledge through my job. . . .And, again knowledge through the clients that I've worked with." As Alexis stated about learning her job, "I was taught on the job how to work with the mentally ill population in the community." And Gale also said that "I really think that the actual experience of doing it has taught me way more than anything the books could have ever taught me. . . I'm thankful for the actual experience, the working experience that I do have now." Lennie discussed his ideas about learning by doing:

121

Um, but I think to do case management, it's really the activity—you have to be in the community day-to-day; this isn't where you can stay in your office and hang out in your office and have people come to you, you have to go to them.  And that's the most important---engage in activity.

Supervisors and co-workers also thought that learning from doing the job was important in casework learning.  Supervisors commented how important learning with and through experiences was and assisted caseworkers in their learning activities.  One supervisor reported that his caseworker had "learned through experience.  For sure, she came from working with another agency and she went through a process to switch the way she approaches a situation."  Another supervisor reported that her caseworker had "some life experiences that someone who is 22 does not have.  That's good for clients that have questions on life chores. . . .So she got some great life experiences that really help."  Another supervisor commented that "a lot of case managers gain their competence by just getting in there and getting their hands in there and learn. . .And that's been a real important learning tool—just getting in there and doing it."  Another supervisor commented that "I guess it's kind of a nice mixture of theory and practice where she's really out in the field, does the work, has learned through that. . . ."

One co-worker remarked that his team mate "was good about using her own experiences as a case manager."  Another co-worker remarked how his co-worker was "real good about reliving her own past and own experiences with situations and sometimes she's right on target about things.  Because, you know, she's been there, and so that is a tremendous help to me."  Another co-worker said of her team mate, "from her past job, she had gotten quite a bit of experience and so, you know, she's a pretty competent person."

*Situational interactions*.  People are pulled together in shared social spaces because of environmental situations.  Situational interactions means interacting with other people within the environment; a major part of learning from doing the job consists of interacting with clients, other caseworkers, and people as people exchange and share information about resources and successful techniques and skills.  Jo thought that getting together with co-workers and "learning from each other was very helpful."  Francis also described situational interactions as:

> It's a combination of different things:  resources that you have out there for your own professional career.  Information that you glean from your co-workers; what you learn from your co-workers.  Hearing your doctor talk.  Having a dialogue, you know, with your supervisor.  And then, knowing your clients.  It's just a whole combination.  You have to be extremely open.  You have to be able to take in the information.  There's time when you are working and you'll—"Oh, I forgot about that."  I have to remember that.

However, supervisors and co-workers did not identify situational interactions as a major source of caseworker learning.

*Trial-and-error*.  Trial-and-error is a process of finding out the best way to do something by trying out one thing or another until a technique or skill is successful. Because the work context of their jobs is uncertain and never the same from day-to-day, caseworkers learned by trying out different styles, techniques, and skills and seeing what worked and what did not work.  As Alexis stated, "I think that's just kind of something that just kind of—I just kind of learn over time and you know, a kind of trial and error type situation working with different types of clients. . .you kind of have to know yourself, and try to work with them [clients] the best you can."

Jo thought that her learning was "kind of through trial and error.  And, you know, when we do our job everyday, sometimes we can just get lost in doing our jobs, doing all

we have to do." Everyday, the job situation changes as caseworkers never know what to expect when they start their workday. And another caseworker said, "it's just jump in and do—like a cannon ball." Through this trial and error process, caseworkers learned what worked for them in their jobs. However, supervisors and co-workers did not identify trial-and-error as a major source of caseworker learning.

*Assessing situations*. Assessment is a process designed to determine and evaluate the importance and/or value of a situation or activity or to give judgment about something for the purpose of understanding or interpreting the situation or event. All of these factors can be referenced as guides to and for action. Caseworkers continually experience new situations each workday that are unplanned and/or occur naturally; therefore, they learn to do their jobs through spontaneous reactions by making assessments about situations, circumstances, and clients involved with their jobs: "Um, kind of do an assessment, I guess, on how I'm going to, you know, what I need to do. . .I just kind of just go out there and see what's going on" as one caseworker defined the assessment process. Dot explained the assessment of uncertain situations and circumstances as "And I think that as a caseworker you need to have the ability to discern situations absolutely. . . .I'm always thinking about what's it going to affect the next time? . . .You have to know when to go for it and when to just kind of back off a little."

Caseworkers made assessments about clients, about solutions to problematic situations, and about associated consequences of clients' actions. CJ reported that

> probably one of the first things that I had to learn when I first got into this
> field, in this job, is how to assess someone, to see what level of psychiatric
> crisis they were in and therefore be able to incorporate the right
> intervention for them. . . .It's all about assessing their situations and
> assessing their level of need, assessing the clients cognitively—where
> they're at cognitively."

124

Ira also concluded that learning to make assessments was a major part of his job:

> Like with certain clients you really have to forecast stuff ahead like you really need to be thinking a couple weeks in advance with some of your clients because if you don't then you're stuck with something and that's a nightmare. . . .It's really trying to think about the future, like you know, trying to prepare ahead of time so you're not reacting to something that when it just comes up.

Supervisors and co-workers also reported that caseworkers learned to do their jobs through assessing situations, events, and client needs. One supervisor stated that his caseworker "has a very organized and reliable way of going about doing that [assessing]. She's able to sort of assess what the clients' needs are and then get right to how to help them meet their goals." Another supervisor stated that her caseworkers were able to assess clients' needs by "talking to the clients about what they are interested in, what have they used in the past, what's worked, what hasn't worked so that she knows that she's heading in a positive direction."

One co-worker stated that her team member was able to make assessments about his clients: "he initially meets our clients through doing an orientation with him. He gets an idea of who the person is." Another co-worker defined how he thought his team member learned from assessing, noting that "She's really good about finding out if she doesn't know."

*From making mistakes.* Caseworkers briefly discussed learning from their mistakes. They reported that if they did something wrong with treatment interventions, then they had that learning processed in their memories and could use those memories as references for treatment provision if they encountered similar situations in the future. Ira admitted that along "with any job you start, you learn from your mistakes; and you really have to do that. . . ." Dot also noted that she learned from her mistakes when she

125

reported: "I know we all make mistakes and I remember talking to co-workers. . . . and realized that I had to get [things] down pat [correctly]." However, co-workers and supervisors did not discuss how caseworkers learned from their mistakes.

*Learning through Mentorship*

Caseworkers also learned from each other. They observed and imitated co-workers who had expertise with situations or from co-workers who provided feedback about job performances.

*Observing and imitating.* Observing consists of looking at someone or some process in order to understand what is happening. Imitating means to follows the patterns and behaviors of the person who has been observed. New, inexperienced caseworkers were paired with an experienced caseworker when they began their jobs. By shadowing the experienced caseworker, new workers began the process of learning from their co-workers.

Caseworkers discussed how, when they first started their jobs, they learned primarily through mentorship, role-modeling, and observations. When Ira began his job, his reliance on his co-workers "to initially help me was the key to really learning what I needed to learn." As a new caseworker, Alexis found that she needed to learn about resources in her community and how to use the resources to resolve client needs. Alexis reported that 'They set me up with another caseworker. Um, and that caseworker would teach me what I needed to know." She concluded that learning from her co-workers was an effective tool: "So as far as competencies on how to do that, that's what the case manager that was assigned to me at that time showed me how to do these things. Or how to communicate with the resources out there for them to be able to give me what I needed for the client."

126

Bo identified that the "ride alongs" were important to her learning processes: "We would go with an experienced case manager to the clients on home visits. And tag along and learn about community resources. Learning about case management was more than sitting in the office and reading books. The actual experience is so beneficial." Huie also reported, "But a lot of it was kind of just kind of a growing situation, learning from peers in my field and from supervisors in my field."

Supervisors agreed that observing and learning from others assisted caseworkers in learning how to do their jobs. One supervisor stated that she thought that it was "the live interactive stuff [with co-workers] and being there and working with clients" that assisted her caseworker in learning how to do the job. Another supervisor identified that the learning "happens in the process of sharing clients." Collaboration and interaction with more experienced team members were identified by supervisors as principal processes for caseworkers to use in order to learn to "do their jobs."

Co-workers also agreed that working in collaborative processes were important means of learning the job. One co-worker stated that she had learned from her team mate because they had worked together: "I collaborated with her with a married couple that we worked together with so I was actually able to spend a lot of time working with her and see how she worked and she was able to teach me so much." Another co-worker thought that her team mate learned because she was "good at observing other people, and she is very articulate."

*Feedback.* Caseworkers learned when other people provided them with constructive criticism or suggestions and advice about how to perform their jobs better. Caseworkers identified clients, co-workers, and supervisors as the principal people that provided them feedback about job performance.

Gale discussed an incident, in which she was provided feedback about a situation with a client when she stated that, "I just had an incident last week and there was another co-worker in the room and the client was getting really upset and I didn't think I was doing my job." And then her co-worker provided her constructive feedback about how she handled the situation.

Gale also praised her supervisor for her feedback when she noted, "That's one thing that I have just been really blessed with and I know I've already mentioned that is—her willingness to let me know that what I am doing well, and maybe this is what I can improve on. . ." Huie's remark also provides understanding about the role feedback plays in caseworkers' learning,

> And I think that was one of the things that I probably gained confidence over time as people kind of reiterated that to me. You know, they might say, "Well, I've noticed that you've handled this situation this way or done well with that." And I kind of internalized that and began to realize that.

Supervisors identified learning from feedback as an important learning activity for caseworkers. One supervisor reported that his caseworker was "eager to learn and very open to supervision. Very open to feedback from her peers." Another supervisor reported that her caseworker "receives feedback or ideas and such in a clinical way . . . but he is usually right on target." Co-workers did not identify feedback as an important learning activity for their team members.

*Learning from Physical and Social Tools*

A major learning activity that emerged from the data concerned caseworkers' learning through interactions with physical and social tools. Physical tools consisted of technology such as computers and cell phones and other non-human resources such as buildings and printed materials. Social tools consisted of co-workers, supervisors,

128

agency staff personnel, subject matter experts, and community resource personnel.

Associated learning activities consisted of actively networking, dialoguing, asking

questions, team meetings, and reading.

*Actively networking.* Active networking is the planned exchange of information

or services among people and agencies for the purpose of acquiring needed information,

making connections, and learning about resources to use for treatment with clients.

Caseworkers actively networked with each other when they exchanged and shared

information about resources and successful techniques and skills.

Caseworkers learned when they networked with community agencies and when

they talked with community personnel about how to obtain services for clients. Contact

would be made either by face-to-face encounters or through the use of telephones. As Ira

explained,

> I had very limited knowledge on that and I had a co-worker that had been
> doing the job for quite a few years and really was connected with those
> folks in the community and he kind of guided me through. I met some key
> people in the community that basically you could go to.

And Jo added that "You know, it's wonderful to have that contact."

Supervisors and co-workers also discussed how active networking was an

important learning process. One supervisor noticed that his caseworker "goes there and

gets that from people who are already doing it." Another supervisor stated that her

caseworker "networked in the community—he's real good about developing resources.

And I think he absorbs all that stuff. . . he goes out in the community and he draws stuff

from all over the place. . .I think he uses everything that he has at his finger tips."

One co-worker stated how his team mate, "if she doesn't know, she tries to find out and

is good about asking our supervisors about things." Another co-worker reported that her

team mate would "call different agencies and find out things. I mean we all have to do that but there's just something—she is very thorough about it. And she's very quick about it."

*Dialoguing.* A dialogue is a conversation between people involving an exchange of words about ideas. Without conversation and effective listening skills, caseworkers could not have learned to do their jobs. Conversations became a mechanism to share ideas and information, especially about resources and client treatment care.

The majority of the caseworkers' workday is spent traveling in their cars to and from client homes. Caseworkers see clients "one-on-one;" therefore, they are often in the field working alone. If they do not know about a needed resource or some information to access, they used their cell phone to call other caseworkers in order to obtain information. One caseworker will say to another caseworker, "hey, I have a question" and then dialogue with their colleague via the cell phone in order to learn about and search and research needed information. Other times, caseworkers used community resources such as the library and personnel who work at churches and food pantries as resources with whom to hold conversations in order learn about and access needed information. Such conversations are likewise conducted over the phone.

Caseworkers also learned through conversations that would occur during work performance. They would discuss problems at team meetings. They would discuss issues and problems with team members in offices or in casual meetings in computer rooms where they did their documentation. They also talked with supervisors. Caseworkers would also listen to others as these people talked. Dialoguing and listening assisted caseworkers with understanding how to do their jobs and locate and find needed information and resources. As Gale reported,

I would say just all my co-workers in general because we do—we have team meetings. . . twice a week. And during that time, we'll talk about problem solving. OK, what's a way we can handle this—I'm stuck on this, please help me. Um, and that is huge, because I can't imagine doing this job on my own. So I'd say that the opportunity that we have during meeting time is huge about how we can problem solve.

Gale added that "we'll talk. . .about any client concerns, that we have."

Dot provided insight into how dialoguing with others enhanced her on-the-job experiences and related learning processes:

and that's how I've learned—just through talking to other people, getting new techniques on how to handle certain situations, going to treatment team, overhearing my office mate while she's on the phone with somebody, and you know you don't absolutely have to agree with them but you can take something from that and that's how you grow.

Like Dot, Francis understood how important dialoguing was to learning to perform as a caseworker,

So again, it's just acquiring knowledge through day by day, paying attention in team meetings, you know, listening to my co-workers' talk, having conversations with them, talking with my supervisor, you know, just—it just comes to you. You don't really say—there's never a light bulb that goes off, I don't think, it's just…hearing their experiences, you know, and they'll talk about a situation, and then I kind of think, well they did this, that was a good idea. . .

Supervisors and co-workers also identified communicating with other people as important to caseworkers' learning to do their jobs. Supervisors reported that they maintained "open door policies" so caseworkers could come into their office and "discuss problems." They also observed caseworkers "talking to their team mates" if they were "unaware of things," being "quick to ask questions and to problem solve." Supervisors reported how they thought caseworkers learned from each other through conversations and discussions.

Co-workers discussed how they understood that their team members obtained information through dialoguing. They would hear their team mates "talking to the medical staff and their supervisors, for information." Other co-workers stated that they understood that her team member, "talked with her team. . .in order to secure information."

*Asking questions.* An important finding that emerged from the data was that asking questions was an important subset of dialoguing. Caseworkers identified that they learned by asking questions and that if they did not ask questions, then learning could not occur. Questions were asked of co-workers, community agency personnel, and even clients as caseworkers attempted to connect with information they needed in order to perform their jobs. Bo asked questions of her co-workers who had been doing their jobs "for awhile," therefore using them "as a resource." Gale would use her supervisor as a resource for asking questions and obtaining information: "Um, and then I would also say my supervisor who's wonderful. Very, willing to do—I can ask her how do I do certain things or ask her for suggestions and then she's wonderful coming up with things. So she's been a great support." Jo also thought that her supervisor was "a wonderful resource." Jo couldn't "tell you how many times in a week that I call her and say 'I've got a question' and she is always willing to help." If caseworkers were out in the field, they asked questions of their colleagues and even of community resource personnel over their cell phones.

Supervisors and co-workers also noted that "asking questions" was a principal mechanism for caseworker learning. One supervisor remarked, "Asking questions. Some people think they know it all so they don't ask questions. She [a caseworker] asks questions. She comes with questions and I think that really helps. If you don't ask

questions, you don't learn."  Another supervisor remarked that "asking questions. . .keeps

you sharpened and kind of keeps you on your toes."  Co-workers reported that if team

members "didn't know about things," then they were "real good about asking questions

and not letting things go."  Another co-worker stated that her team member would "come

to you if she had a question about something."

*Team meetings*.  Team meetings provided a place to interact with all team

members, and therefore was an excellent context for learning to take place.  Team

meetings provided a context for a lot of useful learning to occur.  Caseworkers talked and

discussed problematic situations.  Then learning occurred as caseworkers listened to the

thoughts expressed by their co-workers.  Gale thought that team meetings were very

important to her job,

> Um and I would say just all my co-workers in general because we do—we
> have team meetings, um, twice a week.  And during that time, we'll talk
> about problem solving.  OK, what's a way we can handle this—I'm stuck
> on this. . . .      Um, and that is huge, because I can't imagine doing this
> job on my own.  So I'd say that the opportunity that we have during
> meeting time is huge. . . .

Jo also saw the importance in using her team members as resources for learning when

they conversed with each other in team meetings.

> Now, our meetings I feel are very beneficial and helpful, you know, to
> how I worked with the clients/consumers.  Um, I think they are really
> helpful because we have an opportunity to kind of say "Ok this is the
> situation that I got in with this consumer [client] and I really don't know
> where to go," you know, what are we thinking as a team, is this something
> you know that we need to get together as a team and think or brainstorm to
> think of ideas to help with this consumer.

Supervisors discussed how team meetings provided caseworkers with

opportunities to learn.  One supervisor discussed how at team meetings, that,

> each one of us is really great with communicating, always putting out our
> strengths, and what we are really good at, and what we are not good at.

> We have someone else to help compensate by saying, "I can tell you what
> I know about resources." Or, "you've got really good clinical
> interventions." So I think we really do a good job as a treatment team
> with helping each other out.

Another supervisor identified how his caseworker, during team meetings, would "draw on them [team members] a lot and bounce ideas off of them."

Co-workers discussed how their team members had opportunities to learn by obtaining information that was provided at team meetings. One co-worker stated that his team member had "a team. He gets a lot of information from them. His team has team meetings twice a week." Another co-worker stated "we meet as a team to talk about clients" and this is how her co-worker obtained information.

*Reading.* Reading was another process that helped caseworkers to learn. They would read such items as reference materials, books, policy and procedure manuals, Internet web sites, emails, articles, newspapers, community bulletins and resource guides. By reading, caseworkers again obtained information that was related to job performance. Bo discussed how she "looked to the *DSM* [*Diagnostic and Statistics Manual-IV*] and I go through it and I look in there to see what the criteria is [sic] for such and such a diagnosis.. . .I will match up what they tell me with the reference [the *DSM-IV]* and come up with what I think their diagnosis might be." Another caseworker discussed how she would read "a good book on psychopharmacology and that's been very helpful because clients are always asking questions about their medications and side effects."

Supervisors and co-workers also identified "reading" as a primary learning tool used by caseworkers. One supervisor noticed that her caseworker read: "And she likes to read. I don't know if she reads for pleasure or reads or studies book about things but she's very inquisitive and I can see that . . .she's very open to learning things" by reading.

Another supervisor stated that her caseworker "liked to read certain things" and "reads literature" in order to learn. One co-worker stated that her team member "sometimes she'll pull out a pamphlet that she got. Sometimes she will put out some books that she has on certain subjects." Another co-worker noticed that her team member would "look over the studies that the drug luncheons provided—I will see her reading through the stuff. . . .I don't know really if she's just a sponge or she just knows her stuff."

As can be seen, many learning activities exist that assist caseworkers in their professional development. Relationships emerged between the learning activities and competence areas that contributed to professional development. The next section looks at how the learning activities contributed to caseworkers' professional development.

Second Sub-Research Question: Learning Activities' Contributions to Competence

This section reports on the findings that emerged from the interviews concerning the second sub-question: From the perspectives of the research study participants, how do these activities contribute to their professional development?

*Dynamic, Complex, and Interrelated Patterns of Learning Activities' Contributions to Competence*

Although the areas of competence and associated learning activities were viewed in a linear manner in order to better describe and understand the learning activities that caseworkers undergo to develop professional competence, learning activities and competences are actually connected like a spider web. They are dynamic, ever-changing, complex, and intertwined. The interconnections will be described in terms of a performance period (Eraut, 1994).

Professional caseworkers are never prepared for what goes on during their job processes because they always work with the unknown, consistently changing conditions,

135

and developing situations (Eraut, 1994).  The performance period of a caseworker consists of working with a problematic situation; therefore, the complexity of caseworker learning takes place in three levels:  individual, client, and group level.

*Individual level.*  The individual caseworker brings his or her internal experiences, thoughts, insights, memories, intuition, judgment, and perceptions to work.  All these cognitive abilities unique to the professional will influence the caseworker in job performance.  At the beginning of each activity, the caseworker will make a reading of the situation and then create almost without hesitation the goals and priorities of the situation.  A caseworker will have stored in his or her long-term memory scenarios of past situations which he or she can use to make meaning out of present problematic situations.

If the caseworker does not have the knowledge or the "know how" to solve a problem, then he or she will use his or her self-directed learning skills.  He or she will communicate that lack of understanding to someone.  He or she will talk to and ask questions of co-workers, supervisors, or community resource personnel about how to resolve the situation.  He or she will conduct search and research measures in order to obtain information that can be used to address and perhaps resolve the situation.  What the caseworker considers as relevant will then go into his or her long-term memory and add to the details of scenarios that can be accessed and used in the future, further improving intuition and clinical judgment about using the best practices for treatment with clients.  Learning is purposeful, informal, unplanned, spontaneous, and incidental as needed and dictated by the contexts of the experiences and situations a caseworker encounters within his or her job activities.

