SESLHD GUIDELINE COVER SHEET

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SUMMARY	The guideline provides a guide for implementing a Strengths Model Mentoring Program as part of the Strengths Model Implementation Plan.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

SESLHD GUIDELINE
COVER SHEET

Strengths Model Mentoring Program Guidelines

Section 1 – Background

The Strengths Model is a recovery promoting practice which provides a framework and process that can facilitate the consistent application of the recovery philosophy within all aspects of service delivery across all service settings. A 2016 critical review of research regarding the use of strength-based approaches in mental health service settings found evidence that the utilisation of a high fidelity, strength-based approach improves outcomes including:

- Reducing hospitalisation rates
- Increased employment/educational attainment
- Intrapersonal outcomes such as self-efficacy and sense of hope.

Mentoring is a key component of the Strengths Model of Case Management, used to transfer knowledge and skills taught during training, into clinical practice. A comprehensive mentoring and supervision program is recommended in the Strengths Model literature, and forms part of the fidelity requirements for successful implementation of the model.

The SESLHD Mental Health Program has been undertaking a comprehensive Strengths Model Implementation Strategy since 2013 to support the facilitation of a recovery based approach to mental health service provision. During this time the program has developed and implemented a high quality training, supervision and competency process to provide clinical staff with the skills and knowledge to use the Strengths Model tools, however services have struggled to integrate this into routine practice. In 2016 a comprehensive Strengths Model Implementation Plan was developed in order to address the barriers and facilitate further implementation and sustainability. It was identified that a mentoring program was a key component missing from the strategy and that the development of this would be essential to supporting full implementation of the model.

References

1. Shepherd G, Boardman J and Burns M (2009*), Implementing recovery: a methodology for organisational change*, Sainsbury Centre for Mental Health, London.
2. Tse S, Tsoi E, Hamilton B, O'Hagan M, Shepherd G, Slade M, Whitley R and Petrakis M (2016), Uses of strength-based interventions for people with serious mental illness: a critical review*, International Journal of Social Psychiatry,* Feb, pp. 1-11.
3. Rapp CA and Goscha R (2011), *The Strengths Model: A recovery-oriented approach to mental health services,* Oxford University Press, USA.

Section 2 - Principles

Recovery Promoting Practices

Recovery is the guiding philosophy for contemporary mental health services in Australia, as outlined in current key State and National documents (Commonwealth of Australia, 2009, 2013; NSW Mental Health Commission, 2014), however; services struggle to integrate this paradigm into routine practice. South Eastern Sydney Mental Health Services have identified and rolled out a range of practices and programs that can promote the cultural shift required for recovery oriented service delivery, including the development of the Peer Workforce, the Recovery College and the Strengths Model of Case Management.

The Strengths Model

The Strengths Model is a model of clinical care developed by Charles Rapp and Richard Goscha (Rapp and Goscha, 2006) which provides a philosophy of service, as well as the tools to aid intervention and to manage fidelity to a clinical treatment process. Tools include the Strengths Assessment, Personal Recovery Plan and Group Supervision Structure. Interventions from other treatment modalities, such as pharmacotherapy, Cognitive Behaviour Therapy, Dialectical Behaviour Therapy, Narrative Therapy, Motivational Interviewing, Brief Solution Focused Therapy and Family Inclusive Psychoeducation Treatments can then be incorporated into individual treatment plans. The Strengths Assessment actively engages the consumer in a process where the Personal Recovery Plan cannot be developed without their collaborative engagement.

Mentoring

Mentoring is used to improve and nurture the skills, knowledge and expertise of a competent learner by pairing them with an experienced and knowledgeable professional.

The mentor will invest in the mutual relationship, spend time with, share knowledge, support and encourage the mentee.

This developmental process allows for growth in skills, confidence and knowledge and allows for a clear understanding of shared interests and values.

Section 3 – Definitions

Strengths Mentor

- Strengths Mentors are clinicians who meet certain criteria (see section 6) and provide support, guidance and knowledge transfer to individual clinicians in implementing the Strengths Model into practice.
- The Strengths Mentor may also be a Strengths Model Educator.

Strengths Mentee

- Strengths Mentees are clinicians who have undergone the two day Strengths Model in Practice training and are engaged in the mentoring process as part of working towards their competencies.

Clinical Managers/NUMs

- Clinical Managers are managers of teams that work with the Strengths Model as part of their model of care e.g. Adult Community Teams, Rehabilitation Units (Nursing Unit Managers).