*Client level.*  Goals and priorities are established many times during the performance period as the caseworker works with and encounters specific, individual clients and their related problems and issues.  The primary reason for interacting with a client is treatment; the primary goal of the interaction activity is resolution of the client's need or problematic situation.  Again, conditions change and situations develop.

At the start of the interaction activity with a client, a caseworker will internally read and interpret the situation and then set goals and priorities for action.  Then the caseworker will involve the client through the communication channels with the decision making processes of "what to do" to resolve the situation.  If they cannot interact or take action to resolve the situation, then the third level of complexity is accessed by using the team's efforts to resolve the problem.

*Group level.*  A caseworker is part of a community of practice which includes his or her team members and perhaps supervisors and other colleagues with whom he or she work.  It is especially at the group level where the learning activities and their relationships with competence are dynamic, complex, and intertwined/interrelated.  The caseworker can use his or her cognitive abilities, intuition, and clinical judgment to solve problems with which he or she has experience and "knows how" to solve

However, in interaction activities with a client and/or participants within the community of practice, the caseworker uses all the people situated in the activity situation.  Together, they assess the situation and establish goals and priorities to address the problem.  Channels of communication are stretched to include all the participants.  External relationships are developed as needed among the group members, broken, and re-established with different physical and social tools as needed in order to find solutions.

Most of the caseworkers' learning occurred in social settings and activities where the emphasis was on relationships and communication and in contexts in which knowledge was deployed in order to solve problems. The caseworkers learned and developed routines and habits to deal with situations with which they had a great deal of familiarity and knew what the solutions were to the problems. If the situations were ambiguous and uncertain, they learned through observations and communication channels with their more experienced co-workers as well as from activity engagement and interactions, establishing relationships with physical and social tools. Learning is often "latent" as defined by Edward Tolman (1948): their mental processes may have changed through exposure to each new and different situation, but their learning was not revealed until they needed to find a resolution to a problem situation. Then they revealed information that they had learned from interaction activities that they had experienced in the past.

Patterns between establishing external relationships with tools, working in problem solving contexts, developing their "self," and integrating their learning with the experiences and situations embedded in the activities and contexts of their work environments emerged. As can be seen in Figure 13, the spider web-like connections between establishing external relationships, solving problems, development of the professional "self," and using integrated learning break and reconnect as the professional activity dictates.
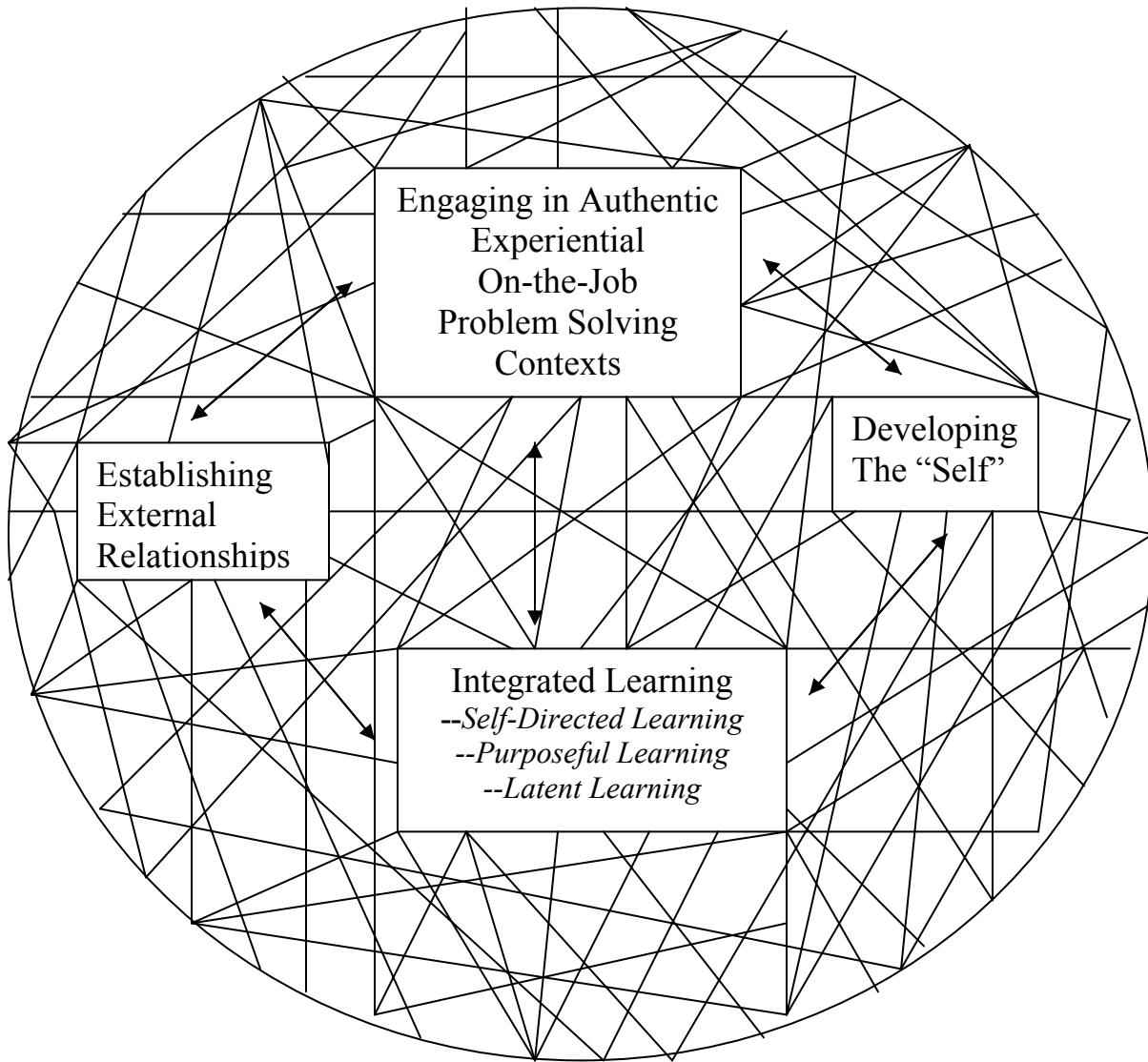
Figure 13:  Patterns of Learning Activities and Development of Professional Competence

Four major relationships between the patterns of learning activities and

competence were revealed in the data:  integrated learning processes and learning

competence, establishing external relationships and tools competence, problem solving

contexts and work competence, and developing the "self" and personal competence.

Each relationship will now be described and detailed.

*Integrated Learning and Learning Competence*

Integrated learning emerged as a pattern for solving problems. Solving problems consisted of assessing situations and locating information and using resources to solve client needs and issues. Integrated learning also emerged as a way to solve work-related challenges and obtain needed resources because caseworkers work daily in ambiguous, unclear, and chaotic performance periods. Therefore learning is integrated and is self-directed, formal and purposeful, informal and unplanned, latent, and/or spontaneous and incidental, depending upon the contexts of the experiences and situations. Figure 14 demonstrates the relationship between integrated learning, associated learning activities, and learning competence. The relationship between integrated learning and learning competence concentrates on caseworkers' abilities to address client needs, solve work-related challenges, and obtain needed resources.

| MAJOR LEARNING CATEGORIES | ASSOCIATED LEARNING ACTIVITIES | DIMENSIONS OF THE COMPETENCE OF LEARNING |
|---|---|---|
| 1. Learning from Formal Opportunities | Trainings/Seminars<br>In-Service Sessions<br>Subject Matter Expert<br>   Presentations | Solve Client Needs<br>Solve Work-Related<br>   Challenges<br> Obtain Needed Resources |
| 2. Learning from Experiences/Situations | Engagement in Authentic<br>   Work Activities<br>  Learning by Doing<br>  Situational Interactions<br>  Trial-and-Error<br>  Assessing Situations<br>  Mistakes<br>Mentorship<br>  Observing<br>  Imitating<br>  Feedback<br>Physical and Social Tools<br>  Actively Networking<br>  Dialoging<br>  Asking Questions<br>  Team Meetings<br>  Reading | |

Learning co-occurs with the experiences and situations located within the context of the job. Therefore learning is integrated and is self-directed, formal and purposeful, informal and unplanned, and/or spontaneous and incidental, depending upon the contexts of the experiences and situations. Search and research activities are also interwoven and co-occur simultaneously throughout the experiences and situations.

Figure 14: Relationship between Integrated Learning and the Competence of Learning

*Establishing External Relationships and the Tools Competence*

Establishing external relationships concerned working with physical and social tools in order to treat clients and resolve their needs and problems. Physical tools consisted of technology (such as computers, telephones, and fax machines) and non-human resources (such as libraries and newspapers) available to help carry out the caseworkers' jobs as efficiently and effectively as possible; the Internet and the cell phone emerged as the principal physical tools caseworkers used in order to "go about their jobs." Human resources consisted of working with other human beings such as co-workers/team members, supervisors, subject matter experts, and community staff personnel. Community resources consisted of agencies located in the communities of the caseworkers' mental health centers. Major community resources included such agencies as the Family Support Division (formerly the Division of Family Services), Social Security Administration, Food Pantry, and The Housing Authority. Establishing external relationships with physical and social tools proved to be important for locating information and resources in order to resolve client problems.

Caseworkers developed tools competence that included using communication channels, making connections, having a positive attitude about working with others, shared knowledge, networking, and interacting with supervisors and team members. Establishing external relationships emerged as the associated major learning foci with the development of work competence. Figure 15 illustrates the relationship between establishing external relationships, associated learning activities, and tools competence.

| MAJOR LEARNING CATEGORIES | ASSOCIATED LEARNING ACTIVITIES | THE DIMENSIONS OF THE TOOLS COMPETENCE |
|---|---|---|
| 1. Learning from Formal Opportunities | Trainings/Seminars In-Service Sessions Subject Matter Expert Presentations | Communication Channels Making Connections Positive Attitude Shared Knowledge Networking |
| 2. Learning from Experiences/Situations | Engagement in Authentic Work Activities Learning by Doing Situational Interactions Trial-and-Error Assessing Situations Mistakes Mentorship Observing Imitating Feedback Physical and Social Tools Actively Networking Dialoging Asking Questions Team Meetings Reading | Supervisor Team |

Learning co-occurs with the experiences and situations located within the context of the job. Therefore learning is integrated and is self-directed, formal and purposeful, informal and unplanned, and/or spontaneous and incidental, depending upon the contexts of the experiences and situations. Search and research activities are also interwoven and co-occur simultaneously throughout the experiences and situations.

Figure 15: Relationships between Establishing External Relationships and the Tools Competence

*Problem Solving Contexts and Work Competence*

Engaging in authentic experiential on-the-job activities means that professionals actively participate in the activities and situations that take place while at work. The professionals learn-by-doing through personal interactions with the social work environment, the activity, tools, and people involved in the activities or situations. Caseworkers discussed how they acquired knowledge as they gained experience as they performed their jobs. Sources for their learning stemmed from resolving client needs and issues. The activities and situations were "authentic" because they were real, occurring in the actual work-routines of the caseworkers. Caseworkers developed skillful processes and behaviors that were important components of their professional practice and performance. With time and experience, these work skills became automatic.

The context of the professionals' work consisted of always working with the unknown, the unexplained, and client crises; therefore, caseworkers consistently faced situations that called for solving problems. The process of solving problems was organized into three parts: assessment, information literacy, and resource research. Caseworkers had to learn to assess client's situations and levels of need when issues and problems arose. They then hypothesized what information and resources were needed in order to address these client issues and problems. Caseworkers had to look for the necessary information that would resolve client needs, apply information to solve these issues and problems, and properly document how the information was used. Locating, accessing, and creatively using information and resources to resolve issues and problems emerged as the last part of the process of solving problems.

Caseworkers developed work competence that included basic job duties, decision making, problem solving, locating resources, information literacy, time management, documentation, and multi-tasking.  Engaging in experiential authentic on-the-job activities emerged as the associated major learning foci with the development of work competence.   Figure 16 illustrates the relationship between problem solving contexts, associated learning activities, and work competence.

| MAJOR LEARNING CATEGORIES | ASSOCIATED LEARNING ACTIVITIES | THE DIMENSIONS OF THE COMPETENCE OF WORK |
|---|---|---|
| 1. Learning from Formal Opportunities | Trainings/Seminars<br>In-Service Sessions<br>Subject Matter Expert<br>   Presentations | Basic Job Duties<br>Decision Making<br>Problem Solving<br>Locating Resources<br>Information Literacy |
| 2. Learning from Experiences/Situations | Engagement in Authentic<br>   Work Activities<br>   Learning by Doing<br>   Situational Interactions<br>   Trial-and-Error<br>   Assessing Situations<br>   Mistakes<br>Mentorship<br>   Observing<br>   Imitating<br>   Feedback<br>Physical and Social Tools<br>   Actively Networking<br>   Dialoging<br>   Asking Questions<br>   Team Meetings<br>   Reading | Time Management<br>Documentation<br>Multi-Tasking |

Learning co-occurs with the experiences and situations located within the context of the job. Therefore learning is integrated and is self-directed, formal and purposeful, informal and unplanned, and/or spontaneous and incidental, depending upon the contexts of the experiences and situations. Search and research activities are also interwoven and co-occur simultaneously throughout the experiences and situations.

Figure 16: Relationship between Problem Solving Contexts and the Work Competence

*Developing the "Self" and Personal Competence*

Developing the "self" consisted of the development of personal qualities, cognitive abilities, and philosophical values related to performing professional roles. Personal qualities included the use of skillful behaviors, emotional competence, interaction relationships, and learning. Cognitive abilities consisted of deliberative processes of retrieving information stored in long term memory, using intuition, and making "sound" and "rational" clinical judgments and decisions. Philosophical values related to performing professional roles included relational and therapeutic roles with clients, client empowerment issues, individualization of client treatment interventions, appropriate professional boundaries, and affective communication processes. By developing their "self," caseworkers were able to enhance their professional job performances and relationships with clients, co-workers, and subject matter experts.

Emotional maturity consisted of learning to offset burnout, handle change, and separate professional life from personal life. Cognitive abilities consisted of using memory processes, intuition, and clinical judgment in order to serve clients with safe and error-free interventions and to perform at the job effectively, efficiently, appropriately, and thoroughly. Values about clients included having compassion, empathy, support for clients, and client empowerment. Caseworkers also learned to overcome stigmas directed at people with disabilities, set boundaries, individualize treatment interventions, not work harder than their clients, and not to take clients' remarks personally. Figure 17 on the next page demonstrates the relationship between developing the "self," associated learning activities, and personal competence.

| MAJOR LEARNING CATEGORIES | ASSOCIATED LEARNING ACTIVITIES | THE DIMENSIONS OF PERSONAL COMPETENCE |
|---|---|---|
| 1. Learning from Formal Opportunities | Trainings/Seminars<br>In-Service Sessions<br>Subject Matter Expert<br>   Presentations | Emotional Maturity<br>  offset burnout<br>  handle change<br>  separate job from<br>    personal life<br>Cognitive Abilities<br>  memory processes |
| 2. Learning from Experiences/Situations | Engagement in Authentic<br>   Work Activities<br>  Learning by Doing<br>  Situational Interactions<br>  Trial-and-Error<br>  Assessing Situations<br>  Mistakes<br>Mentorship<br>  Observing<br>  Imitating<br>  Feedback<br>Physical and Social Tools<br>  Actively Networking<br>  Dialoging<br>  Asking Questions<br>  Team Meetings<br>  Reading |   intuition<br>  clinical judgment<br>Values about Clients<br>  compassion<br>  empathy and support<br>  client empowerment<br>  overcoming stigmas<br>  boundary setting<br>  individualization<br>  not work harder than<br>    clients<br>  don't take clients'<br>    remarks personally |

Learning co-occurs with the experiences and situations located within the context of the job. Therefore learning is integrated and is self-directed, formal and purposeful, informal and unplanned, and/or spontaneous and incidental, depending upon the contexts of the experiences and situations. Search and research activities are also interwoven and co-occur simultaneously throughout the experiences and situations.

Figure 17 : Relationship Between Personal Competence and Developing the "Self"

Summary

Caseworkers learn through two main channels: formal learning opportunities and experiences/situations embedded in their work-related environments and activities. One requirement for being hired as a caseworker was having at a minimum a bachelor's degree from an accredited institution. Community mental health facilities required continuing education and encouraged participation in formal learning settings; attendance at in-service sessions and trainings were viewed by supervisors and co-workers as important activities for job growth and professional development. In addition, supervisors reinforced the organizations' expectations of attending required mandatory hours of formal learning. However, caseworkers did not place as high a value on learning from formal opportunities as their supervisors and co-workers, stating that learning from experiences and "by doing" the job had much more influence on professional development.

Learning from experiential and situational contexts of the job co-occurred with engagement with authentic job activities and processes which were real and occurred in the actual work-routines of the caseworkers. Learning by doing, situational interactions, trial-and-error, assessment of situations, and mistakes were important learning activities. Caseworkers also learned by being mentored by more experienced peers while they observed and imitated their peers in job processes and/or received feedback about job performances. Caseworkers also learned through interactions with physical and social tools located within the job activities and environments; learning occurred as caseworkers dialogued and asked questions of each other, read printed information from physical tools, and discussed problematic situations at team meetings.

149

Learning became integrated, as caseworkers were self-directed with their learning needs. Learning was also purposeful, latent, spontaneous, incidental, and informal as required by the dictates of the work environment, processes, and activities. Integrated learning influenced how caseworkers established relationships, engaged in authentic experiential on-the-job problem solving contexts, and developed their "self."

Four relationships emerged from the findings that influenced the development of professional competence. Integrated learning emerged as a pattern for solving problems in order to resolve client needs, solve work-related challenges, and obtain needed resources. Establishing external relationships emerged as a relationship for working with the physical and social tools in order to treat clients and resolve their needs and problems. Problem solving contexts emerged as a relationship with work competence as caseworkers consistently worked in ambiguous, unclear, and uncertain situations; caseworkers assessed situations and they sought out the needed information and resources in order to help clients with their problems and needs. Caseworkers also developed their "self," which emerged as a relationship for personal competence as they learned emotional maturity, cognitive abilities, skillful processes and behaviors, and values about clients related to performing their job roles and connecting with clients.

The next chapter will summarize the problem statement, the method, the findings, and the limitations of this study. Then the discussion of the findings will be presented in the context of the review of the literature. The conclusions and the implications for practice, education, and future research will conclude the final chapter.

CHAPTER 5

CONCLUSIONS AND IMPLICATIONS

This chapter summarizes the study's problem, method, findings, and limitations.

Then, a discussion of the findings is provided.  Implications for practice and future

research are provided at the end of the chapter.

## Summary of the Problem

Understanding professional development and learning activities in professional

competence with-and-in-practice is important for professional practice settings because

of the shift to a service-providing economy, the interconnections of work contexts, and

the explosion of knowledge and technology.  Professionals must be able to make

effective and appropriate judgments and use critical thinking skills in activities that are

ambiguous and have unclear solutions to problem situations.  Accountability is the

primary focus used when discussing professional competence—or how professionals are

best able to minimize risk and errors while rendering the most effective and efficient

services to clients.  Government, professional associations, and the general public today

demand accountability in the forms of re-certification and re-licensure.  Although

continuing education has been the predominant medium through which to ensure such

competence, continuing education struggles between updating professionals' knowledge

and improving their practice.

One main focus of accountability emphasizes the need for professionals to

maintain up-to-date and effective use of skills, knowledge, information, and clinical

judgment.  The explosive growth of knowledge and information related to healthcare, the

obsolescence of skills with advances in technology and scientific research, the public's

demand for professional accountability, and the specialization and differentiation of professional practice have influenced the need for competence (The Education Council of the American Academy of Physician Assistants, 1996) and learning processes that support the development and maintenance of competence. Professionals must be able to develop their competence in order to effectively serve both clients and team members with appropriate clinical processes. Professional competence development is important in all areas of healthcare practice settings, including the development of competence in professionals who practice in the mental health context.

Like other professionals, members of mental health casework teams work in complex, uncertain, and ambiguous environments. Prescribed protocols for work processes do not exist. Although the majority of caseworkers have at least a bachelor's degree from an accredited institution of higher learning, education has not taught caseworkers how to perform their jobs. Although having a college degree is a qualification for working as a caseworker, no one degree exists that serves as the overriding qualifying educational program for caseworkers. As in all professions, the field of mental health is also experiencing rapid change and development. A range of quality mental health services is needed which are individualized and responsive to client needs. Therefore, understanding the learning activities that influence the development of professional competence of caseworkers is important in order to ensure risk minimization, the delivery of error-free quality services, and professional accountability.

## Summary of the Method

Qualitative research processes were used in order to identify and describe patterns of learning activities in which caseworkers in a community mental health center engage to develop and maintain professional competence with-and-in practice. The central

152

question in this study was:  From the perspectives of the study participants, what are the learning activities that caseworkers use in order to develop and/or maintain competence with-and-in professional practice?  Two sub-questions answer the central question.  The two sub-questions are:  According to the perspectives of the study participants:

1.  What different learning activities do caseworkers use in their professional development?

2.  How do these learning activities contribute to their professional competence development?

The participants interviewed for this study were eleven mental health caseworkers that worked in one of two community mental health facilities that were located in a mid-western metropolitan city within the United States.  Five interviews were conducted in one of the mental health centers; six in the other.  Seven of the caseworkers were female, four were male. I also interviewed co-workers and supervisors for additional sources of and triangulation of data.  The interviews were completed over a two-month period.  One community mental health center was referred to as Western Community Mental Health because it was situated on the western side of the metropolitan geographical area.  The second community mental health center was referred to as Eastern Community Mental Health because it was situated on the eastern side of the metropolitan geographical area.  Because the metropolitan area crossed state boundaries, the mental health centers were each located in a different state.

Inductive data analysis was used to analyze the data collected for this research project.  Very shortly after I collected my data, I began the coding process.  I transcribed the interview data by coding the data in two stages.  The first stage of coding consisted of

reducing the data by assigning codes to small pieces of information until all transcribed data had been coded; this process assisted me in identifying categories.  In the second stage of coding, I used the first set of codes to analyze the data for inter-relationships between the categories.  From these categories, I developed themes concerning the learning activities that contributed to caseworkers' development of competence.

## Summary of the Findings

After coding the data was completed, two major learning categories emerged from the data:  learning from formal opportunities and learning from experiences/situations embedded in the work environment of the caseworkers.  Four relationships between patterns of learning and development of competence emerged:  integrated learning and the competence of learning, establishing external relationships and the tools competence, problem solving and work competence, and developing the "self" and personal competence.

Establishing external relationships concerned the connections, channels of communication, and networking processes made with human, physical, and community resources.  Human resources consisted of co-workers/team members, supervisors, agency staff personnel, and community staff personnel.  Physical resources consisted of tools such as computers, telephones, fax machines, libraries, and newspapers.

Engaging in experiential authentic on-the-job problem solving contexts means that professionals actively participate in the activities and problematic situations that take place while at work.  The professionals learn by doing through personal interactions with the environment, the activity, tools, and people involved in the activities or situations.

154

The context of the professionals' work consisted of always working with the unknown, the unexplained, and client crises; therefore, solving problems emerged as a central professional process. Problem solving consisted of three sub-processes: assessment, information literacy, and locating resources.

Development of the "self" involved the development of emotional maturity, cognitive abilities, and values concerning clients. Caseworkers developed emotional maturity in terms of offsetting burnout, handling change, and separating their professional lives from their personal lives. Caseworkers developed their cognitive abilities in terms of memory processes, intuition and clinical judgment. Caseworkers also developed values about working with clients.

Learning was integrated—the types of learning took place according to the demands of the specific situation in which the caseworkers were engaged. Learning consisted of being self-directed, informal, spontaneous, latent, or incidental.

Relationships emerged between the competence areas and learning activity patterns. Personal competence was related to developing the "self;" work competence was related to engaging in experiential authentic on-the-job problematic contexts; tools competence was related to establishing relationships; and learning competence was related to integrated learning.

<div align="center">Limitations</div>

The research project was circumscribed by the number of participants and the specific geographic area. A small group of professional caseworkers and two mental health centers were the focus of the research study, thereby limiting the sample and settings in terms of size and location. The results of this research project, therefore, may not be transferable to every situation.

<div align="center">155</div>

Another consideration which could or could not be a limitation was the fact that the researcher had ten years of experience in the mental health field, five years as a caseworker and five years as the supervisor of a casework team. Therefore, the researcher was able to interpret the reality of the research participants more clearly than other researchers who do not have experience in the mental health field. However, her experiences in the mental health field might also have interfered with her ability to interpret participants' experiences from more analytical perspectives.

Discussion of the Findings

Many of the findings that were revealed in this project are consistent with research described in the review of the literature. A discussion of the findings also reveals gaps in the literature as well as areas that have implications for practice and research. First, the discussion will pertain to the learning activities of the caseworkers. Then, the discussion will look at how the learning activities contributed to professional development. These two discussions will provide answers to the central question: From the perspectives of the research study participants, what are the learning activities that caseworkers use in order to develop and/or maintain competence with-and-in professional practice?

*First Research Sub-Question: Two Major Learning Categories*

Two major categories of learning emerged from the findings of the data. Supervisors and co-workers reported that formal opportunities were important to casework learning. However, caseworkers reported that they learned primarily through on-the-job experiences and situations embedded in the work environment—much more so than they did by attending formal learning opportunities.

156

*Learning from formal opportunities.* Caseworkers do not undergo a unified educational program of study (Farkas & Anthony, 2001); instead, caseworkers from various disciplines are hired to work with clients who have a mental health disability. Therefore, they do not have an educational or discipline-specific knowledge base about psychosocial rehabilitation. As with other professionals, caseworkers are mandated by the upper management of the community centers in which they worked to undergo continuing education through formal opportunities in order to stay current with the knowledge base of psychosocial rehabilitation and recovery treatment protocols.

Supervisors maintained the view that caseworkers developed professionally because they attended in-service sessions, seminars, and subject matter presentations. Supervisors even remarked how returning to school (i.e., to work on a master's degree) assisted with the development of professional competence. Supervisors represented the organizations' cultures and viewpoints that caseworkers had to engage in mandated continuing educational sessions (Bolman & Deal, 1997; Schein, 1992); co-workers also associated formal learning opportunities with their peers' learning because caseworkers saw each other at formal training sessions more than they did at any other time during working relationships.

*Learning from Experiences/Situational Contexts.* Professional caseworkers reported that they learned primarily through on-the-job experiences and situations embedded in the work environment—much more so than they did by attending formal learning opportunities such as in-service sessions and subject matter presentations. They did not perform alone or engage in solitary activities but participated in social interactional processes (Wertsch, Minick, & Arms, 2002) located within performance periods (Eraut, 1994). Therefore, they learned because they constructed their knowledge

157

as they engaged in practice (Daley, 2002), being present within and actively involved in events and situations that took place within their working environments (Brown & Duguid, 2002; Nowlen, 1988; Rogoff, 1990).

The findings of this study are congruent with the work of Nowlen (1988) and LaDuca (1980).  These two authors discuss how professionals learn through social processes, and the findings of this study demonstrated that most of the caseworkers' learning was a social process and a function of the interactions of their individual selves, colleagues, their working environments, the clinical problems, and the work-related contexts.  They learned their jobs by "doing their jobs."

Within communities of practice (Wenger, McDumott, & Snyder, 2002; Brown & Duguid, 2002), caseworkers interacted with each other in social environments and from the tools located within these environments.  Both new and experienced caseworkers learned through activities that are contained in ideas of guided apprenticeship (Rogoff, 1990), guided participation (Rogoff, 1990), the zone of proximal development (Vygotski, 1986), and legitimate peripheral participation (Lave & Wenger, 2002).  Caseworkers learned from each other as they interacted with colleagues that had expertise in areas of practice, observing and discussing techniques and skills that worked in certain situations while the more expert caseworker role-modeled how to apply the skills and techniques. New caseworkers learned the processes of "being an experienced caseworker" from their experienced peers.

New caseworkers began the process of treating clients on a one-on-one, face-to-face basis very soon after they started their jobs.  They had many "gaps" between "actual performance levels" and "levels achievable with the help of a more experienced peer" (Vygotski, 1986).  The new caseworkers participated in activities that were out of the

realm of their comfort zones.  Through the supportive structure of team meetings and conversations, new caseworkers advanced their understanding of situations through communication channels of conversing, listening, taking in information, and then applying what they thought were important aspects of what they had learned to their own practice contexts with clients.  The new caseworkers shadowed their more experienced co-workers by going with them into client's homes and observing the interactions and treatment interventions as their experienced colleagues modeled, explained, provided feedback, and reinforced what was going on in the situational interactions (Lave & Wenger, 2002).

Caseworkers worked in teams.  As team members, caseworkers performed and interacted with each other through activities of coordination and cooperation, collaboration, negotiation and compromise, and shared awareness in problem solving and decision making (Wiecha & Pollard, 2004; McCallin, 2001).  They learned by building a shared knowledge base about practice and treatment protocols.  Regular team meetings provided the context for effective communication in which to actively network in order to exchange information, of which asking questions was the main method of acquiring and understanding information and developing the team's shared knowledge base.

At team meetings and in discussions, caseworkers share problems and dilemmas that they have encountered when working with their clients or within the general context of their practice.  Caseworkers interact with each other and brainstorm and discuss solutions that potentially can be used to solve practice and client problems.  Caseworkers build relationships with peers to draw from each other in their daily work-related functions; such group learning assists with the creation of an agency "shared knowledge" about best practices with clients.  Caseworkers are members of teams who build

159

"negotiated belief structures (Walsh, 1995, p. 291) as team members develop "shared knowledge structures" from the social processes encountered with working with each other.

Caseworkers consistently worked with novel and ambiguous situations and under conditions Eraut (1994) termed "hot action." Caseworkers learned to solve problems as they dealt with diverse client needs that had unknown solutions and made decisions rapidly and responded instantaneously to problematic situations (Eraut).

Eraut (2000) looked at the level of intention in learning. He created a continuum with implicit learning at one end. Implicit learning means acquiring knowledge independently of conscious attempts to learn without explicit knowledge about what was learned being present (Reber, 1993, cited by Eraut, 2000). Caseworkers, if they did not know something about a situation, they gained their knowledge by experiencing the events of the situation. On the other end of the continuum, Eraut listed deliberative learning in which time is specifically set-aside for learning. Caseworkers often made time to attend trainings or read in order to acquire knowledge. Reactive learning falls in the middle of the continuum and was defined as learning that is explicit but takes place spontaneously and in response to recent, current or imminent situations but without any time being set aside for it. Caseworkers would often react in response to a problem that was happening; they would spontaneously go out and connect with resources or call someone and ask questions in order to resolve client needs.

Similar to Eraut's (2000) continuum of learning and because they worked with problematic situations and environments, caseworkers integrated their learning: they used self-directed, informal, spontaneous, incidental, and latent learning—depending upon what type of situation called for what type of learning. By learning from

160

experiences and situational contexts, caseworkers acquired the skills and techniques of psychosocial rehabilitation and recovery that they used in treatment interventions with their clients.

Second Sub-Research Question: Learning Activities' Contributions to Competence

Most of the caseworkers in this study identified that their more effective learning occurred as they naturally went about their job duties and interacted with physical and social tools. The individual professional acquires and accumulates knowledge, skills, attitudes and insights from daily experiences and exposure to the work environment. While involved in on-the-job activities, caseworkers developed their "selves" when they interacted in multiple events with clients that reconstructed their "mental representations" (Lave & Wenger, 2002). They established external relationships with the physical and social tools that were located in the environment and activities that were situated in the performance period (Rogoff, 1990; Wenger, 1998). Physical and social tools acted as resources to assist with accessing information and using information for learning (Wenger, 1998). Patterns emerged that assisted caseworkers in the development of their competence. Integrated learning was related to learning competence; establishing external relationships was related to tools competence; engaging in authentic experiential problem solving contexts was related to work competence; and developing the "self" was related to personal competence.

*Integrated learning was related to learning competence.* Caseworkers identified a need to continuously learn because new problems, needs, new resources, organizational challenges, and situations arose constantly during treatment time periods; therefore, they used problem solving and judgments skills in order to assess and manage client problems,

161

skills that resemble Norman's (as cited in Eraut, 1994) description of generic skills of gathering and interpreting information. When engaged in activities, caseworkers remembered relevant clinical information to use in order to provide appropriate client treatment and care, and they used problem solving and judgment in order to assess and manage client problems. They learned to find, evaluate for use, use, and communicate with information as needed to resolve problematic situations. Their skills of evaluating and using information resembled Eraut's (1994) discussion of how such skills assist the professional in the successful resolution of client problems more so than the use of a propositional knowledge base that has been stored in memories.

Caseworkers discussed how they had to learn how to treat clients; the majority of their learning was based upon solving clients' problematic situations, despite environmental constraints such as scarce financial and material resources and limited time frames. As Eraut (1994) stated, the caseworkers developed expertise when they developed the ability to cope with difficult, ill-defined problems, demonstrated the ability to correctly read situations, and resolved client problematic situations. In order to do so, they integrated their learning as the demands of the situations shifted and changed. Caseworkers would shift from self-directed, formal, informal, incidental, spontaneous, and latent forms of learning as required and needed.

*Establishing external relationships was related to tools competence*. The caseworkers did not perform alone or engage in solitary activities but participated in social interactional processes with colleagues, clients, community resource personnel, and subject matter experts. Just as authors such as Wertsch, Minick, and Arms (2002) and Liberman (2001) highlighted the important use of relational skills with clients, the findings of this study emphasized the importance of caseworkers using relational skills.

162

Caseworkers developed relational skills by maintaining collaborative, supportive, and respectful relationships with the clients and colleagues who they encountered (Liberman, 2001).

Caseworkers developed the ability to maintain interagency contacts with outreach resources such as housing, financial entitlements, and vocational rehabilitation. They worked collaboratively with all resources for the best interests of clients. Caseworkers also created supportive networks with co-workers, support staff, clients' families, community resource personnel, and other service providers; these networks often became an important source for learning as caseworkers used them to locate, access, and acquire information. Teams provided the social structure through which caseworkers generated and shared the knowledge that they needed and developed and transferred the most accepted professional practices and skills because they learned from each other. This is similar to Brown and Duguid's (2002) discussions pertaining to their perspectives about how members of communities of practice interact with and learn from each other.

*Problem solving contexts were related to work competence.* Engaging in on-the-job activities assisted the caseworkers in their learning activities that contributed to their professional development. As Nowlen's (1988) Performance Model suggested, caseworkers constructed their knowledge for practice as they engaged in practice. They also made decisions about their treatment interventions based upon the interpretations that they derived from the interactions with the activities in which they were engaged within related environmental contexts (Nowlen). Caseworkers' learning involved more than acquiring information; it was through work engagement that learning occurred, as suggested by Brown and Duguid (2002). Caseworkers, as noted by Wertsch, Minick, and

163

Arms (2003), gained experiences from the social settings in which they participated; these experiences helped them gain understandings about information, thus developing skills with decision making, problem solving, and behaviors to perform their job roles with competence. Caseworkers were "socialized" into the processes of "how to do" their professional job duties.

A great deal of the time caseworkers performed at their jobs in the instant/reflex mode (Eraut, 1994) in which they make rapid and intuitive decisions about how to solve clients' problems. Feedback provided by learning from mistakes that were made through these accumulated trial-and-error activities and from advice and suggestions provided by colleagues assisted the caseworkers in learning what was successful or not and what worked or did not work in successful practice performance. As caseworkers learned, they became more proficient in their work activities and treatment procedures. Throughout all these situations, communication was integral because communication processes provided a learning medium that improved work-related processes.

Interactions such as with colleagues and clients developed caseworkers' expertise (Wertsch, Minick, & Arms, 2003; Brown & Duguid, 2005; Rogoff, 1990). Expertise within practice entails the correct, efficient, and effective reading of client situations and problems and the ability to problem solve in order to reach effective treatment procedures for clients within appropriate time frames. Expertise is also considered as the ability to perform appropriately and effectively in interactions with clients and colleagues.

With time and through practice, caseworkers acquired the ability to effortlessly do clinical tasks because they had experience; with experience they no longer had to think about the individual steps to perform and carried out tasks from start to finish while

thinking about other things. Caseworkers also developed "skillful behaviors" (Eraut, 1994). Caseworkers engaged in skillful performance through their use of intuitive actions, tacit understanding, and analytical approaches (Dreyfus, as cited in Eraut, 1994) because they had gained experiences with using perception and decision making. Caseworkers performed complex sequences of action that had become routine and automatic (Eraut, 1994). As Anthony (1992) concluded: "most of the knowledge about psychosocial rehabilitation is acquired by mental health workers through on-the-job activities. . . ."

*Developing the "self" was related to personal competence.* Three main areas of personal competence were identified through analyzing the findings: emotional maturity, values about clients, and cognitive abilities. A gap exists in the literature concerning emotional maturity. Although caseworkers discussed how important it was for them to learn to offset burnout, handle change, and separate their professional lives from their personal ones, the review of the literature did not reveal any discussions related to this area of personal competence.

Caseworkers developed competence in the areas related to values about clients that coincide with ideas from Eraut (1996), Epstein and Hundert (2002), and Curry, Wergin, and Associates (1993). For example, Epstein and Hundert stated that professional competence involves relationships. Caseworkers' values about clients are related to the generic competencies identified as including effective communication, building therapeutic relationships, responding to clients' situations, empowering clients by involving them in the decision making processes of their treatment, and decreasing their anxieties and stressors as related to treatment. Caseworkers need effective communication, emotional, and interpersonal skills in order to perform effectively.

165

The relationship between personal competence and development of the self coincides with ideas based upon the Four-Stage Model of Clinical Expertise discussed by Boshuizen (cited in Eraut, 1994); these ideas relate to the development of cognitive processes that include memory, intuition, and clinical judgment. Caseworkers developed relationships between interrelated details of the situation that they encountered which added to their understandings of the processes of how they clinically treated clients. They accumulated experiences acquired from working with clients. Caseworkers developed scenarios about situations which they stored in their long-term memories and used these scenarios as references for "what to do" when they encountered similar situations in the future.

Caseworkers' ability to identify patterns among cases developed with experiences and exposure to multiple cases. Knowledge and principles were recalled and recognized in the essential form that they were learned. Caseworkers used their memories to connect patterns within and between problem situations, forming a basis for "knowing" solutions to use to solve problems. Because they learned what to expect and how to use techniques of treatment, caseworkers learned what to look for in treatment and how to respond to work related and client situations. Their "knowing-in practice" became tacit, spontaneous, and automatic, as Eraut (1994) stated. They developed skills, understandings, and scenarios in their long term memories that developed intuition and clinical judgment about solving problematic situations.

Eraut (1996) and Schon (1983) discussed how important meta-cognition and reflection was to practice and were important as integral components of professional development. However, caseworkers did not discuss even once how they used these processes in their development as professionals.

166

Caseworkers developed the effective use of individual skills needed within professional practice:  intellectual skills, attitudes, and performance abilities (Nowlen, 1988).  They used personal experiences, personal knowledge, cognitive and reasoning abilities, skillful professional performance with deliberative processes and skilled behaviors, and relational skills—all intertwined and interconnected with performance (Eraut, 2004; Epstein & Hundert, 2002).  The learning activities and  patterns and relationships between areas of competence have implications for practice and future research.  These implications will be discussed in the next sections.

<div align="center">Conclusions</div>

Five conclusions are drawn from the findings of this study.

1. Caseworkers adjust their needs for integrated learning to resolve client needs and/or solve their problem situations.

2. Effective communication processes expand networking possibilities.

3. The environment stimulates and constrains the problem solving learning activities caseworkers use.

4. Shared group learning and shared knowledge develop caseworkers' skillful behaviors and deliberative processes through learning co-occurring with experiences.

5. Supervisors and co-workers perceived that most caseworkers' learning occurs through formal educational opportunities; caseworkers perceived that most of their learning occurs with on-the-job activity engagement.

*Caseworkers Adjust their Needs for Integrated Learning to Resolve Client Needs and/or*

*Solve Problem Situations*

Caseworkers interacted with their environment as they used interaction behaviors with physical and social tools located within the environment and their "activity" or "performance period." Caseworkers daily encountered performance periods which do not have well-designed activity processes or solutions to reach the goal of the activity that is going on within the performance period. The focus is on the caseworkers' practical work situations or "activities. An "activity" is seen as the basic unit of analysis and human activities are driven by human needs in order to achieve certain purposes (Rajkuman, 2006).

Many interaction activities occur throughout the performance period. An interaction activity begins when a caseworker initiates contact with a client. Through dialoguing with and listening to the client, the caseworker begins to understand that the client has a need to address or a problem to solve. The client's need or problem situation acts as a starter button to turn on the caseworker's "learning" processes.