Section 4 - Responsibilities

Mentors are responsible for:

- Completing the required training and supervision for mentors
- Providing individual mentoring to allocated clinicians
- Acting as a Team Lead and resource person for the Strengths Model within their clinical service
- Following the processes outlined in the Strengths Model Mentoring Guidelines.

Mentees are responsible for:

- Completing the minimum requirements outlined in the SM Competency Assessment tool
- Completing the Strengths Model mentoring program
- Following the processes outlined in the Strengths Model Mentoring Guidelines.

Clinical Managers/NUMs are responsible for:

Supporting and facilitating the Strengths Model Guidelines within their team. This includes:

- Ensuring all relevant staff undertake the required Strengths Model training, competency and mentoring processes
- Monitoring participation of their staff in the mentoring process
- Identifying and supporting the development of mentors within their team
- Allowing protected time for mentors to provide mentoring to staff according to the Guidelines.

Community Services Managers are responsible for:

- Ensuring clinical managers are aware of and adhere to the Strengths Mentoring Guidelines
- Monitoring and facilitating the implementation of the guidelines within their service.

Section 5 – Mentoring Program Structure

5.1 Mentoring Numbers

Any service within the SESLHD Mental Health Service may choose to participate in the Strengths Mentoring Program however the Adult Community Mental Health Teams and the Mental Health Rehabilitation Units (MHRUs) will be the initial focus. In accordance with the SESLHD Strengths Model Implementation Plan 2016-2018 and the Adult Community Model of Care (draft 2017), each adult community mental health team will have at least one identified Strengths Mentor. It is recommended that the MHRUs identify up to three mentors per unit. For sustainability, additional mentors should be identified and developed as suitable candidates become available.

5.2 Mentoring Pathway

Clinicians from teams using the Strengths Model as part of their model of care are required to undertake the two-day Strengths Model in Practice course followed by the competency process (6-12 months). In addition, clinicians will be required to complete a minimum of six mentoring sessions to support the transfer of knowledge and skills into practice. Clinicians who have trained in the past may also be offered mentoring by recommendation of the clinical manager.

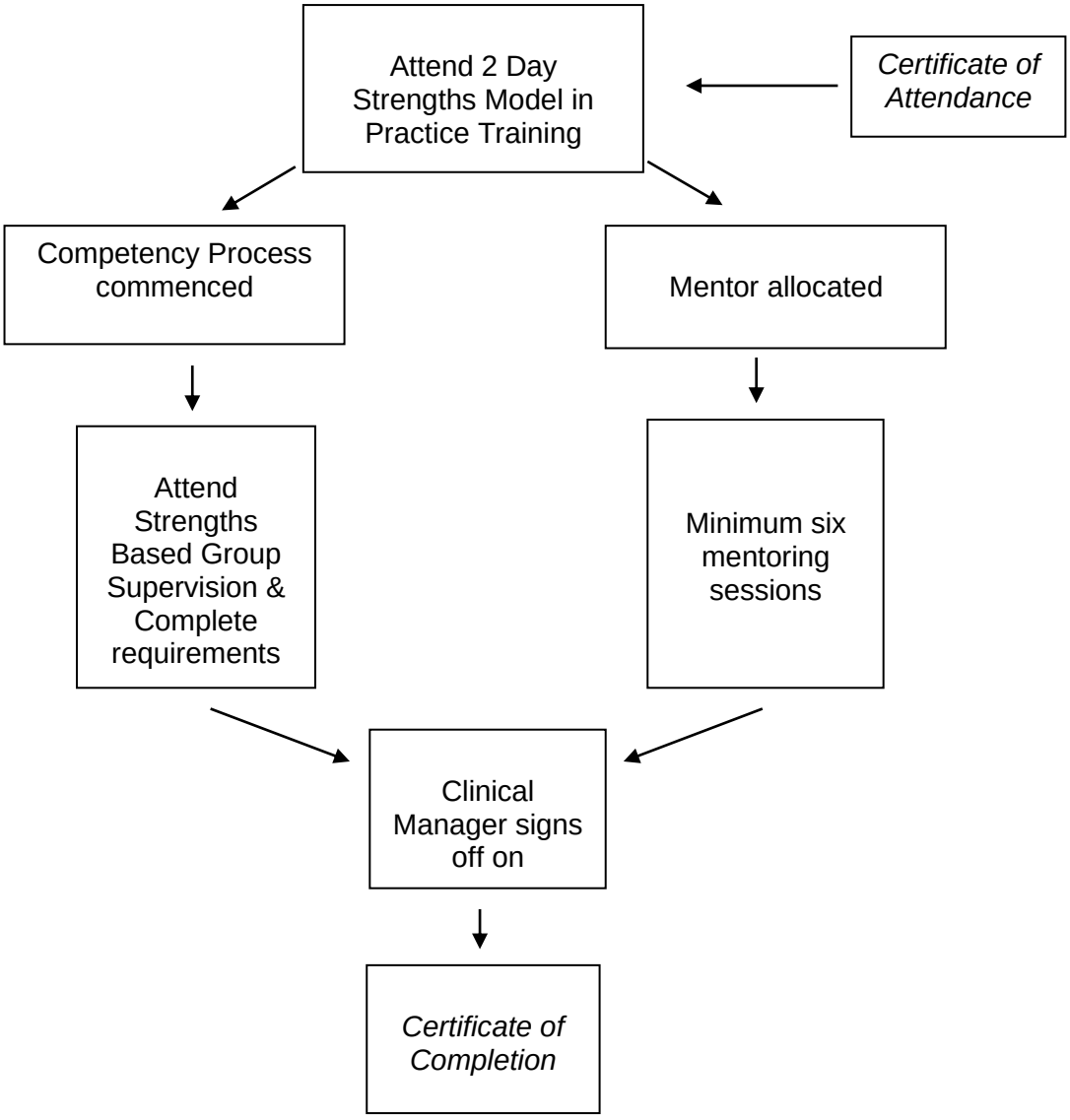
Following completion of the two-day Strengths Model training, the clinical manager will allocate clinicians to the mentor on their team.