If caseworkers are engaged in an activity in which they do not have familiarity, they will integrate their learning. They will use their external connections with physical and social tools in order to find out what must be done in order to resolve the problem or need. Searching for, locating, and applying information and resources comprises the principal operations used in these activities related to client problems. For example, a client needs extensive dental work; Medicaid no longer pays for dental services. The caseworker treating this client will look for information that will assist in locating dental resources that perhaps the client can afford. The caseworker will ask

team members and subject matter experts about resources, make telephone calls, and/or surf the Internet for such resources. Usually the activity ends as does this distinct performance period when the need is resolved and/or the problem situations solved.

*Effective Communication Processes Expand Networking Possibilities.*

Effective communication processes are very important for caseworkers to use in locating and obtaining information and resources. Caseworkers have two roles within the communication process. They are either the senders of the messages or they are supporting, assisting, and guiding clients in being the senders of messages. Messages contain queries about information and resources with which clients need to connect in order to solve problems and take care of needs.

Caseworkers establish external relationships with physical or social/human tools in order to locate information needed to resolve client needs and problem situations. When searching for and researching information and resources, caseworkers use technological resources. Cell phones enable caseworkers to contact social/human tools quickly without face-to-face contact but still provide opportunities for quick, verbal communication of the messages that require responses. Searching the Internet also provides opportunities for quick access to printed information and resources.

Social and human tools are also used when locating and obtaining information. Given the context of face-to-face contact, the senders of the messages receive verbal responses. If the responses do not contain the needed information, then the caseworkers can ask the necessary questions that will connect them or clients with additional tools to access in order to expand information and resource contacts. Caseworkers also listen to responses so that they can make meaning out of messages. By being able to connect

169

through the communication process with physical and social tools, caseworkers expand their networking sources for locating and obtaining information and resources.

*The Environment Stimulates and Constrains the Problem Solving Learning Activities*

*Caseworkers Use*

The context of the mental health environment impacts practice. Quality customer service in today's professions is emphasized. The environment provides many constraints as well as opportunities that impact the professional caseworkers' ability to engage in problem solving learning activities.

Environmental constraints are multiple. Scarce financial and material resources limit caseworkers' abilities to secure an abundance of services for their clients. Caseworkers travel many miles while out in the community providing services to clients during the course of a work day, thereby limiting the time available for treatment. Limited access to needed technology and community resources happens as caseworkers are in the field, possibly visiting with clients in homes that are miles outside of city limits and who cannot afford even a telephone. Because they deal with human beings, caseworkers also contend with issues of personal safety and client crisis situations.

The context of caseworkers' jobs hinder problem solving abilities. Because they serve individual clients one-at-a-time but see many clients within a day's time, caseworkers address multiple client needs and issues within a working day. Caseworkers, therefore, serve multiple purposes while multi-tasking within their professional roles. For example, a caseworker may be driving with a client in his or her car on the way to communicate with a community resource person while listening to the client speak about his or her problems while providing suggestions for possible ways to solve the problem.

The environment also provides opportunities for caseworkers to effectively use problem solving learning activities. Because they are engaged with professional job activities, caseworkers consistently have continuous opportunities to learn and grow with and in their jobs. They have team members they can use for feedback about problem solving strategies. New resources, new treatment interventions, and new techniques are being researched and put into practice. Caseworkers can tap into knowledge/information via dialoging with co-workers, supervisors, and other social/human tools and/or using technological tools.

*Shared Group Learning and Shared Knowledge Develop Caseworkers' Skillful Behaviors and Deliberative Processes*

Shared learning and knowledge creation coupled with on-the-job experiences and authentic work activity engagement enabled caseworkers to develop skillful behaviors and deliberative processes. Dialogue provided a social context for learning in which caseworkers developed understandings of and used their team members' ideas of "best practices." Through dialogue coupled with experience, caseworkers developed the intuitive and automatic "know how" to "conduct the various processes that contributed to [their] professional actions (Eraut, 1994, p. 107). They learned to tacitly use such deliberative processes and decision making, clinical judgment, and problem solving skills (Eraut, 1994).

*Supervisors and Co-workers Perceive that Most Caseworker' Learning Occurs through Formal Educational Opportunities; Caseworkers Perceive that Most of Their Learning Occurs with On-the-Job Activity Engagement*

The perceptions of the importance of learning from formal opportunities differed between supervisors, co-workers, and the caseworkers who were interviewed.

171

Supervisors identified that learning from formal opportunities was "very important" to caseworkers' continued learning and ranked it above informal learning opportunities that occurs within job activities and experiences. Co-workers, as the supervisors did, noted that formal learning opportunities assisted the caseworkers' to maintain and develop their competence more so than informal learning opportunities did.

After analyzing the data and reflecting about the reasons why co-workers and supervisors emphasized formal learning as more important than informal learning, I concluded that supervisors, because they represent the management side of the mental health centers, concentrated on the perceptions that formal learning is the most important aspect of learning the job. I also concluded that co-workers saw the caseworkers as learning formally because they see each other at formal learning sessions, subject matter presentations, and team meetings more so than in work situations.

Caseworkers, however, had totally opposite viewpoints about the value and benefits of formal educational opportunities. Consistently during the interviews, caseworkers reported that they did not find formal learning opportunities useful to developing overall competence. They valued formal learning more so for keeping them up-to-date with specific knowledge and skills or learning about new information or techniques that were being developed for treatment.

Caseworkers identified that their learning from physical and social tools and from doing the job was far more effective and important than attending formal educational opportunities. However, significant aspects of informal learning did emerge from the data on the parts of supervisors and co-workers. Both supervisors and co-workers specifically identified the activities of *learning by doing*, *asking questions*, and *actively*

172

*networking* as important aspects of developing competence. Co-workers added their perceptions that *dialoguing* was important to learning and developing competence.

In summary, clients have needs and problems that caseworkers assist clients in resolving. Much of the caseworkers' professional job duties therefore revolve around problem solving processes. Environmental factors can support or constrain problem solving. Client problems and needs trigger caseworkers' just-in-time learning processes. Caseworkers develop their skillful behaviors and deliberative processes through learning that co-occurs with experiences and from acquiring knowledge from their team. Supervisors and co-workers, however, perceived that caseworkers' learning stemmed primarily from attendance at formal learning opportunities.

<div align="center">Implication for Practice and Future Research</div>

Caseworkers' learning is a dynamic, complex, consistently changing, intertwined, and interrelated process that maintains and contributes to professional development. This study began with the desire to better understand how the professional learning activities of caseworkers developed their professional competence. This study has contributed to the literature in three ways. The findings of this study: (a) identified four major areas of competence, (b) classified two major learning categories and related learning activities, and (c) described four relationships between the competence areas, emerging patterns, and associated learning activities. These findings only begin to tap into the knowledge about how caseworkers use professional learning activities to develop their professional competence. These findings have implications for practice and for future research.

*Implications for Practice*

     This study reveals four areas of implications for practice.  Accessing and sharing information is important for learning processes.  Environments of mental health centers need to support informal learning opportunities, cultivate informal learning networks, and provide learning opportunities that teach caseworkers to be self-directed learners.

     *Accessing and sharing information.*  Caseworkers identified that an important learning process included accessing and sharing information, especially through establishing external relationships with physical and social tools.  Community mental health centers may wish to consider the following three suggestions for accessing and sharing information.  First, the centers can create physical space where caseworkers can informally interact as members of communities of practice.  Second, facilities' managers can provide opportunities for adequate use of computers and telephones so that practitioners can access information in a timely manner.  Third, a list that specifies each practitioner's areas of expertise could be put somewhere that is easily accessible and visible so that it could be referenced by caseworkers who "have a need to know" and thus have access to that co-workers' knowledge.

     *Creating environments that support informal learning opportunities.*  Upper management needs to align the organizational environment in ways that supports informal learning opportunities.  Many questions occur on a daily basis related to resources that solve client problems.  Problem solutions often occur through spontaneous brainstorming processes of caseworkers that arise out of casual conversations, questions asked, and interactions with colleagues.  An organization that recognizes and supports informal learning will improve the quality of the learning activities that assist with the professional development of the caseworkers.

Organizational management needs to recognize that providing informal learning opportunities will not guarantee that informal learning will take place unless supportive strategies and mechanisms are also provided. Such strategies can include recognizing the value of informal discussion and encouraging co-workers to discuss problem situations while at work and supporting the role of discussion and providing time for co-worker interactions.

*Supervisors and co-workers value and cultivate skills of creating informal learning networks.* Supervisors and co-workers have limited contact with caseworkers because caseworkers spend the majority of their work day out in the field seeing clients one-on-one; therefore supervisors and co-workers have limited insight into how caseworkers actually use informal learning activities to develop professionally.

Discussions could take place between caseworkers and supervisors about the importance of informal learning mechanisms for caseworkers' to learn how to do their jobs. Time can be taken during team meetings for reflection. Team meetings can be a time to ask what worked, what did not work, what advice exists for co-workers to assist in solving client problems. These times of reflection can be used as sources for sharing expertise about learning and knowledge development that arise out of informal learning activities; awareness of the importance and value of informal learning activities can also be discussed so that all value the informal learning channels. Caseworkers could present skills programs at supervisory meetings about the importance of informal learning and/or how to foster informal learning environments in the work place.

*Training programs designed especially to teach self-directedness in informal learning.* Training programs can be incorporated into practice that teaches caseworkers how to improve self-directedness in their informal learning activities. They will then be

175

more motivated to know how to frame important clinical questions and answers, access information, and interpret information so that information can be applied to clinical problems as well as practice situations.

*Implications for Future Research*

This study was done in order to understand better how the learning activities of caseworkers assist in their professional development. During the course of the literature review, I discovered that there were very few studies actually done that specifically targeted the learning activities of caseworkers because most of the healthcare studies were aimed primarily at physicians and nurses. Therefore there is a vital need to understand the learning processes of mental health workers; further research is therefore needed in five areas: (a) the impact of informal learning on mental health organizational learning, (b) the influence of interactive and situational factors on informal learning opportunities, (c) the influence of organizational processes on the informal learning of caseworkers, (d) the roles that reflection, meta-cognition, and emotional maturity play in professional development, (e) how informal learning contributes to service practices, and (f) the difference in values that supervisors and caseworkers put on formal learning opportunities.

*The impact of informal learning on mental health organizational learning.*
Limited research is available that specifically targets organizational learning of mental health facilities. Understanding the impact of informal learning at the organizational level is needed to help round out the knowledge of how all organizations learn in general. More studies with an even larger sample of participants would identify more patterns of learning and related contributions to professional development, even further advancing the knowledge about organizational learning.

*The influence of interactive and situational factors on informal learning opportunities*.  Research should look at the social learning aspects of a team, especially at the level of team norms and the role of the team in decision making on individual performance, problem solving, and learning activities.  Studies about motivation could look at the learning of caseworkers involved with specific clients and their need to resolve specific problem situations.  Replication of studies in rural settings could look at the learning patterns of caseworkers where populations are not as heavily concentrated as in urban settings.  Such studies as the above mentioned ones could help shed light on the conditions, resources, and environmental contexts that constrain as well as support caseworkers' learning activities.

*The influence of internal organizational processes on the informal learning of caseworkers*.  Internal learning processes influence memory processes, intuition, and clinical judgment.  Studies could find out how problems are recognized and questions are formulated in order to be asked.  Studying internal learning processes can also shed light on how problems are solved and answers to questions are located.  The processes of searching for and researching information to solve problems can also be better understood through studies concerning internal learning processes of caseworkers.

*The roles that reflection, meta-cognition, and emotional maturity  play in professional development*.   This study looked at caseworkers who used a range of related learning activities.  In-depth research concentrating on the impact that reflection, meta-cognition, and emotional maturity has on professional development would be important.  Organizational leaders could then design strategies to incorporate these activities into the learning climate of the mental health centers.

*How informal learning contributes to service practices.*  Because of environmental constraints such as limited time and resources, learning activity strategies and styles have important implications for practice.  In order to determine the effectiveness of learning activities, studies could look at the clinical effectiveness of solving client problems.  Studies should also look at the role of space, staffing, and resource allocation in learning.

T*he difference in values that supervisors and caseworkers put on formal learning opportunities*.  Supervisors and caseworkers had different perspectives about the value of formal learning opportunities and the development of competence.  Studies could look at the impact of formal learning on competence development which could lend insight into the development of effective programs that would benefit caseworker learning and therefore improve practice.

## Summary

This research looked at learning activities of caseworkers that contributed to their professional development.  After conducting a review of the literature, the researcher discovered that few studies existed that specifically targeted the learning of mental health caseworkers.  Therefore, this study has many implications for practice and research. Studies are needed that focus on how informal learning activities impact organizational learning of mental health facilities.  One finding that emerged from the data was totally unexpected:  supervisors and co-workers concentrated on formal learning as a mechanism for professional development while caseworkers focused on informal learning processes. Therefore, as an implication for practice, informal learning networks could be created in which supervisors and caseworkers take part so that all members of the community of practice learn to value the importance of informal learning in caseworkers' professional

178

development.  Creating work spaces designed for informal learning, having timely access to technological tools, and developing self-directedness of caseworker learning are other implications for practice.

Research targeting the learning of healthcare professionals has concentrated on physicians and nurses.  Research is needed on the informal learning activities of mental health caseworkers so that their learning can be better understood and effectiveness and quality of practice can be improved.

APPENDIX 1

CASEWORKER CONSENT FORM

I agree to participate in a research study entitled "Understanding Learning Processes of Caseworkers for the Development of Professional Competence." This study is conducted by Jan Iseminger, a doctoral candidate at the University of Missouri at Columbia, MO, in the Department of Educational Leadership and Policy Analysis, as part of her dissertation research.

The following have been explained to me:

1. The overall purpose of this research is to identify and describe patterns in learning processes and/or activities that caseworkers in community mental health centers undergo in order to develop and maintain professional competence.

2. The benefits that I may expect to obtain from this study are an opportunity to gain a better understanding of the skills and activities involved in maintaining professional competence which I can incorporate in my work activities, and a better sense of how I can improve my practice and service to clients.

3. I understand that, if I agree to participate in this study, I will be interviewed for approximately 60-90 minutes. The questions that I will be asked will pertain to learning processes and activities which members of mental health teams use in order to develop and/or maintain competence their work. I also understand that the researcher will contact me for two follow-up sessions after the interview. I understand that all personal information that is provided during the interview will be kept confidential. I understand that I may be asked to participate in a follow-up interview if the researcher requires clarification or more information.

4. I understand that the researcher will interview 1-2 of my co-worker/team members about their perceptions of the processes and activities that I have undergone and/or used in order to gain and maintain competence. I understand that this information that is provided will be kept confidential.

5. I understand that the researcher does not foresee any discomfort or stress that I will experience during the interview process.

6. I understand that the researcher does not foresee any risks associated with this research project.

7. I understand that participation is entirely voluntary, and that I can withdraw at any time with no penalty. Should I choose to withdraw, the results that can be identified as mine will be removed from all records and destroyed.

8.  I understand that the results of participating in this research project will be kept confidential and that a pseudonym will be assigned to my name for publication of the research project.  I understand that any information collected for data analysis will be kept for a minimum of three years after the research project is finished.

9.  I understand that the researcher will answer at any future time questions that I will have related in any way to this research project.

10.  I understand that I may contact any of the persons named below if I have any more questions or need more information concerning this research project:

**The Researcher:**  Jan Iseminger
Address:  12916 S. Al Gossett Road, Lone Jack, MO   64070

Home number:   816-697-3654
Work number:    660-826-5885
Email address:   janmarise@netzero.net

**Graduate Advisor:**  Dr. Joe Donaldson, Professor
Address:  Higher & Continuing Education
Department of Educational Leadership & Policy Analysis
University of Missouri-Columbia
202 Hill Hall
Columbia, MO   65211

Work number:   573-884-9330
Fax number:    573-884-5714
Email address:  donaldsonj@missouri.edu

**Institutional Review Board Contact:**

Address:  483 McReynolds            Julie Dusold, BA
University of Missouri            Compliance Specialist
Columbia, MO   65211            Email:  dusoldj@missouri.edu
Phone:  573-882-9585
Fax:     573-884-0663

Michele Reznicek, RN, MBA, JD       Janelle Greening, BS
Compliance Officer            Compliance Specialist
Email:  reznicekm@missouri.edu       Email:  greeningjm@missouri.edu

_____  _____  _____
Signature of Researcher          Signature of Participant          Date
Research involving human subjects is overseen by the Institutional Review Board at the University of Missouri.

APPENDIX 2

SUPERVISOR CONSENT FORM

I agree to participate in a research study entitled "Understanding Learning Processes of Caseworkers for the Development of Their Professional Competence." This study is conducted by Jan Iseminger, a doctoral candidate at the University of Missouri at Columbia, MO, in the Department of Educational Leadership and Policy Analysis, as part of her dissertation research.

The following have been explained to me:

1. The overall purpose of this research is to identify and describe patterns in learning processes and/or activities that caseworkers in community mental health centers undergo in order to develop and maintain professional competence.

2. The benefits that I may expect to obtain from this study are an opportunity to gain a better understanding of the skills and activities involved in maintaining professional competence which I can incorporate in my work activities, and a better sense of how I can improve my practice and service to clients.

3. I understand that, if I agree to participate in this study, I will be interviewed for approximately 30 minutes. The questions that I will be asked will pertain to my perceptions of how my caseworker learned to be competent. I understand that all personal information that is provided during the interview will be kept confidential.

4. I understand that the researcher does not foresee any discomfort or stress that I will experience during the interview process.

5. I understand that the researcher does not foresee any risks associated with this research project.

6. I understand that participation is entirely voluntary, and that I can withdraw at any time with no penalty. Should I choose to withdraw, the results that can be identified as mine will be removed from all records and destroyed.

7. I understand that the results of participating in this research project will be kept confidential and that a pseudonym will be assigned to my name for publication of the research project. I understand that any information collected for data analysis will be kept for a minimum of three years after the research project is finished.

8. I understand that the researcher will answer at any future time questions that I will have related in any way to this research project.

9.  I understand that I may contact any of the persons named below if I have any more questions or need more information concerning this research project:

**The Researcher:**    Jan Iseminger
                  Address:  12916 S. Al Gossett Road, Lone Jack, MO   64070

                  Home number:   816-697-3654
                  Work number:   660-826-5885
                  Email address:  janmarise@netzero.net

**Graduate Advisor:**  Dr. Joe Donaldson, Professor
                  Address:  Higher & Continuing Education
                  Department of Educational Leadership & Policy Analysis
                  University of Missouri-Columbia
                  202 Hill Hall
                  Columbia, MO   65211

                  Work number:   573-884-9330
                  Fax number:   573-884-5714
                  Email address:  donaldsonj@missouri.edu

**Institutional Review Board Contact:**

Address:  483 McReynolds
University of Missouri
Columbia, MO   65211
Phone: 573-882-9585
Fax:     573-884-0663

Michele Reznicek, RN, MBA, JD       Janelle Greening, BS
Compliance Officer                  Compliance Specialist
Email:  reznicekm@missouri.edu      Email:  greeningjm@missouri.edu

Julie Dusold, BA
Compliance Specialist
Email:  dusoldj@missouri.edu

_____  _____  _____
Signature of Researcher         Signature of Participant         Date
Research involving human subjects is overseen by the Institutional Review Board at the University of Missouri.

APPENDIX 3

CO-WORKER/TEAM MEMBER CONSENT FORM

I agree to participate in a research study entitled "Understanding Learning Processes of Caseworkers for the Development of Their Professional Competence." This study is conducted by Jan Iseminger, a doctoral candidate at the University of Missouri at Columbia, MO, in the Department of Educational Leadership and Policy Analysis, as part of her dissertation research.

The following have been explained to me:

1. The overall purpose of this research is to identify and describe patterns in learning processes and/or activities that caseworkers in community mental health centers undergo in order to develop and maintain professional competence.

2. The benefits that I may expect to obtain from this study are an opportunity to gain a better understanding of the skills and activities involved in maintaining professional competence which I can incorporate in my work activities, and a better sense of how I can improve my practice and service to clients.

3. I understand that, if I agree to participate in this study, I will be interviewed for approximately 30 minutes. The questions that I will be asked will pertain to my perceptions of how my co-worker learned to be competent. I understand that all personal information that is provided during the interview will be kept confidential.

4. I understand that the researcher does not foresee any discomfort or stress that I will experience during the interview process.

5. I understand that the researcher does not foresee any risks associated with this research project.

6. I understand that participation is entirely voluntary, and that I can withdraw at any time with no penalty. Should I choose to withdraw, the results that can be identified as mine will be removed from all records and destroyed.

7. I understand that the results of participating in this research project will be kept confidential and that a pseudonym will be assigned to my name for publication of the research project. I understand that any information collected for data analysis will be kept for a minimum of three years after the research project is finished.

8. I understand that the researcher will answer at any future time questions that I will have related in any way to this research project.

9.  I understand that I may contact any of the persons named below if I have any more questions or need more information concerning this research project:

**The Researcher:**    Jan Iseminger
          Address:  12916 S. Al Gossett Road, Lone Jack, MO   64070

          Home number:   816-697-3654
          Work number:    660-826-5885
          Email address:  janmarise@netzero.net

**Graduate Advisor:**  Dr. Joe Donaldson, Professor
          Address:  Higher & Continuing Education
          Department of Educational Leadership & Policy Analysis
          University of Missouri-Columbia
          202 Hill Hall
          Columbia, MO   65211

          Work number:  573-884-9330
          Fax number:    573-884-5714
          Email address:  donaldsonj@missouri.edu

**Institutional Review Board Contact:**

Address:  483 McReynolds
University of Missouri
Columbia, MO   65211
Phone: 573-882-9585
Fax:     573-884-0663

Michele Reznicek, RN, MBA, JD        Janelle Greening, BS
Compliance Officer                Compliance Specialist
Email:  reznicekm@missouri.edu        Email:  greeningjm@missouri.edu

Julie Dusold, BA
Compliance Specialist
Email:  dusoldj@missouri.edu

_____  _____  _____
Signature of Researcher          Signature of Participant         Date
Research involving human subjects is overseen by the Institutional Review Board at the University of Missouri.

APPENDIX 4

TWELVE SETS OF COMPETENCIES

- Competency #1 describes the basic attitudes, values, knowledge, and behaviors that are the foundation of a person-oriented service program.

- Competency #2 describes the basic understanding, knowledge, and behavior that shape the ways providers engage and provide relevant services to the family and other close relationships of the consumer.

- Competency #3 outlines the basic psychosocial knowledge that providers need to know about severe mental illness.

- Competency #4 outlines the basic biological and pharmacological knowledge that providers need.

- Competency #5 describes the range of psychosocial interventions that staff members need to know and to practice.

- Competency #6 focuses on individualized treatment and the providers' ability to design, deliver, and document their interventions.

- Competency #7 describes what providers must know about community resources, entitlement and benefit programs in order to link clients with them. The staff members must also balance their activity in public education and advocacy with sensitivity to community, anti political concerns.

- Competency #8 highlights the need for staff members to be knowledgeable about the relevant laws and legal issues.

- Competency #9 focuses on active collaboration within and across the multiple funding, governing, and service agencies.

- Competency #10 describes how the provider adheres to professional and ethical standards, and pursues professional development.

- Competency #11 describes the elements of culturally competent mental health treatment.

- Competency #12 focuses on research and other types of feedback to improve personal and agency outcomes.Dimensions of the Twelve Competencies Below are the dimensions of the 12 competencies that provide a comprehensive view of highly competent service providers.

Competency #1: Engages adults with serious mental illness as people with dignity and competence and as full collaborators in service planning, delivery, and evaluation

A. Uses language and behavior that consistently reflect and enhance the dignity of individuals with mental illness.

B. Fosters client empowerment.

C. Fosters consumers' recovery.

D. Demonstrates holistic understanding of adults with mental illness, including awareness of their basic needs, personal experiences, individual strengths, and the multiple factors that impact the illness.

E. Works in partnership with service recipients in all aspects of service planning, treatment, and support activities.

F. Provides needed information and education about mental illness, medications, coping skills, services, resources, self-help, and the consumer movement.

G. Facilitates normalization of life by focusing on developmental tasks, normal challenges across the life span, natural support systems, and by accepting the legitimate feelings of sorrow, anger, frustration, etc.

H. Works to diminish discrimination.

Competency #2: Where relevant, includes family members and caring others in all aspects of service planning, delivery, and evaluation.

A. Understands the unique issues facing family members of persons with mental illness.

B. Engages families in the treatment and rehabilitation process, when appropriate and desired.

C. Becomes knowledgeable about family support resources and intervention strategies.

D. Addresses the expressed needs of individual families.

Competency #3: Demonstrates current knowledge of issues related to mental illness.

A. Demonstrates up-to-date knowledge of different characteristics and courses of mental illnesses, the risk factors, and the biochemical, neurological, behavioral and experiential dimensions of the disorders.

B. Recognizes the unique needs of individuals with mental illness and co-occurring disorders (e. g., substance abuse, developmental disabilities, physical disabilities, personality disorders, trauma, brain injury).

C. Knows about societal, cultural, ethnic, gender, and other issues related to mental illness and its treatment.

Competency #4: Demonstrates current knowledge of the biological aspects of severe mental illness.

A. The level of expertise in the biological aspects of SMI disorders should be related to the various roles that staff members provide in the service delivery system. However,

188

everyone should have some basic knowledge of the biological dimension of SMI.

B. Knows the relevant structures and functions of the brain.

C. All direct service staff members should know about psychotropic medications and their side-effects.

D. Everyone prescribing medications should be fully trained and accredited, follow relevant clinical guidelines, work closely with staff, and be able to speak fluently the language of their patients.

<div align="center">

Competency #5: Knows and uses best practices of intervention

and support strategies.

</div>

A. Demonstrates basic communication and intervention skills, and knows about the empirical validity, practice guidelines, and relevant standards of care for different interventions.

B. Teaches both simple and complex skills, including physical, social, cognitive, emotional, and other relevant skills.

C. Understands the value of choice and is attentive to the possible iatrogenic effects of both biological and psychosocial interventions.

D. Knows a variety of program models and their philosophies.

E. Knows about a range of crisis prevention and crisis intervention approaches.

F. Understands the principles of community support, rehabilitation, and managed behavioral healthcare.

<div align="center">

Competency #6: Designs, delivers, and documents highly individualized

services and supports.

</div>

A. Encourages and facilitates personal growth and development toward recovery and wellness.

B. Routinely solicits personal goals and preferences.

C. Designs service plans based on individual needs, choices, and preferences.

D. Ensures individualized services and supports.

E. Facilitates support networks.

F. Designs, delivers, and documents services that meet the requirements of state, regulatory, and funding agencies (e.g., managed care companies, professional and ethical guidelines, utilization reviews).

Competency #7: Effectively accesses and employs community resources.

A. Develops and maintains good links with a wide range of community resources, including consumer-run organizations, medical, social service, advocacy, legal, recreational, transportation, and religious.

B. Knows about entitlements and benefit programs and works to achieve positive outcomes while avoiding potential negative consequences.

C. Integrates community resources and entitlement programs into service planning and delivery.

D. Participates in public education and advocacy by providing accurate information about persons with mental illness, by identifying and challenging situations that are stigmatizing and discriminating, and by advocating for policies and procedures that respect individual rights and dignity.

Competency #8: Demonstrates knowledge of legal issues and civil rights that are relevant to work setting and occupation.

A. Knows relevant legal and ethical issues such as the Americans with Disabilities Act, commitment laws, Tarasoff and the duty to warn, reporting requirements such as child and elder abuse, advance directives, informed consent for treatment and research, etc.

B. Knows about individual civil, legal, and human rights, e.g., confidentiality and civil rights, patient rights including rights to treatment, to refuse treatment, to proper care.

C. Recognizes ethical guidelines and boundaries for community support work.

D. Knows about and connects individuals to legal and advocacy resources as needed and/or requested.

Competency #9: Works collaboratively within and across the service system.

A. Demonstrates knowledge of own agency and its place within the mental health care system.

B. Assists in building positive working relationships within and across the service system.

C. Knows about and skilled in working within a managed behavioral healthcare framework.

Competency #10: Conducts activities in a professional and ethical manner.

A. Adheres to recognized ethical and other relevant standards.

B. Performs work in a positive manner

C. Demonstrates commitment to professional development.

D. Values accountability and observes proper procedures.

Competency #11: Conducts activities in a culturally competent manner.

A. Understands and values cultural and ethnic differences, their alternative perspectives

191

on mental illness, help-seeking, and healing practices, as well as lifestyles, goals, family, and community life.

B. Able to clearly understand and communicate effectively by using language and community style that is understandable.

C. Makes a diagnosis that is culturally informed.

D. Makes an assessment that is culturally informed.

E. Develops a treatment plan that is culturally informed.

E Provides a culturally competent treatment.

Competency # 12: Knows methods of evaluation and applies them appropriately

to own work.

A. Knows research findings relevant to own position.

B. Knows basic research methodology, and applies it in evaluations.

C. Uses evaluation and feedback in own work.

D. Systematically evaluates own work; obtains and uses feedback from consumers, and where relevant, family members:  contributes to program evaluations: uses supervisory, and collegial reviews; evaluates for diminished capacity and obtains informed consent when collecting data.

(from:  Coursey, R. D., Curtis, L.,  Marsh, D. T., Campbell, J., Harding, C., Spaniol, L, et al.  (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), 378-393).

APPENDIX 5

PROPOSED GUIDE FOR INTERVIEW QUESTIONS FOR CASEWORKER

The proposed opening question:

Tell me a time when you had to learn something new on your job that you did not know before in order to be able to do your job.

1. Possible questions to elaborate on the opening question:
   a. Tell me about the process(es) that you used when searching for the information you needed.
   b. Describe to me how you went about looking for the information you needed.
   c. Describe the decision making processes you used in order to locate resources and processes that assisted you with your learning.
   d. What criteria was met when you reached the decision that you had learned what you needed to know?

2. Possible questions to ask that reference professional development and training:
   a. Describe to me the types of learning activities that you engaged in before you went to work for your organization.
   b. Describe to me the types of learning activities and situations that you engage in now that you work for this organization.
   d. Describe to me your perceptions about the effectiveness of these learning situations and activities in terms of being able to do your job in a better and more appropriate manner.

3. Possible questions to ask that reference professional competencies:
   a. How do you learn or acquire the needed skills for your job in order to perform your job?
   b. Tell me about a situation that you were involved with in which you had to learn to use new skills or abilities.
   c. What were the results of acquiring these new skills or abilities?  Please tell me the results from the processes of learning these new skills or abilities.

4. Possible questions to ask that reference the environment and activities involved in the context of the learning situation.
   a. Who are the major players that impact your professional learning?
   b. What are the major situations that impact your professional learning?
   c. Describe the resources you use when engaged in learning situations.
   d. Describe the types of activities you use when engaged in learning situations.
   e. How do these people, situations, resources, and activities interact in helping you acquire and use the information you need in order to learn?

5. Possible question to ask about the preferred activities, processes, or situations for learning:

a.   Describe to me other activities you have engaged in for learning the information you need for your job.
b.  What other learning processes come to mind when you talk about learning new information or skills related to your job.
c.  Can you brainstorm any other types of processes, activities, or resources you would have used for learning?
d.  Of all these processes, activities, and resources involved in your time spent working for this organization, which ones do you thing you have used the most because of the effectiveness of these processes, activities, and resources in your job-related learning needs?
e.  Describe some other learning mechanisms that would have possibly been beneficial to your learning

6.  Possible questions to use to close the interview:
   a.  What can you suggest or recommend for making your professional learning more effective?
   b.  Do you have any suggestions for learning-related mechanisms for possible future needs for your organization?
   c.  Do you have any other information to provide about learning within and for your organization that will improve professional performance.

Thanks you for allowing me to interview you.

APPENDIX 6

PROPOSED GUIDE FOR INTERVIEW QUESTIONS FOR SUPERVISOR

1.  Would you nominate some caseworkers for my study that you consider "competent?" Why do you see them as "competent?"  Do you see them competent in different ways?

Then ask the following questions concerning individually nominated caseworkers:

Name of nominated caseworker:  _____

1.  Describe the qualities or characteristics this caseworker possesses that make you think of him or her as being "competent."

2.  Describe the professional learning processes that this caseworker has undergone in order to develop and/or maintain his or her competence.

3.  Describe the professional learning activities that this caseworker has undergone in order to develop and/or maintain his or her competence.

4.  How does this caseworker go about obtaining needed information in order to perform his or her job?

5.  How did this caseworker learn or acquire the needed skills for his or her job in order to perform his or her job?

6.  What types of resources does this caseworker use in order to perform his or her job?

7.  What have you seen this caseworker do in order to stay competent?

APPENDIX 7

PROPOSED GUIDE FOR INTERVIEW QUESTIONS FOR CO-WORKER

_____ was nominated for participation in this study.  You work with this person as a team member.


1.  Describe the professional learning processes that your co-worker has undergone in order to develop and/or maintain his or her competence.

2.  Describe the professional learning activities that your co-worker has undergone in order to develop and/or maintain his or her competence.

3.  How does your co-worker go about obtaining needed information in order to perform his or her job?

4.  How did your co-worker learn or acquire the needed skills for his or her job in order to perform his or her job?

5.  What types of resources does you co-worker use in order to perform his or her job?

6.  What have you seen you co-worker do in order to stay competent?

APPENDIX 8

CONSLUSIONS FROM INTERVIEWS WITH INDIVIDUAL CASEWORKERS

a. CONCLUSIONS BASED UPON INTERVIEW WITH "ALEXIS"

These conclusions have been broken down into five components concerning learning activities and/or processes:

1. On the job learning--includes trial and error situations as the caseworker engages in work-related activities and searches and locates resources and information and also includes learning from dialoging with clients concerning needs and problems. Clients' problems drive the learning processes and/or activities that caseworkers must use in order to locate information to solve clients' problems. The Internet is an important starting point for locating and searching for information; however, the very act of accessing information can be overwhelming because there is so much information available. A caseworker knows when a problem is solved when all questions have been answered and there are no more questions asked to locate information in order to provide answers. Working with the population that has a mental illness is a learning process in itself as the caseworker is taught on the job how to work with these clients. Learning about community resources is integral to the learning process. One resource will serve as a network or bridge to locating and using additional resources. Community resource staff personnel also serve the same purposes.

2. The use of role models: people that you have known from your past can serve as a source for role modeling as well as supervisors, directors, community staff personnel, etc. Role models assist in learning through the provision of people to use for assistance in

locating and/or applying information.  Role models can serve as a resource for caseworkers to learn [metacognition skills] how they learn and work.

3. What is important to bring personally to the learning processes:  personal experiences and prior knowledge.  These areas include life experiences acquired through growing up, past employment, and interacting with environmental situations and activities.   Personal and prior experiences can serve as reference points to help guide future learning processes and activities.

4.  Group/team learning.  Through mentorship by an experienced caseworker, the novice caseworker learns the job by being shown actual work-related activities.  The experienced caseworker shows the novice caseworker how to do the job via modeling the job in authentic activities.  Even for an experienced caseworker, learning from team members is important because one person does not know everything but, collectively, the team members do as they can serve as resources for what is not known.

5.  Training and/or formal educational engagement.  You cannot learn how to be a caseworker from reading a "how-to-do book."  Models based upon theory do exist that can guide a caseworker's knowledge about how to do the job but only parts of different models work; no one model exists that can meet every learning need for caseworkers. And formal training is not very beneficial to caseworkers because most of the content of such is aimed toward improving knowledge and information about therapy work. Caseworkers need knowledge and information that can be transferred to authentic work contexts.  One such source of information concerns medications and diagnosis; such information is important and beneficial to improving caseworker's jobs.  An important resource for learning about such comes through dialogues and education provided by pharmaceutical representatives.

b. CONCLUSIONS BASED UPON THE INTERVIEW WITH BO

Bo concentrated a lot on personal qualities that a person brings to the job. Her summary statement about her learning processes: on the job and prior life experiences and the team as a resource.

1. Formal education: this job cannot be learned in college. School classes help you with your thinking processes, problem solving and decision making abilities. The core general education classes are important; for example, English Composition teaches you how to write (a skill needed for documentation) and research classes teach you how to find information (a basic skill needed to solve client problems).

2. Formal training is not very beneficial to the job. It probably is more so for the novice worker but for a worker who has been on the job for a long time, formal training such as in-services and seminars do not contain new information to help a seasoned worker learn. The most beneficial training concerns keeping current on new medications and learning leadership skills. Most of the information given in training sessions is not useful for caseworkers to do their jobs.

3. A caseworker brings her or his own personality traits to the job that will impact how he or she performs at work. However, most of the learning comes from experiences with on-the-job activities. Learning is accomplished via a trial and error method. The caseworker "jumps into" a situation every though he or she does not know what is going on and finds out how processes occur. Learning occurs via dealing with clients and their problems/issues, learning community resources, and interacting with clients and team members.

4.  Life experience is the best "educator" for this job.  As the caseworker has gone through the problems of life, he or she can use personal life experiences as reference points.  When clients have problems, the caseworker can reference a life experience in order to help a client learn coping skills with and how to deal with their problems.  Life experiences also help the caseworker develop skills that make building a therapeutic relationship with a client successful—such as patience, empathy, listening, setting limits, setting boundaries, and "don't work harder than your clients."  Life experiences can also teach the caseworker how to let clients do for themselves so that they are not enabling clients.  A caseworker learns from his or her own philosophy and personal qualities such as patience and understanding.

5.  A caseworker cannot do the job without the resources of the team.  Team members are people who do the job but who provide support, back up, and feedback about what the caseworker does.  They have experiences with similar problems and therefore, if the caseworker does not know, can point the caseworker in the right direction in order to figure out what to do to solve clients' problems and make sense out of the processes (is this called "making connections"?).  Learning occurs by asking question and being involved with resources and processes.

6.  Two main important learning processes exist:  (1) learning the baseline characteristics of clients.  The caseworker spends a lot of time with clients, getting to know them well enough to understand when their symptoms increase.  Caseworkers become "experts about clients" and (2) how to look things up (or find and locate information).  Accessing information is accomplished by many sources ("looking things up") such as using the Internet, reference books, asking questions (of team members, experts such as the

medication staff, and community resources staff personnel).

7. Two important skills exist for successful learning" (1) being able to solve problems. This is accomplished by using resources, gathering information, formulating explanations and (2) intuition or "sixth sense." Intuition develops but the caseworker cannot verbally explain how it is developed. "You just know" and this intuitive feeling, if you listen to it, can assist you with successful problem solving and decision making.

8. For the future, these learning processes would be beneficial: (1) have more "ride alongs" in which the more experienced caseworkers take the new caseworker along and explains entire processes to the new person; and (2) if new caseworkers could be hired to work along side caseworkers who are leaving the position so that the new caseworker could learn from the experienced one, and treatment services could then be transferred to the new caseworker in a continuous manner.

c. CONCLUSIONS FROM INTERVIEW WITH CJ

CJ discussed at length how important personal qualities/characteristics is for job success as well as seeking information and assessing client situations in order to resolve these situations. A summary of her conclusions includes how formal education and on-the-job experiences impact the job, how seeking information helps solve client situations, and how making connections—both internally and externally—help one to be successful with the job.

1. Formal education and daily job experiences. A formal education is required as a qualification to be a casemanager but it is really not necessary. "The textbook cannot teach you" how to deal with these clients. Caseworkers learn from the daily experiences they encounter with the job—what has happened before will act as a learning situation that will teach a person how to perform in future situations that are similar to the one that was encountered from the past. Therefore, learning experiences is what the caseworker goes through daily as he or she performs his or her job. There exist two main types of daily learning through job situations. The first type concerns general casemanagement duties. The caseworker must learn basics such as entitlements, housing resources, and medications by learning about the functions and mechanics of such processes. The second type of learning concerns how to individualize the treatment plan by breaking the plan down step-by-step so that client can attain his or her rehabilitation goals. The immediate individualization of client needs is what drives the learning processes of the day-to-day job of the caseworker.

2. Seeking information to help solve client needs. Seeking and locating information is very important to this job. The caseworker has to have the ability to

202

access, seek out, and be creative in locating resources. Examples include asking questions, talking to others who know about resources (team/co-workers, agency staff, supervisor, community resource staff personnel, etc.), searching for information through the use of technology (telephone, computers—i.e. the Internet), and obtaining ideas from training. Locating and using information helps solve problems encountered on the job with clients. The caseworker identifies that there is a problem, identifies that a problem does exist, assesses the situation and level of need, finds interventions through searching and locating information and using resources, and uses information to resolve client problems. The assessment part of problem solving is very important because without assessing correctly, the caseworker cannot locate the correct information that will assist in designing the appropriate intervention in order to solve the problem.

3. Making connections both internally and externally: Internal connections occur inside the person. The caseworker has to learn not to personalize what is said to him or her or about himself or herself. The caseworker has to learn the differences between exploring and helping a client solve problems versus enabling them. The caseworker must also learn to not always to do for the client and rescue the client from his or her problems and crisis but help them learn from mistakes made so that independence in daily life will develop.

Another personal quality includes learning to wear "many hats" as caseworkers become a support system to clients, a liaison between clients and resources, financial consultants, and independent living overseers; therefore, they have to learn to be flexible, open to changes, and adapt quickly to changing situations and times.

Being able to use memory processes is also useful when learning about and on-the-job.  If the caseworker has interventions and information in long-term memory, then he or she can retrieve it and use it in similar situations.