Note: Allocation will be dependent upon the availability and experience of mentors and other team resources. It is recommended that a new mentor start with one mentee until they build competence and familiarity with the process. Mentors may be asked to support mentees on different clinical teams if there is no mentor available on that team, if the mentor for that team does not currently have capacity or if this provides a better personal match.

5.3 Governance

- The clinical manager/NUM is responsible for ensuring that all relevant staff undertake the required Strengths Model training, competency and mentoring processes.
- Participation in the competency process is monitored by the locally allocated staff member (e.g. rehabilitation coordinator, strengths educator, CNC) via My Health Learning.
- Participation in the mentoring process is monitored by the clinical manager/NUM in consultation with the mentor.
- Completion of the Strengths Competency process is signed off by the clinical manager/NUM – at this time a Certificate of Completion is awarded by the Workplace Capabilities Coordinator or delegate through My Health Learning.
- The local District and Local Strengths Model Leadership Groups should include mentoring as an agenda item.

Strengths Practitioner Development Pathway



Section 6 – Mentors and Mentees

6.1 Selection of Mentors

Mentors will be invited from current clinicians within the respective teams who are competent and confident in utilising the Strengths Model and who have been champions in working with the approach.

Mentors must meet the following criteria:

1. Completed the SESLHD Strengths Education and Competency process (or equivalent by negotiation).
2. Demonstrates ability to develop high quality strength assessment and recovery goal plans with consumers.
3. Demonstrates ability to integrate Strengths Assessment and Personal Recovery Plan in routine practice.
4. Demonstrates ability to form collaborative, person-centered relationships with consumers to support their recovery.
5. Demonstrates high level of knowledge of the recovery paradigm and recovery supporting practices.
6. Personal commitment and skills to provide clinical supervision to assist colleagues to develop their competence and confidence.
7. Agree to participate in the required training and supervision.

In addition, mentors must demonstrate the following:

1. Willingness to commit the time and energy required for the mentoring relationship.
2. Commitment to maintaining up to date knowledge of the Strengths Model and other recovery supporting practices.
3. Willingness to share personal experiences, failures and successes to enhance learning opportunities.
4. Ability to provide feedback in a constructive manner.
5. Willingness to challenge deficit focused practices within the organisation and promote recovery and strengths focused alternatives.

6.2 Training and Supervision for Mentors

A number of opportunities are available to assist and support clinicians undertaking a mentoring role.

The following courses are required prior to formally commencing a mentoring role:

1. One Day Strengths Model Mentor training– SESLHD MHS Strengths Educators.
2. One Day Coaching/Mentoring Workshop – SESLHD MHS Workforce Capabilities.