Other important personal qualities exist.  The caseworker must learn how to keep his or her mental health in order, manage emotions, and manage burnout.  The caseworker must learn to be open-minded so that he or she can separate what he or she thinks is the correct thing or right way for a client to live versus what will help the client the most.  The caseworker must be able to learn to have a heart to do this job:  have patience and a passion for helping people, genuinely care about someone, and have the ability to establish and maintain relationships with people.  The caseworker must learn to use these personal qualities for personal growth and maturity for doing the job in order to improve his or her compassion and desire to help a client improve his or her quality of life.  With growth and maturity, the caseworker becomes aware of how she or he acts so that clients know and understand that the caseworker truly cares.

External connections occur outside the caseworker and include connections with the supervisor, team members, agency and staff, and community resources.  The caseworker learns information and processes from talking with his or her supervisor through such processes as shadowing peers/co-workers, observing, doing home and in-office visits, accessing community resources and processes, and using a lot of hands-on experiences and situations with team, agency, and clients.  Both team members and the supervisor will support the individual caseworker, listen to the caseworker, de-escalate problems, and allow the caseworker to vent in order to solve problems.  Knowing and

having contact people who work in community agencies is another source of connections for learning as these people can provide the information and opportunities to obtain needed resources. Such processes that assist the caseworker to learn include modeling, imitating, watching, observing, and doing.

Through going though the experiences of being a caseworker, the caseworker learns to become independent in making decisions, seeks out information, needs less required oversight and supervision, and gains confidence in finding the right intervention to put into place in order to solve client problems.

d.  CONCLUSIONS FROM INTERVIEW WITH DOT

Dot provides a lot of insight into the affective domain of a caseworker, from starting "confused" as a new caseworker to feeling "better" or "competent" as a caseworker who has learned to integrate his or her personal and educational background with job-related experiences.  Communication channels, accessing and acquiring and using information, and developing personal understandings and insights are important developments in this process.

1.  Communication channels:  Communication channels include the caseworker's supervisor, the psychiatrist, the nurse, co-workers, agency staff, and community resource personnel.  These communication channels assist the caseworkers with acquiring and using the information and skills to develop and grow as a caseworker—how to take the information and decide how to use it to assist clients with treatment.  The main process used for accessing such channels is "asking questions" to locate information.  Team meetings are excellent places to exchange information:  the caseworker learns about client situations and needs, can use the team effort to problem solve and make decisions to assist clients with meeting their needs.  Team meetings also provide a source of support and feedback to caseworkers on actions they have taken but are not sure about.  Teams interact with each other to do what's needed, to support each team member, and to help out in order to get jobs done.

2.  Information:  Acquiring, accessing, and using information is vitally important to developing as a caseworker.  For example, by having accurate information about a client, the caseworker is informed about his or her clients' past and present; the information follows the client throughout the client's treatment and assists with

identifying the client's behavior patterns and symptom patterns. Information is integrated with assessment: the caseworker uses information to help solve and/or satisfy client needs. Without information, the caseworker could not successfully do his or her job. A "big chunk" of information content is concentrated on learning about resources and a major responsibility of casework is linking clients with resources so that they can keep up with the things they need to. A major roadblock to acquiring needed information occurs when personnel in community agencies do not help in an effective way; teamwork between community resources is very important.

3. Personal understandings and insights: Developing personal understandings and insights related to job processes and outcomes is important for a caseworker to not feel confused about his or her job. Personal understandings develop through personal and educational knowledge that the caseworker brings to the job.

When a caseworker acquires new clients, these clients have already been connected with resources; this serves as a starting point for a caseworker to begin learning the process of treating clients. As the caseworker does his or her job, he or she gains experience with the job. Then previous experiences can assist the caseworker with knowing how to handle situations that occur that have similarities from past-occurring events. It is helpful to have someone to go to who is already been through the process and who can pass this knowledge and information on to others so that these others can learn to perform the job. This is an important role for the caseworker's team members.

Education is also an important part in the caseworker's development because it gives the caseworker a theoretical background that can be used to assist clients with understanding the reasons why things are happening to them. For instance, Abnormal Psychology helps the caseworker understand the differences between diagnoses and

symptoms; however, a caseworker must have the combined background of education and experience in order to understand that the clients are individuals and do not re-act to situations like text-book examples:  clients are unique individuals.

Personal insights develop also through experiences with the day-to-day practice of the job and contribute to a caseworker overcoming his or her confusion about how to perform with the job.  The following insights are important to be able to do the job effectively and efficiently.  A competent caseworker learns to do what is needed to be done, do this correctly, and make as few mistakes as possible and in the most efficient manner.  A competent caseworker also learns that when he or she has done all that he or she can for a client, documented such, and has kept his or her supervisor informed of all progress, then he or she must step back and not take ownership of clients' problems—that clients must be provided the information for making decisions and then make the decisions themselves that will impact their lives.  Caseworkers must learn not to become enmeshed in clients' problems but maintain professional boundaries.  Caseworkers must learn that clients have made decisions in their past that have put them in the situations that they are in now; therefore it is not the caseworker's fault or responsibility.  The caseworker's responsibility in to provide the education and information and then let clients' make and/or resolve their own problems and live with the associated consequences.  A competent caseworker self-examines his or her job and learns to realize when he or she needs to pull back involvement with a situation, that burnout comes when he or she continuously thinks that he or she could have and should have done more.

A competent caseworker understands the importance of helping clients develop a sense of autonomy, decision making skills, and interests they need to follow.  The

208

caseworker's job is to provide support, not to tell clients' what to do. On the flip side of helping a client, a caseworker must constantly use his or her intuition to be attuned to situations so that clients cannot hurt caseworkers physically, emotionally, or mentally.

For Dot, her major learning activities have included attending seminars, watching and observing other people at work, talking with others at work, learning better techniques, asking questions, keeping up with self-learning (by reading and acquiring information), and maintaining her mental health. Her main goals for learning include developing more effective interactions and interventions with clients, maintaining the viewpoint that clients are individuals, efficiently doing her "basic to do list" that initiates clients' treatment, using new solutions to solve clients situations that are similar to ones solved in the past, and building effective relationships with clients. For her, a caseworker can keep learning by attending seminars, talking to others about what is going on, talking to co-workers/agency staff/community resource personnel, and developing different techniques that make the job more efficient.

e.  CONCLUSIONS FROM INTERVIEW WITH FRANCIS

Francis provided a lot of insight about the work context of the caseworker, roadblocks caseworkers encounter when learning, and skills they need to learn when interacting with clients and the job.  The caseworker brings to the present job some knowledge from formal education and knowledge gained through experiences from their jobs.  The job context always provides "training" as the caseworker constantly works with new clients and is always encountering the unexpected while working.  The caseworker always has to be on top of things, be prepared for the unexpected, and assess and make judgments about how to deal with the unknown.  Especially when dealing with crisis encountered on the job (primarily through clients), the caseworker has to look for clues that informs him or her that a crisis is happening; if crisis pertain to clients, then the caseworkers has to look for those clues that point to decompensation and be supportive throughout the crisis process. After the crisis has been resolved, then the caseworker has to assess situations in order to attempt to re-engage the clients back into treatment interventions in order to regain and maintain baseline behaviors and symptoms.  This is the major responsibilities of the work context of caseworkers.

Francis also discussed other learning needs, activities, and processes of caseworkers.  Some things that were discussed at length concerned time management issues and roadblocks to learning and performing on the job that the caseworker encounters that interacts with learning.

1.  Most learning is accomplished through experience of the job, or, as "gaining knowledge through the job."  When a caseworker starts the job, then he or she just jumps

in and starts performing. As the caseworker works with clients, he or she then sorts out what is needed and starts to learn the processes to satisfy the needs.

2. The caseworker has personal qualities to learn to develop. He or she must learn to be persistent, negotiable, and be genuine. Intuition develops as the job becomes implicit and/or tacit.

3. The caseworker must also learn to be supportive of clients. Skills include the following. The caseworker must learn to provide encouragement and be honest with clients. The caseworker should review his or her needs with his or her supervisor in order to acquire information and advice as to what he or she can further do (if anything). The caseworker must learn to dialogue with the client about what they do, consequences of their actions and behaviors in order to see future repercussions, and how to use coping skills when feeling stressed and anxious. The caseworker must learn to encourage and motivate clients so that clients will stay on their medications and reach their goals. The caseworker must learn how to educate clients about their mental illnesses and what works in terms of reaching long-term goals. The caseworker must learn to help clients with accessing and connecting with resources in order to satisfy their problems and needs.

4. The caseworker must learn time management skills. He or she must be able to balance life and job and offset burnout. Because the job of being a caseworker is stressful, the caseworker must be able to maintain schedules while performing in and with the job: see clients as scheduled to meet both client and caseworker needs and availability, manage multiple crises, maintain productivity levels, and be timely in documentation. Documentation also has to be "truthful" because documentation provides information about what has and is happening with clients and this information is accessed

and used by multiple clinicians, including the doctor, therapist, nurse, and casework team.

    5. Skills, processes, and activities that help in the learning processes include: acquiring knowledge through daily job situations, paying attention in team meetings, listening to co-workers, having conversations with co-workers, talking with supervisors, acquiring information, talking to clients, asking questions, interacting with clients, problem solving, learning from perspectives of co-workers, dialoging with staff members, and getting to thoroughly know and understand clients.

    6. The caseworker also has to learn to offset roadblocks such as social stigma, limited resources, HIPPA, and overcrowded office space. Because of social stigmas, clients may be seen only as a bundle of symptoms and behaviors, then be viewed negatively and believe what the stigmas say about them. The will learn "learned helplessness" and isolate and not feel a part of anything. Clients will not be viewed as individual people. Also, community resources may have limited financial and basic needs resources, so caseworkers have to make due with less. HIPPA also has complicated the process of acquiring information. Crowded office space makes it difficult to concentrate or hold private conversations with clients when you see them in the office or make confidential phone calls. Too many people are around. For Francis, she concludes experience, knowing your clients, and being able to combine lots of resources and actions are important parts of a caseworker's job.

## f.  CONCLUSIONS FROM INTERVIEW WITH GALE

Gale offered important themes about the differences between learning as a new caseworker and as an experienced caseworker.  She discussed learning in the areas of social learning, personal learning, and self-directed learning.

In social learning, caseworkers learn from other people.  Important to the learning processes are the tools to use which consist of the caseworkers' co-workers, peers, supervisors, agency staff, clients, clients' families and support systems, experts within the field and within specialized areas (subject matter experts), psychiatrists/medical staff, and community resource personnel.  Team meetings, in-house trainings, continuing and formal education are other tools that can be used within social learning processes that caseworkers use.

Learning from peers/co-workers and supervisors is important to the advancement of a caseworker's competence.  Caseworkers use each others' expertise and knowledge in order to learn by asking questions of team members, conversing with each other about how to solve problems, and accessing each other for information and knowledge of resource processes.  Such processes are also used with supervisors but, in addition, effective supervisors encourage and support caseworkers in their learning processes so they can advance in their skills and strengths.  Caseworkers also learn how effective their learning has developed when they receive feedback about treatment and use of processes from peers/co-workers and from supervisors.

Caseworkers also learn from clients and clients' families and support systems.  Clients have experiences with the processes that are used in order to solve their needs;

therefore clients are a source of information caseworkers can tap into in order to learn about the processes and how to assist clients with resolving their problems. Likewise, healthy support systems and family members know the clients and can assist the caseworkers with learning about clients and their problems.

When working with specialized subject matter experts such as those trained in OCD and anxiety disorders, caseworkers learn skills that advance them in their treatment interventions with clients. The subject matter expert models the skills and guides the caseworkers in building use with these new skills. The experts and the caseworkers also discuss the processes. Then, with practice of the new skills through implementation with treatment interventions that consist of real life environmental situations with clients, the caseworker is able to integrate these new skills with their professional development. The same holds true when networking with community resources and staff associated with these resources; the caseworker learns about needed information and services as a result of networking.

Team meetings provide a source for caseworker learning also. In team meetings, co-workers dialogue with each other about clients' problems and needs and how to problem solve in order to handle these problems and needs. In addition, other staff members who are involved with the clients' treatment can access the caseworkers and discuss where the clients' are in their treatment and how they are doing; this serves as further learning processes for the caseworkers. Throughout all these opportunities for learning, caseworkers learn best when they ask open-ended questions. Caseworkers also learn best when positive team morale is developed and at its optimum.

Other meetings that are important learning tools include team retreats. Retreats provide opportunities to learn about different topics, to discuss information concerning these special topics, and to understand how to use these new skills in treatment with clients.

In social learning, caseworkers gain perspectives that are needed for the different problems they encounter and also learn about different casemanagement styles. Caseworkers can decide then what will work for them, what will not work for them, what they can use in their jobs, and what they do not want to use while engaged with and in their jobs. Mutual respect for individual casemanagement styles is important. This regular contact with other co-workers and people involved in the lives and treatment of the clients assist with keeping the job for the caseworkers running smoothly as caseworkers learn from each other and from others.

Learning that involves personal characteristics, talents, and interests of the caseworkers is also important. Such learning processes concern the development of a caseworker's personality, philosophy, and style. Effective caseworkers must have a "heart" and really want to help people. Effective caseworkers must be flexible and make time on the spur-of-the-moment if clients need to talk. Effective caseworkers learn to allow clients to make their own decisions and guide them, and not do everything for them; such empowerment motivates and excites clients to do better in their recovery, especially if the caseworkers learn to work with the clients' strengths, skills, and capabilities for what the clients are able to do. Caseworkers who learn to instill hope in a client about his or her life assists clients in having better quality of life and recovery from the mental illness they experience. Effective caseworkers learn to assess client situations and associated risks, discuss with clients what their options are, and then let the clients

take their treatment into their own hands; effective caseworkers do not work harder than their clients in regards to treatment issues.

Effective caseworkers also continue to learn in order to be the best caseworker possible. If a caseworker is not open to being teachable and continuously learning, then he or she cannot expand and grow because there will always be situations that come up that a caseworker must learn from and grow with. Tools to use for life-long learning include attending trainings, learning about job-related interests, and obtaining feedback from co-workers/clients/supervisors and growing with learning provided by these assessments of how the caseworkers perform at their jobs.

Actual on-the-job experiences teach caseworkers to do the job better than any education or books can do. At the start of engagement with the profession, caseworkers will often feel overwhelmed and feel a need to fix every client problem and need. They will stay with interventions that have worked. With experience, the caseworker will learn to step back and let clients make their own decision. They will also try new types of interventions, take more risks with new situations and opportunities, and even learn to specialize in new techniques and skills. Competence means that the caseworkers know and understand their clients, observe symptoms, and recognize when something is going wrong. Competent caseworkers are able to build an effective relationship with clients so that the clients open up to the caseworkers and trust them. With time and experience, caseworkers will learn to feel more confident about doing their jobs.

# g. CONCLUSIONS FROM INTERVIEW WITH HUIE

Huie provided an excellent discussion about the learning processes that caseworkers experience as they develop through the novice state to an experienced state. He emphasized that the effective use of relationships, communication, and intuitive use of skills is very important to use as an experienced caseworker, but such use is developed through time with experience.

At the beginning of their careers, caseworkers come to the mental health field with a variety of educational degrees. The college preparatory classes do not specifically prepare caseworkers to perform on their jobs. However, the experience of attending college provides opportunities for caseworkers to develop skills in rational thinking and making good decisions. Individual classes can also assist caseworkers in preparing important skills to use for their jobs; specifically mentioned was a class in interpersonal communication because effective communication is a vital job-related skill. Caseworkers have to learn to communicate with a variety of sources such as clients, co-workers, agency staff, and community personnel.

Learning the job of a caseworker is accomplished via experiential learning. Previous life and job experiences are important to beginning caseworkers to use as frames of references in order to start learning their job processes: at the start of their careers, caseworkers rely upon the skills that they have either gained from life experiences or from skills learned from jobs that they have done before coming to this job. Then, caseworkers learn on the job. At the start of the learning processes, caseworkers usually say the right things, do the right things, and use what has worked in

the past.  Then, as they gain experience, they build upon what they have done in the past and form a bank of experiences and skills from which they can use to do their jobs.  Such use becomes "intuitive," in the sense that the caseworkers automatically use their skills but cannot explain exactly why and how.

Four main learning processes exist.  Through formal learning and in-services, caseworkers learn about diagnosis, symptoms, and models.  Caseworkers also learn on-the-job from interactions with various co-workers and clients; such learning processes include conversations, modeling, observing, interactions, searching for information, and accessing community resources.  Caseworkers can learn from staff members who have been around for a while and have experienced similar situations and experiences.  Through formal and informal conversations, caseworkers learn about alternative points of view and different skills and activities that allow the caseworker to successfully do their jobs.  Caseworkers also learn about community resource processes, again, through interactions with co-workers or by contacting and networking with community staff members directly.

Caseworkers also learn from their clients.  They are continually having new clients added to their case loads.  Each client has unique needs and situations.  Caseworkers search for information and locate resources in order to resolve these unique needs and situations.  Caseworkers learn the processes connected with community resources because caseworkers have to hook clients up with these resources; therefore, caseworkers have to learn to find resources that are located within the clients' communities and then learn how these processes work.  The job requires research because caseworker should present accurate information to their clients when they render to them treatment interventions.

Caseworkers learn about resources when they ask their co-workers and even clients about needed information. Technology is also helpful to the learning processes, especially the Internet. The Internet provides a convenient and easy way to look up resources, telephone numbers, addresses, and other information as needed to perform the job. Team meetings also help in learning processes as team members share with each other information, resources, similar situations, and different perspectives. This can be considered "networking within your own team."

Most of the learning about how to do their jobs is accomplished via trial and error methods. Caseworkers discover that they have a continuous need to learn because they daily encounter situations that they don't know anything about and therefore have to find the information and resources (key learning needs) in order to make their encounters successful. Thus, they come into contact with constant variety and change with-and-in their jobs; and the longer they do their jobs, the more familiar they become with situations, processes, and ways of doing things. Learning is constantly adapting and changing as situations demand caseworkers to do so.

With experience, caseworkers become "competent" in the sense that they learn to trust their own instincts, personalities, and abilities. They must learn to empower clients to do for themselves and take responsibility for their own lives. They must learn to not work harder than their clients because this often leads to burn-out; burn-out can be offset by maintaining a healthy balance between their lives, work, and recreational interests. Caseworkers must learn that they don't have to be the "superhero in every situation," but learn to support, guide, and assist clients—thus maintaining real-life boundaries between their jobs and clients and private lives. Competent caseworkers know their short comings

219

and downfalls about their jobs and then seek needed learning processes in order to overcome them.

Competent caseworkers also learn to develop relationships and effective communication skills.  If positive relationships are established in all areas of the casework job, then the job will move forward and the caseworkers will be more successful with their jobs; most importantly, clients will be receptive to the caseworkers and will see them for treatment; thus productivity levels will be easily accomplished. Effective communication skills are equally important as caseworkers must constantly communicate with clients, co-workers, and community resource staff members in order to acquire information and locate resources.

h. CONCLUSIONS FROM INTERVIEW WITH IRA

Ira presented some pertinent information about the development of a novice caseworker into a competent caseworker and the important learning processes involved in this development.

At the start, a new person who becomes a caseworker feels overwhelmed because he or she has to learn the terminology used on the job, the demands of paperwork associated with documentation, and about the processes of helping clients connect with resources and information they need in order to undergo and be involved with their treatment. A caseworker faces a lot of stress because he or she is constantly attempting to figure out how to put in place everything which clients need, learning to balance his or her time between all the job demands, and always encountering change associated with novel situations involved with doing the job.

For the new person involved in the learning processes, he or she has several important tools that he or she can use to learn to do the job: learning from co-workers, doing research to find useful information, reviewing client charts, looking things up on the Internet, and having a sense of awareness of what is needed to be done or what is being dealt with.

Learning from other people is the most important tool. If the caseworker is having a client to whom the caseworker is struggling to render successful treatment, then he or she can bring up these issues either with individual co-workers or in team meetings. The caseworker can learn from co-workers who have been on the job for awhile and who have encountered similar situations to the ones that the new caseworkers does not understand or who are knowledgeable about the processes that are used to connect clients

with useful treatment resources. The established caseworkers are able to tell the new worker where to locate the information and resources that are the most helpful, what works, and what does not work. The experienced co-workers guide and support the new person in learning how to do the job.

Team meetings are also helpful. Experienced team members who have faced similar situations can also help the caseworker learn because they have encountered similar situations, but the shared knowledge of the team can be put to use in order to share with the new person approaches that are effective, what has worked or not worked in these similar situations. It is often helpful for team members to use each other and every member's strengths and to share information with each other so learning occurs within teams. People on teams may have information that the new learner needs and/or can get for the new learner that information more quickly than if the new caseworker looks up the information by himself or herself. The new caseworker, likewise, can use the same approach with discussing and dialoguing with experts such as therapists and personnel associated with important community resources because these people can get what is needed for clients and their treatment. Clients likewise are an important source for learning because they have experiences with accessing resources and information.

During these learning processes, with time and experience, a new caseworker develops. He or she learns to expect change to occur as it is always inevitable. Therefore, the new person learns to go with the flow of things, to be adaptable, and to be flexible.

A new caseworker also learns from past job experiences and skills; these past experiences and skills transfer to new job situations. For example, if a caseworker has learned to apply the casemanagement model in a past job, then the essence of the model

(the experiences and skills) transfer to working with clients on the new job. The caseworker serves at first as a mediator with different community resources and clients and he or she helps clients put into place the services that the clients need. Then the caseworker learns to back off with his or her services, letting the clients take the responsibility for taking care of their own needs. However, the caseworker remains in touch with the clients through being supportive and encouraging.

Caseworkers learn this process via trial-and-error methods. If something does not work, then these types of situations serve as feedback for the caseworkers to learn what works and what does not work for them as they learn from their mistakes through these hands-on experiences. The longer caseworkers perform on their jobs, the more they begin to feel comfortable with performing their jobs as they learn to apply new skills and techniques.

There are several important learning outcomes that competent caseworkers learn to do. Competent caseworkers learn to support and educate clients about how to break their stressors down into manageable units and focus on small areas on which to work. The caseworkers' roles become that of supporters and encouragers. Competent caseworkers help clients learn the skills that clients need in order live independently and/or how to survive in life.

Competent caseworkers develop a philosophy and a casemanagement style that works for them. They learn to give clients the responsibility to take charge of their own treatment by not controlling clients and doing everything for clients. In addition, competent caseworkers learn to be proactive in putting resources in place that will offset crisis and emergencies and symptom decompensation. Caseworkers are able to get clients to buy into treatment by focusing on where they would like to be in the future.

Competent caseworkers are positive workers, maintain good morale, learn to multi task, balance work life between paperwork and time needed to spend with clients, and learn to balance their own work lives separated from their personal lives. Competent caseworkers learn to use skills to seek out information and resources. And competent caseworkers continuously learn; for example, through a professional development plan put into place between a caseworker and a supervisor, areas in which the caseworker needs to grow and developed can be supported and encouraged. The caseworker can attend training or classes or undertake other learning opportunities that pertain to these areas of growth and development.

A recommendation exists that would assist caseworkers to learn in a more effective and efficient manner: a facility staff person could go around and ask each staff member what their perceived area(s) of expertise is and then make a list of people's names and their areas of expertise. This list could be posted in a common area where people could access it and thus know who they could go to in order to ask questions related to whatever information for which they are searching.

### i. CONCLUSIONS FROM INTERVIEW WITH JO

Jo concludes that caseworkers learn every day with their jobs as they interact with consumers, clients and their issues, and treatment techniques and skills. She reports that everyday is a learning opportunity that can be used to pull out skills and techniques from activities with which caseworkers have been involved and used them with similar future activities and clients. She broke the learning opportunities down into four main categories: learning from co-workers, learning from one's supervisor, learning from experiences, and learning from education.

1. Learning from co-workers: Caseworkers encounter situations which they do not know what to do about and need advice in order to be able to be successful with taking care of the situations. They therefore ask questions and seek advice from their co-workers who guide and support the caseworkers throughout the learning process. Learning from caseworkers happens also at team meetings where caseworkers interact with each other when they review situations and brainstorm ways in which to resolve situations. At such meetings, they resolve problems as a team by working together in order to do so. Team members also provide feedback about what has worked or what will work. Also at meetings, the caseworkers learn from in-services where they are taught new skills and techniques. Also, professionals such as doctors, nurses, and community staff personnel come to meetings and present information which the caseworkers can use in order to learn the information for use with their jobs.

2. Learning from supervisors. Again, caseworkers encounter situations that may contain crisis and/or situations that the caseworkers cannot successfully handle. Therefore, they will go to their supervisors and seek assistance, advice, guidance,

225

feedback, and support.  They call the supervisor and ask questions.  They learn from their supervisors when their supervisors supply them with information, give advice on what to do, and offer to help.  Through feedback, caseworkers learn what works and what does not work.

3.  Learning from experiences:  Prior and on-the-job experiences is the most valuable contributions to caseworkers' learning.  Caseworkers learn as they go.  They learn what is effective, what is not effective, what works for certain individuals, and what does not work with these individuals.  Caseworkers learn to rely upon past experiences to help them resolve current situations and problems because they match what is going on with memories they have stored in their brains of situations that are similar to the ones they are encountering in the present.  Through continuous engaging in their job activities, caseworkers have opportunities to learn all the time.  From undergoing past experiences, caseworkers may experience situations that remind them of the past which will act as triggers and provide meanings to current situations because "they know" or "because they understand."

4.  Learning from education:  Caseworkers usually need to have a college degree as a requirement for being qualified to do their job.  Some classes are important for developing skills; in particular, an ethics class because ethics teaches you what you can and cannot do as a professional worker.  However, combined with experience, learning becomes a lot easier.  Caseworkers have a theoretical background from school that informs the caseworker about their professions.  With experience, caseworkers understand and know how to interact with clients and situations.  They learn how to

handle interactions with clients.  They understand diagnosis and symptoms.  They understand what actually is going on behind the theoretical background.

At the start of their jobs, caseworkers are excited to learn their jobs but do not know what they are getting into about their work.  They feel lost and do not understand what to do.  They have to learn to find their way to do their jobs.  They learn from their co-workers, their supervisors, experiences, and formal educational opportunities. Problem solving is a major part of the learning processes.

As a competent worker, caseworkers need to learn to partner with clients in decision making processes as clients decide where they want to be in the future, set goals to reach that point, and then work towards those goals.  In return, caseworkers learn to support and assist clients in their process while establishing and setting appropriate boundaries for interactions with clients on a professional basis.

On a personal basis, competent caseworkers are positive workers and are always willing to learn.  They are able to accept positive criticism and use this feedback to grow and mature.  They learn to have empathy and understanding that clients can recover; therefore, they learn to focus on what clients' want to do in their recovery processes. Caseworkers are future oriented with clients as they assist clients in establishing incremental steps and goals so that clients can achieve where they want to be in the future.

Competent caseworkers learn that clients are people who did not ask to be sick; so they are a support in helping clients attempt to achieve success in their recovery. Through trial and error methods, caseworkers form supportive relationships with clients

and learn to look beyond their client's illness and the stigmas that society places on clients.

Competent caseworkers learn to use their intuition. They sense when clients are not telling them the complete truth. Caseworkers also learn to sense safe and unsafe situations.

Competent caseworkers learn to offset burnout when they are able to separate their personal life from their work life. They learn to be supportive with client during working hours but leave the support at work when it is time for their personal life.

Competent caseworkers also learn to manage their time effectively. They learn to schedule time with clients out in the community that meet productivity levels. They learn to finish their documentation in a timely manner yet do their documentation with quality content with is factual. They document what they have observed as techniques that can be used later as references to what happened during treatment.

Competent caseworkers also learn about their own sense of self-awareness. They learn that clients "are not their mental illness" and therefore assist and support clients in the development of their personal potentials. They teach clients to be independent and learn to take control of their own lives. They learn to realize that they cannot mesh with everyone but that does not mean that they are failures if they have a client that they cannot work with. Competent caseworkers also have to learn to use their own style and techniques: what works with clients, what does not work, and how to change techniques and styles as situations warrant that they do so. The bottom line is: caseworkers must continuously learn, get together with people they work with and learn from each other, ask a lot of questions, and individualize cases.

## j.  CONCLUSIONS BASED ON INTERVIEW WITH LENNIE

Lennie offered some new perspectives on the roles and significance of caseworkers and their interactions with clients.  He discussed how one's first job impacts other jobs; building the therapeutic relationship with clients assists with client recovery; and working where there is a perfect fit between the mission and vision of the worker and the agency.

Lennie discussed how his first job was working in the inner city.  He was born in the suburbs and in an affluent neighborhood.  He had to learn about working with people who did not have a home, who lived in poverty, and who did not have access to many resources that included transportation, money, or agencies.  These experiences helped him in jobs that he had after working with the agency in the inner city.  Lennie spoke of several learning experiences that are important to caseworkers.

1.  A caseworker must learn to adapt.  He or she must learn to understand what people are really saying, learning the difference between the ideas that clients are telling you what they think you want to hear but not really what is going on in their lives.  The caseworker must learn "to read people."

2.  Casework will teach the caseworkers about lifestyles to which they may not know anything about.  For example, if they grow up in an affluent neighborhood, they will have to learn about poverty and related issues.  Related issues include a lack of transportation options, a lack of assessable and affordable healthcare, and a lack of community resources such as housing, financial assistance, and basic needs.  Such learning can make a caseworker appreciate the resources that are

available in more affluent communities if this is the type of environment in which they are working.

3. Working in environments that are connected with poverty and limitations, caseworkers still learn that the symptoms of people with mental illness are still the same no matter the type of place and environment that they are working in.

4. When working in the inner cities, the caseworkers have to learn to be "creative" about finding resources by finding things on their own that they did not know existed—in order to find what they need to get their clients taken care of. In more affluent environments, caseworkers have more options of learning about resources such as asking team members and acquiring information from them ("I found this") or by asking people who work within social services agencies. Other options for locating resources and acquiring related information include searching on the Internet and finding resources because of "luck."

5. Caseworkers learn models that help them in the delivery of services: Strengths Perspective Model, Recovery Model, and Wellness Model.

6. Caseworkers, if their life mission/vision is a good match with the mission/vision of the agency for which they work, they then learn to be better workers because they will feel "in sync" with the agency and how things are suppose to work. Missions vary between "managing" people's illness and helping people "recover" and move forward with their lives despite people telling them they cannot do so. The job for caseworkers, in the long run, is to help their clients recover so that they will not be dependent upon services forever. Sometimes, caseworkers are the first people that have ever told them that they could do so.

7. Problem solving skills are very important to the job: (a) from the first meeting, ask questions about the client in order to get to know the person so well that when a caseworker sees a client, the caseworker intuitively knows that something is not going good with the client. (b) Use a lot of reflective listening so clients will talk about their issues. (c) Understand the clients so that the caseworker can give them viable options and validate their feelings.

8. The therapeutic relationship must be good in order for clients to engage in treatment. A beneficial relationship means that clients know that their caseworker is always there for them, know that the caseworker is not going to hurt or steal from them, and know that what the caseworker says is honest and truthful. For the majority of clients, the caseworkers is the only person who comes to see the clients, are interested in what they say, accepts them for who they are, and does not judge them. "They [caseworkers] have an important role to play."

9. Working as a caseworker is really only an activity and the caseworker goes out in the community daily; he or she does not stay in the office. The caseworker goes "to work where clients live" and learn to do their job.

10. Therefore, caseworkers learn from their clients. They learn that clients have similar needs but that the caseworker has to learn the style that each client uses in

11. order to get their needs met, such as being manipulative, being assertive, being dependent. Caseworkers look for information in order to meet these needs and teach clients how to use natural supports in order to meet their needs.

12. Caseworkers have to have "people skills" in order to connect with clients. Such skills can also be termed "skills of compassion." Caseworkers cannot learn such skills in formal educational settings.

13. Caseworkers do their jobs.  Jobs become more personal if a caseworker has a

special interest he or she would like to develop within the job, is able to specialize

in this niche, and use this specialization within his or her job activities.

Lennie concluded by describing how he grew up where he is currently works.  His

first job was in an environment totally different from where he grew up and he knew

from childhood that he did not want to move away.  He wanted to always work in the

community in which he was raised.  He felt it was an "honor" to work in his home

community and serve people whom he thought of as his "neighbors."  He reported

that "this gives you a sense of impacting your community."  And that sense

transcended into having the compassion and pride that he has in doing his job, and

this is a good learning tool to use in order to be the best worker a caseworker can

be—to have that sense of pride in his or her job.

k.  CONCLUSIONS FROM INTERVIEW WITH PAT

Pat's conclusions provide important insights into the developmental process of a novice caseworker becoming a competent caseworker.  Specifically, he mentions the processes and activities that are important for this development.

Activities include learning through one-on-one supervision with the supervisor. The caseworker asks questions, and the supervisor provides the information to answer the questions, and guides and supports the caseworker throughout the development.  The same types of activities apply to learning from one's co-workers.  The learner asks questions of team members who provide support and guidance when helping the learner learn to access information and locate needed resources.  Other tools that a caseworker as a learner can use include attending trainings (which provide additional learning of skills that can be used to do the job to the best of one's ability), and using the medical staff and therapists as resources to learn about information and techniques for treatment interventions.

At the start of the job as a novice worker, the caseworker does not have a clue about performing on the job and feels "lost" and is dependent, in particular, upon the supervisor and co-workers.  At the beginning, it is vitally important to have one-on-one weekly supervisions with the supervisor because the caseworker does not know what she or he is doing.  The supervisor can tell the caseworker how to do the skills such as documentation and the techniques to use as well as modeling, guiding, and supporting the caseworker through the developmental process.  The caseworker also learns from his or her co-workers because team members can help him or her learn about how to locate needed information and resources and related processes connected with hooking clients

up with such information and resources.  Supervisors and co-workers are people that the caseworker can vent to and also receive feedback about how he or she is doing as far as job performance; without this feedback, how would she or he know if she or he is developing into a "good caseworker?"  When the caseworker becomes more experienced and understands what he or she is doing, he or she does not have such a vital need to have as much contact and reinforcement from supervisors or co-workers.

Formal education can also help in this developmental process, especially if the caseworker is working at the master's level and is specifically taking classes related to mental health.  Such classes teach the skills and techniques that work with client interactions.  Examples of skills and techniques include motivational interviewing and harm reduction models.  Likewise, on-the-job trainings provide opportunities to learn new skills.

A caseworker faces constant change daily with his or her job.  Because the caseworker deals with people, each job activity is unique and different. The caseworker deals daily with these situations and, through hands-on involvement with clients and novel situations, learns to deal with "not knowing" what the job will be like from day to day.  In fact, the caseworker builds up examples in his or her mind of situations and is able to use these memories of situations and apply them to situations that arise in the future that are similar to the ones stored in memory.  The caseworker learns to read clues and with intuition knows what to look for and how to react to certain situations.  The caseworker also learns what different techniques and skills work with different people.

When a caseworker becomes competent, he or she has learned to support clients through their recovery process and instill hope in them.  The caseworker also learns to work with community resources.  He or she is able to listen to his or her "gut feeling" and

234

"feel" when something is wrong.  The caseworker learns to deal with change in a positive

way.  These are skills that are learned daily through on-the-job activities and become

used with intuitive response.

BIBLIOGRAPHY

Addison-Wesley.  (1996).  Reflective conversation with materials:  An interview with
    Donald Schon by John Bennet.  *Bringing design to software* (chap. 9).
    Retrieved June 22, 2005, from http://hci.stanford.edu/bds/9-schon.html.

Advisson, B., Lofgren, H., & Fridlund, B.  (2000).  Psychiatric nurses' conceptions of
    how group supervision in nursing care influences their professional competence.
    *Journal of Nursing Management, 8(3)*, 175-186.

Alliance for Community Health Plans.  (n.d.).  *What is health care quality?*  Retrieved
    June 22, 2005, from http://www.achp.org/upload/health%20care%20quality.pdf.

American Board of Internal Medicine.  (2004).  *Attending physicians:  Your role in
    evaluating internal medicine residents*.  Retrieved May 14, 2005, from
    http://www.abim.org/resources/publications/Attendig.pdf.

American Medical Student Association.  (2005).  *The primary care team*.  Retrieved
    December 8, 2005, from http://www.amsa@smsa.org/programs/gpit/pcteam.cfm.

Anthony, W. A.  (1992).  Psychiatric rehabilitation:  Key issues and future policy.  *Health
    Affairs, 11*(3), 164-171.

Anthony, W. A., & Liberman, R. P.  (1986).  The practice of psychiatric rehabilitation:
    Historical, conceptual, and research base.  *Psychosocial Rehabilitation
    Journal, 12*(4), 542-559.

Association of American Medical Colleges.  (2003).  *Patient safety and graduate
    medical care.  A report and annotated bibliography by the Joint Committee
    of the Group of Resident Affairs and Organization of Resident
    Representatives*.  Retrieved June 22, 2005, from
    http://www.musc.edu/qu/patsafety/staffinformation/patientsafetygme.pdf.

Aubry, T. D., Flynn, R. J., Gerber, G. G., & Dostaler, T.  (2005).  Identifying the core
    competencies of community support providers working with people with
    psychiatric disabilities.  *Psychiatric Rehabilitation Journal, 28*(4), 346-353.

Berry, R. S. Y.  (1999, September 2).  *Collecting data by in-depth interviewing*.  Paper
    presented at the British Educational Research Association Annual Conference,
    University of Sussex at Brighton.  Retrieved June 22, 2005, from
    http://ww.leeds.ac.uk.educol/documents/00001172.htm.

Billet, S. R. (1994).  Searching for authenticity—A sociocultural perspective of
    vocational skills development.  *Vocational Aspects of Education, 46*(1),
    3-16.

Bolman, L. G. & Deal, T. E. (1997). *Reframing organizations.* San Franciscl: Jossey-Bass Publishers.

Boeree, C. G. (2003). Qualitative methods: Part four. *Qualtitative Workbook.* Shippensburg University. Retrieved February 15, 2005, from http://www.ship.edu/~cgboeree/qualmethfour.html.

Bowers, B. (1993a). *Qualitative research in nursing: Varieties and types of qualitative methodologies, paper 2.* University of Wisconsin-Madison.

Bowers, B. (1993b). *Qualitative research in nursing: Reflections on the state of the art, paper 3.* University of Wisconsin-Madison.

Boyd, M. A. (1994). Integration of psychosocial rehabilitation into psychiatric nursing practice. *Issues in Mental Health Nursing, 15*(1), 13-26.

Brekke, J. S., Long, J. D., Nesbitt, N., & Sobel, E. (1997). The impact of service characteristics on functional outcomes from community support programs for persons with schizophrenia: A growth curve analysis. *Journal of Consulting and Clinical Psychology, 65*(3), 464-475.

Brink, U. (1994). Psychiatric care and social support from people with long-term mental illness in Sweden. *International Journal of Social Psychiatry, 40*(4), 258-268.

Brown, J. S., & Duguid, P. (2002). *The social life of information.* Boston, MA: Harvard Business School Press.

Burke, C. S., Salas, E., Wilson-Donnelly, K., & Priest, J. (2004). How to turn a team of experts into an expert medical team: Guidelines from the aviation and military communities. Retrieved December 20, 2005, from http://qhc.bnjjournals.com/cqui/content/full/13/supp_1/96.

Callahan, C. A., Erdmann, J. B., Hojat, M., Veloski, J. J., Rattner, S., Nasca, T. J., et al. (2000). Validity of faculty ratings of students' clinical competence in core clerkships in relation to scores on licensing examinations and supervisors' ratings in residency. *Academic Medicine, 75(10)*, 871-873.

Cavanaugh, S. H. (1993). Connecting education and practice. In L. Curry, J. F. Wergin, & Associates (Eds.), *Educating professionals: Responding to new expectations for competence and accountability* (pp. 107-125). San Francisco: Jossey-Bass Publishers.

Cervero, R. M. (2000). Trends and issues in continuing professional education. In V. W. Mott & B. J. Daley (Eds.), *Charting a course for continuing professional education: Reframing professional practice* (pp.3-12). *New Directions for Adult and Continuing Education, No. 86.* San Francisco: Jossey-Bass.

Clasen, C., Meyer, C., Brun, C., Mase, W., & Cauley, K. (2003). Development of the competency assessment tool—mental health, an instrument to assess core

competencies for mental health workers. *Psychiatric Rehabilitation Journal, 27*(1), 10-17.

Cnaan, R. A., Blankertz, L., Messinger, K., & Gardner, J. R. (1989). Psychosocial rehabilitation: Towards a theoretical base. *Psychosocial Rehabilitation Journal, 13*(1), 33-55.

Cohen, N., Gantt, A. B., & Sainz, A. (1997). Influences on fit between psychiatric patients' psychosocial needs and their hospital discharge plan. *Psychiatric Services, 48*(4), 518-522.

Cole, M. (2003). Cultural psychology: Some general principles and a concrete example. In Y. Engestrom, R. Miettinen, & R. L. Punamaki (Eds.), *Perspectives on activity theory* (pp. 87-106). Cambridge: University Press.