The following courses are required but can be undertaken after commencement of the role:

1. Two Day Recovery Supporting Services and Systems – Recovery College.

To supplement this, a Strengths Mentoring Supervision program will be established to provide ongoing, specialist support to enable the mentors to develop their own skills and competency.

This will consist of a monthly/bi-monthly group supervision session facilitated by an external expert in Strengths Model Clinical Supervision. It is a requirement that all mentors participate in this program. In addition to this, strengths mentors may provide support to each other through peer supervision and/or informal discussion.

6.3 Mentees

The mentees will be clinicians on teams participating in the Strengths Model program. All new clinicians who complete the two day Strengths training will be allocated to a mentor as part of the competency process. Clinicians who have trained elsewhere or in the past may also access mentoring through negotiation with the Clinical Manager. Mentees are expected to:

- Be committed to professional development, learning and acquiring new skills
- Be receptive and act on honest and constructive feedback provided by the mentor
- Seek out assistance from the mentor and commit to meeting on a regular basis
- Provide feedback to the mentor about the mentoring relationship.

Section 7 – Mentoring Model

7.1 Mentoring Program Steps

The mentoring program is designed to be offered on a one to one basis, however mentors may choose to conduct small group sessions to support the program if they feel this would be helpful. The following steps should be undertaken:

1. Clinical Manager refers the mentee to the appropriate mentor, matching the individuals where possible within the constraints of the available resources.

2. Mentor and mentee meet to discuss the process. At this meeting the following should be undertaken:
    a. Discussion of expectations of both mentor and mentee
    b. Establishment of the boundaries of the relationship in relation to confidentiality and line management reporting structure
    c. Establishment of clear learning goals
    d. Negotiation of strategies and type of mentoring that will be provided
    e. Negotiation of frequency and timing of the sessions
    f. Documentation and signing of a Mentoring Agreement.

3. Minimum of six sessions are to be offered at least monthly. At each session, the Mentoring Agreement should be reviewed and updated as necessary. The clinical manager should check in with both mentor and mentee to determine how the relationship is working and how the process is progressing. *Note: Additional sessions may be negotiated with the clinical manager if required.*

4. Once the mentoring sessions have been completed, the mentor will provide feedback to the clinical manager regarding the outcomes and achievement of learning goals:
    a. If the mentoring is deemed successful, this should be fed back to the person monitoring the competencies so that the mentoring component can be marked complete.
    b. If the mentoring has not been successful or if further support is required, the clinical manager should facilitate other strategies such as allocating a different mentor, offering additional mentoring sessions or providing further training.

7.2 Mentoring Strategies

The Strengths Model literature outlines three key mentoring activities:

1. Reviewing Strengths Assessments and Personal Recovery Plans
2. Providing direct staff feedback on the quality of the tools
3. Field mentoring (modelling skills, observing and feedback on skills, promoting skills)

These three activities form the basis of the Mentoring Program and are covered in detail in the Strengths Mentoring Workshop training. The mentor and mentee will collaboratively design an individualised mentoring program that may incorporate any or all of these strategies, depending on need and capacity. This process provides an opportunity for the mentor to model collaborative planning to the mentee.

7.2.1 Reviewing Strengths Documentation

This process involves the mentor undertaking a detailed review of the Strengths documentation. In preparation for a mentoring session, the mentee should provide the mentor with a copy of the Strengths Assessment and Personal Recovery Plan for the consumer/consumers they are using the model with. The mentor should assess this documentation using the Quality Review Tools (Appendices 2 and 3).

7.2.2 Providing Direct Feedback

Following review of the documentation, the mentor will meet with the mentee to discuss their assessment of the strengths model documents. Constructive feedback is used to highlight competency and skills demonstrated by the mentee, suggestions for ways of improving and possible strategies for supporting the consumer's efforts to achieve recovery-focused goals. The mentor will support the mentee to reflect on their work with the consumer, to enable them to develop their insight and awareness, and support their development of strengths-based practices to support recovery.

7.2.3 Field Mentoring

Field mentoring is a supervisory tool used to help staff further develop and refine their use of skills and/or tools in actual practice. Field mentoring reinforces the strengths of staff, enhances transfer of training into practice, builds skills and confidence and assists staff in areas they struggle with. Field mentoring will be offered as capacity allows i.e. interventions 1 and 2 below can be integrated into routine practice and do not require substantial additional time.