Cook, J. A., Graham, K. K., & Razzano, L. (1993). Psychosocial rehabilitation of deaf persons with severe mental illness: A multivariate model of residential outcomes. *Rehabilitation Psychology, 38*(4), 261-274.

Coursey, R. D., Curtis, L., Marsh, D. T., Campbell, J., Harding, C., Spaniol, L., et al. (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), 378-393.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks: SAGE Publications.

Cunningham, L. (1983). *The workplace: A learning environment*. Paper presented at the First Annual Conference of the Australian Vocational Education and Training Research Association. Sydney: Australia.

Curry, L., Wergin, J. F., and Associates. (Eds.). (1993). *Educating professionals: Responding to new expectations for competence and accountability*. San Francisco: Jossey-Bass Publishers.

Daley, B. J. (1999). Novice to expert: an exploration of how professionals learn. *Adult Quarterly, 49*(4), 133-147.

Daley, B. J. (2000). Learning in professional practice. *New Directions in Adult and Continuing Education, 86*, 33-42.

Domrose, C. (2003). All for one: Health care teams pool their individual strengths and ideas to deliver top-notch patient care in an atmosphere of mutual respect and open communication. *Nurse Week News.* Retrieved December 23, 2005 from http://www.nurseweek.com/news/features/03-12/teamwork_print.html.

Donaldson, J. F. (1997). *Researching professional practice. The integrated practice perspectives model and continuing education.* Paper presented at the Adult Education Research Conference, May 17, 1997. Stillwater, OK.

Dreyfus, H. L. (1998). *Intelligence without representation*. Retrieved June 22, 2005, from http://www.hfac.uh.edu/cogsci/dreyfus.html.

Duff, D. (2005). Understanding health care restructuring, 2001. Centennial College. Retrieved December 20, 2005 from http://dl.cencol.on.ca/aahs/cc1/unit7/print.htm.

Duffy, F. D., Gordon, G. H., Whelan, G., Cole-Kelly, & Frankel, R. (2004). Assessing competence in communication and interpersonal skills: The Kalamazoo II report. *Academic Medicine, 79(6)*, 495-507.

Dynamic Research Corporation. (2005). *Chapter 4: Medical team training*. Retrieved December 8, 2005, from http://ww.ahrq.gov/qual/medteam/meadteam4.htm.

The Educational Council of the American Academy of Physician Assistants. (1996). *Professional competence—A position paper*. Retrieved September 21, 2004, from http://www.aapa.org/policy/professional-compet.html.

Ellis, E., Worthington, L. A., & Larkin, M. J. (2004). *Executive summary of the research synthesis on effective teaching principles and the design of quality tools for educators*. Area of Teacher Education Programs in Special Education, University of Alabama. Retrieved February 21, 2005, from http://www.idea,uoregon/~ncite/docum.

Engestrom, Y. (2003). Activity theory and individual and social transformation. In Y. Engestrom, R. Miettinen, & R. L. Punamaki (Eds.), *Perspectives on activity theory* (pp. 19-38). Cambridge: University Press.

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *American Medical Assoication, 2(287)*, 226-235.

Eraut, M. (1994). *Developing professional knowledge and competence.* Washington, D. C: The Falmer Press.

Eraut, M. (2000). Non-formal learning, implicit learning and tacit knowledge in professional work. In F. Coffield's *The Necessity of Informal Learning*, Bristol: The Policy Press.

Farkas, M., & Anthony, W. A. (2001). Overview of psychiatric rehabilitation education: Concepts of training and skill development. *Rehabilitation Education, 15*(2), 119-132.

Farmer, J.  (2004).  How to get the most from performance reviews.  *Magazine of Physical Therapy, 12*(11), 46-49.

Fish, D., & Coles, C.  (1998).  *Developing professional judgment in health care: Learning through the critical appreciation of practice*.  Oxford: Butterworth Heinemann.

Fitzpatrick, C.  (2002).  A new word in serious mental illness:  Recovery. *Behavioral Healthcare Tomorrow*.  Retrieved June 22, 2005, from http://www.bu.edu/cpr/about/publicity/2002-8BHTRecovery-Fitzpatrick.pdf.

Garderbring, S. S.  (1996).  *Developing Health Care Teams*.  A Report by the Academic Health Center Task Force on Interdisciplinary Health Team Development.  Retrieved December 8, 2005, from http://www.ahc.umn.edu/tf/ihtd.html.

Gates, G.  (2003).  *Dietetic professionals are ethically obligated to maintain personal competence in practice.*  The Ethics Committee:  The American Dietetic Association.  Retrieved April 21,2004, from http://www.eatright.org/Member/Print/85_17253.cfm.

Graves, M.  (1998)  *Learning in context*.  Retrieved April 21, 2004, from http://www.apple.com/education/LTReview/winter98/context.html.

Greenlick, M. R.  (1992).  Educating physicians for population-based clinical practice.  *The Journal of the American Medical Association, 67*(12), 1645-1649.

Hansburg, R., Solomon, P., & Meyerson, A. T.  (1990).  Integrating a research agenda into a new psychosocial rehabilitation program.  *New Directions for Mental Health Services, 45*(1), 91-102.

Hara, N.  (2001).  *Formal and informal learning:  Incorporating communities of practice into professional development*.  Paper presented at the American Educational Research Association Annual Meeting, April 10-14, Seatle, WA.  Retrieved April 21, 2004, from http://www.slis.indiana.edu/CSI/WP?PO2-04B.html.

Harris, I. B.  (1993).  New expectations for professional competence.  In L. Currey, J. F. Wergin, and Associates (Eds.),  *Educating professionals: Responding to new expectations and accountability* (pp. 17-52).  San Francisco:  Jossey-Bass Publishers.

Heppner, P. P., & Heppner, M. J.  (2004).  *Writing and publishing your thesis, dissertation, & research:  A guide for students in the helping professions.*  United States:  Brooks/Cole.

Hoepfl, M. C.  (1997).  Choosing qualitative research:  A primer for technology educational researchers.  *Journal of Technology Education, 9*(1), 1-12.

Hueser, N. G.  (1999*).  Grounded theory research:  Not for the novice*.  Retrieved February 21, 2005, from http://ww.users.qwest.net/~nhueser/grounded/html.

Huggins, K.  (2004).  Lifelong learning:  The key to competence in the intensive unit care.  *Intensive and Critical Care Nursing, 20*(1*)*, 38-44.

Institute for International Medication Education.  (2005).  *Global minimum essential requirements in medication education*.  Retrieved May 29, 2005, from http://gmer/iime/documents/htm.

Jacobson, N., & Curtis, L.  (2000).  Recovery as policy in mental health services:  Strategies emerging from the state.  *Psychiatric Rehabilitation Journal, 23*(4), 333-341.

Kazarian, S. S., & Joseph, L. W.  (1994).  A brief scale to help identify outpatients' level of need for community support services.  *Hospital and Community Psychiatry, 45*(10), 1015-1020.

Knight, E. L.  (2004).  *Exemplary rural mental health service delivery*.  Paper submitted to the Timothy J. Coakley Leadership Award, American College of Mental Health Administration Foundation.

LaDuca, A.  (1980).  The structure of competence in health professionals.  *Evaluation and the Health Professional, 3(3)*, 253-288.

LaDuca, A., Engel, J. D., & Risley, M. E.  (1978).  Progress toward development of a general model for competence definition in health professions.  *Journal of Allied Health*, 149-156.

Lamb, H. R.  (1994).  A century and a half of psychiatric rehabilitation in the United States.  *Hospital and Community Psychiatry, 45*(10), 1015-1020.

Lave, J., & Wenger, E.  (2002).  *Situated learning:  Legitimate peripheral participation*.  Cambridge, MA:  Cambridge University Press.

Leach, L.  (2004).  Employee performance appraisal and the 95/5 rule.  *Community College Journal of Research and Practice, 28*, 404-414.

Lenburg, C. B.  (2000).  Promotion of competence through clinical self-reflection and portfolio development:  The inside evaluator and the outside context.  *Tennessee Nurse, 63(3)*, pp. 11, 14-15, 18, 20.

Lenburg, C. B.  (1999).  Redesigning expectations for initial and continuing competence for contemporary nursing practice.  *Online Journal of Issues in Nursing.*  Retrieved April 15, 2004, from http://www.nursingworld.org/ojin/tlopic10-htm.

Leonard, N. H., School, R. W., & Beauvais, L. L.  (1996).  *The impact of group cognitive style on strategic decision making and organizational direction.*  Paper presented at the annual meeting of the Academy of Management in August, 1996.

Levin, S., & Brekke, J. S.  (1993).  Factors related to integrating persons with chronic mental illness into a peer social milieu.  *Community Mental Health Journal, 29*(1), 25-34.

Liberman, R. P., Hilty, D. M., Drake, R. E., & Tsang, H. W. H.  (2001).  Requirements for multidisciplinary teamwork in psychiatric rehabilitation.  *Psychiatric Services, 52*(10), 1331-1342.

Lincoln, Y. S., & Guba, E. G.  (1985).  *Naturalistic inquiry.*  Newbury Park:  SAGE Pulications.

Lindeke, L. L., & Sieckert, A. M.  (2005).  Nurse-physician workplace collaboration.  *Online Journal of Issues in Nursing, 10*(1).  Retrieved December 8, 2005, from http://www.nursingworld.org/ojin/topic26/tpc26~4.htm.

Lypson, M. L., Frohna, J. G., Gruppen, L. D., & Wooliscroft, J. O.  (2004).  Assessing resident's competencies at baseline:  Identifying the gaps.  *Academic Medicine, 79*, 564-570.

Marshall, J. G.  (1993).  The expanding use of technology.  In L. Currey, J. F. Wergin, and Associates (Eds.), *Educating professionals:  Responding to new expectations and accountability* (pp. 53-77).  San Francisco:  Jossey-Bass Publishers.

Martini, P.  (1996).  The day center in the service network of the department of mental health.  *International Journal of Mental Health, 25*(2), 70-82.

McCallin, A.  (2001).  Interdisciplinary practice.  A matter of teamwork:  An integrated literature review.  *Journal of Clinical Nursing, 10*(4), 419-429.

McGaghie, W. C.  (1993).  Evaluating competence for professional practice.  In Curry, L., Wergin, J. F., & Associates (Eds), *Educating professionals:  Responding to new expectations for competence and accountability* (pp. 229-261).  San Francisco:  Jossey-Bass Publishers.

McGaghie, W. C.  (1980).  The evaluation of competence:  Validity issues in the health professionals.  *Evaluation & the Health Professional, 3*(3)*, 289-320.*

McGaghie, W. C. (1991). Professional competence evaluation. *Educational Researcher, 20(1)*, 3-9.

McGuire, C. H. (1993). Sociocultural changes affecting professionals and professionals. In L. Currey, J. F. Wergin, and Associates (Eds.). *Educating professionals: Responding to new expectations and accountability* (pp. 3-16). San Francisco: Jossey-Bass Publishers.

McPherson, K., Headrick, L., & Moss, F. (2001). Working and learning together: Good quality care depends on it, but how can we achieve it. *Quality in Health Care, 10*, 46-53.

McReynolds, C. J. (2002). Psychiatric rehabilitation: The need for a specialized approach. *International Journal of Psychosocial Rehabilitation, 7*(1), 61-69.

McReynolds, C. J., & Garske, G. G. (2003). Psychiatric disabilities: Challenges and training issues for rehabilitation professionals. *Journal of Rehabilitation, 69*(4), 13-18.

Mental Illness Recovery Center. (2005). *Recovery Model.* Retrieved June 20, 2005, from http://www.mirci/resources.htm.

Merriam, S. B., & Caffarella, R. S. (1999). *Learning in adulthood: A comprehensive guide (2nd ed.),* San Francisco: Jossey-Bass Publishers.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook.* Thousand Oaks: SAGE Publications.

Miller, G. E. (1990). The assessment of clinical skills/competence/performance. *Academic Medicine, 65(8),* 563-567.

Nagaswami, V. (1995). Psychosocial rehabilitation: The other side of the mountain. *International Journal for Mental Health, 24*(1), 70-81.

Nesseh, B. (2004). *Continuing professional education models.* Retrieved April 21, 2004, from http://ww.bus.edu/classes/nasseh/bn1000/profess.htm.

Norcini, J. J., & Shea, J. A. (1993). Increasing pressures for recertification and relicensure. In L. Currey, J. F. Wergin, & Associates (Eds.), *Educating professionals: Responding to new expectations and accountability* (pp. 78-104). San Francisco: Jossey-Bass Publishers.

Nowlen, P. (1988). *A new approach to continuing education and the professions.* New York: MacMillan Publishing Company.

Padgett, D. K. (1998). *Qualitative methods in social research: Challenges and rewards.* Thousand Oaks: SAGE Publications.

243

Pathways Behavioral Healthcare, Inc.  (1999)  *CPRC manual:  Policies and procedures.*  Published by Pathways Behavioral Healthcare, Inc., Clinton, Mo.

Peck, E., & Norman, I .J.  (1999). Working together in adult community mental health services: Exploring inter-professional role relations**.** *Journal of Mental Health 8*(3), 231-245.

Peterson, C. L., Patrick, S. L., & Risemeyer, K. J.  (1990).  Social work's contribution to psychosocial rehabilitation.  *Social Work, 35*(5), 468-472.

Rafferty, A. M., Ball, J., Aiken, L. H., & Fagin, C. M.  (2001).  Are teamwork and professional autonomy compatible, and do they result in improved hospital care?  *Quality in Health Care, 10*, 32-37.

Rajkuman, Sam.  Activity theory.  School of Library and Information Science.  Indiana University.  Bloomington, IN   47405-3907.  http://www.slis.indiana.edu/faculty/yrogers/act_theory.  Retrieved December 12, 2006.

Rogoff, B.  (1990).  *Apprenticeship in thinking:  Cognitive development in social* c*ontext*.  New York and Oxford:  Oxford University Press.

Rogoff, B., & Gardner, W.  (2000).  Adult guidance in cognitive development.  In B Rogoff & J. Lave (Eds.), *Everyday cognition:  It's development in social context* (pp. 95-116).  Bridgewater, NJ:  Replica Books.

Ryle, A.  (2003).  Object relations theory and activity theory:  A proposed link by way of the procedural sequence model.  In Engestrom Y., Miettinen, R. & Punamaki, R. (Eds.), P*erspectives on activity theory* (pp. 4-7, 418).  Cambridge, MA:  Cambridge University Press.

Rutledge, K.  (2000).  *Social learning theory*.  Retrieved February 15, 2005, from http://teachnet.edb.utexas/~/ynda_abbott/social.htm.

Salas, E., Sims, D. E., Klein, C., & Burke, S.  (2003).  Can teamwork enhance patient safety?  Harvard Medical Institutions:  Risk Management Foundations Retrieved December 23, 2005, from http://www.rmf.harvard.edu/risklibrary/articles/Forum_V23N3_a3.pdf.

Schein, E. H.  (1992).  *Organizational culture and leadership* (2nd ed.).  San Francisco:  Jossey-Bass Publishers.

Schmidt, H. G., Norman, G., & Boshuizen, H.  (1990).  A cognitive perspective on medical expertise.  *Academic Medicine, 65*(10), 611-621.

Schon, D.  (1983).  *The reflective practitioner:  How professionals think in action*.  New York:  Basic Books.

Scribner, L. (2000).  Studying working intelligence:  Thinking and learning in social context.  In B. Rogoff & J. Lave (Eds.), *Everyday cognition:  Its development in social context (*pp. 9-40).  Bridgewater, NJ:  Replica Books.

Silverman, D.  (2001).  *Interpreting qualitative data:  Methods for analysing talk, text, and interaction (2$^{nd}$ ed.)*.  Thousand Oaks:  SAGE Publications.

Sliwa, J. A., & Kowalski, K. J.  (2000).  Assessing resident clinical competence.  *American Journal of Physical Medicine and Rehabilitation, 79(5)*, 468-*473*.

Smith, P. J.  (2003).  Workplace learning and flexible delivery.  *Review of Educational Research, 73*(1), 53-88.

*Social learning theory of Albert Bandura*.  (2003).  Retrieved February 21, 2005, from http://www.mhhe.com/socscience/comm/bandura-sm.html.

Stark, S., Skidmore, D., Warne, T., & Stronach, I.  (2002).  A survey of 'teamwork' in mental health:  Is it achievable practice? *Mental Health Nursing, 14*(3), 178-186.

Strauss. A., & Corbin, J.  (1998).  *Basics of qualitative research:  Techniques and procedures for developing grounded theory (2$^{nd}$ ed.)*.  Thousand Oaks:  SAGE Publications.

Tikhomirov, O. K.  (2003).  The theory of activity changed by information technology.  In Engestrom Y., Miettinen, R. & Punamaki, R. (Eds.), *Perspectives on activity theory* (pp. 347-376).  Cambridge:  University Press.

Tilson, H., & Gebbie, K. M.  (2004).  The public health workforce.  *Annual Review of Public Health, 25*, 341-356.

Tolman, E. E.  (1948).  Cognitive maps in rats and men.  *Psychological Review*, 55, 189-208.

Tuijnman, A., & van der Kamp, M.  (1992).  *Learning across the lifespan: Theories and research policies.*  New York:  Pergamon Press.

University of Washington School of Medicine:  (1999).  *Interdisciplinary Team Issues*.  Retrieved December 21, 2005, from http://eduserv.hscer.washington.edu/bioethics/topics/team.html.

Von Gunten, C. E., Ferris, F. D., & Emanuel, L. L. (2000). Ensuring competency in end-of-life care: Communication and relational skills. *Journal of American Medical Association, 284(21)*, 3051-3057.

Vygotsky, L. (1986). *Thought and language.* Cambridge, MA: MIT Press.

Wachs, J. (2005). Building the occupational health team: Keys to successful interdisciplinary Collaboration. *American Association of Occupational Health Nurses, 53*(6). Retrieved December 20, 2005, from http://www.aaohnjournal.com/backissue.asp?page=3.

Wagner, E. H. (2000). What is a patient care team? *British Medical Journal, 320,* 569-572.

Wales C. E, Nardi, A. H., & Stager, R. A. (1993) Emphasizing critical thinking and problem-solving. In L. Curry, J.F. Wergin, & Associates (Eds.), *Educating professionals: Responding to new expectations for competence and accountability* (pp. 178-226). San Francisco: Jossey-Bass Publishers.

Walsh, J. P. (1995). Managerial and organization cognition: Notes from a trip down memory lane. *Organizational Science, 6*(3), 280-321.

Walsh, J. P., & Charalambides, L. C. (1990). Individual and social origins of belief structure change. *Journal of Social Psychology, 120*(4), 517-532.

Walsh, J. P., & Henderson, C. M. (2001). An attributional analysis of decisions about making commitments. *The Journal Of Social Psychology, 129*(4), 533-459.

Walsh, J. P., & Ungson, G. R. (1991). Organizational memory. *Academy of Management Review, 16*(1), 57-91.

Watson, R., Stimpson, A., Topping, A., & Porock, D. (2002). Clinical competence assessment in nursing: A systematic review of the literature. *Journal of Advanced Nursing, 39(5)*, 421-432.

Welsh General Medical Services Committee. (1994). Education and debate: Patient care and the general practitioner. *British Medical Journal, 309*, 1144-1146.

Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity.* Cambridge, MA: Cambridge University Press.

Wenger, E., McDumott, R., & Snyder, W. M. (2002). *Cultivating communities of practice.* Boston, MA: Harvard Business School Press.

Wertsch, J. W., Minick, N., & Arms, F. J. (2000). The creation of context in joint problem solving. In B. Rogoff, & J. Lave (Eds.), *Everyday cognition: It's development in social context* (pp. 151-171). Bridgewater, NJ: Replica Books.

Western Regional Professional Development Program. (2004). Effective Models of Professional Development, 1-6.

Wiecha, J., & Pollard, T. (2004). The interdisciplinary ehealth team: Chronic care for the future. *Journal of Medical Internet Research Electron Resource, 6*(3). Retrieved December 23, 2005, from http://www.jmir.org/2004/3/e22/.

Wolcott, H. J. (1994). *Transforming qualitative data: Description, analysis, and interpretation.* Thousand Oaks: SAGE Publications.

VITA

Janice Marie Iseminger was born February 6, 1951, and raised in Independence, Missouri. She grew up living with her parents and sister and graduated from Truman High School in 1969. She received her BS in Education, BS in Therapeutic Recreation, MS in Social Gerontology, and her Education Specialist Degrees from Central Missouri State University, and her Doctor of Philosophy in Educational Leadership and Policy Analysis from the University of Missouri-Columbia. Janice is married but does not have any children. She has worked for a community mental health center for the past ten years as a caseworker and then as a supervisor of a case management team. She has also taught for State Fair Community College and Central Missouri State University as an adjunct professor for the past six years.