The following are some examples of ways to provide field mentoring:

Field Mentoring Interventions

<u>Intervention #1</u> Observe ↓ Provide Feedback ↓ Role Play ↓ Discuss	<u>Intervention #2</u> Model ↓ Discuss ↓ Observe ↓ Provide Feedback
<u>Intervention #3</u> Observe ↓ Prompt Skills ↓ Model Skills ↓ Discuss/Provide Feedback	<u>Intervention #4</u> Role Play ↓ Provide Feedback ↓ Observe ↓ Provide Feedback

Intervention #1 – Here the clinician takes the lead role in working with the client with minimal involvement from the mentor. After the session, the mentor and clinician discuss what worked well and what did not. Using role play, the mentor models as the clinician and presents alternative ways the session might have been conducted. The role play is discussed, along with possible switching of roles for further practice.

Intervention #2 – Here the mentor takes the lead role in working with the client for the purpose of modelling how to use a specific skill or tool. The mentor and clinician discuss the session afterwards. On a subsequent session, the mentor observes the clinician using the skill or tool. Afterwards, they discuss the session.

Intervention #3 – Here the clinician takes the lead role in working with the client and will try using a new skill or tool. If needed the mentor might intervene during the session and assist by modelling the skill or tool. Afterwards the mentor and clinician discuss the session.

Intervention #4 – Here the mentor and clinician role play using a new skill or tool prior to meeting with the client. The mentor gives the clinician feedback on using the skill or tool. The mentor then goes out with the clinician to observe him/her using the skill or tool with an actual consumer. Afterwards, the mentor provides feedback to the clinician.

Appendix 3 is from the Strengths Manual and provides further details about Field Mentoring. It includes a Field Mentoring Checklist which should be used during each mentoring session and a Field Mentoring Log used to track how many sessions the mentor has provided.

7.3 Other tasks that can be undertaken by a Mentor

In addition to providing individual mentoring, the Strengths Mentor will be the lead contact and resource person for the Strengths Model within the clinical team. Activities that they can contribute to include:

- Strengths documentation review for the purposes of auditing or fidelity review
- Advice on integrating strengths and recovery approaches into clinical processes and models of care
- Challenging practices and language that do not support recovery and promoting recovery and strengths focused alternatives
- The Strengths Mentor may also be a Strengths Model Educator.

Section 8 – Troubleshooting

8.1 What to do if the mentor/mentee relationship is not working

In this situation, the Clinical Manager/NUM should attempt to resolve the issues with both parties. If this is not possible, a new mentor should be allocated if available. Note mentors from different teams may be used to manage these situations.

8.2 What to do if the mentee is not making any progress

If the mentor is concerned that the mentee is not making progress, they have 2 possible courses of action:

1. If minimal additional assistance is required, the mentor and mentee may negotiate a fixed number of extra mentoring sessions to bring the mentees skills to the required level of competence.
2. If the mentor is concerned that the mentee is not able to meet basic competence, they should discuss this with the clinical manager who will determine the best course of action and may consult the service manager. The mentor is not expected to address any performance issues and has no authority to enforce any actions.

Section 9 – References, Revision and Approval History

References

SESLHD

- SESLHD Strengths Model Implementation Plan

Others

- Shepherd G, Boardman J and Burns M (2009*), Implementing Recovery: a methodology for organisational change*, Sainsbury Centre for Mental Health, London.
- Tse S, Tsoi E, Hamilton B, M O'Hagan, G Shepherd, M Slade, R Whitley and M Petrakis (2016) Uses of strength-based interventions for people with serious mental illness: a critical review*, International Journal of Social Psychiatry,* Feb, pp. 1-11.
- Rapp CA & Goscha R (2011), *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services,* Oxford University Press, USA.
- St. Vincent's Hospital Melbourne Strengths Mentoring Programme Design document
- Department of Health: National Framework for recovery-oriented mental health service

Revision and Approval History

Date	Revision no:	Author and approval
10/8/17	0	Jo Sommer, Clinical Rehabilitation Coordinator.
	0	Strengths Model Mentoring Working Party.
6/10/17	0	Reviewed by Francesca Coniglio and Jo Sommer.
24/01/18	0	Reviewed by Leonie Dunn, A/Clinical Rehabilitation Coordinator.
9/03/18	0	Reviewed by SESLHD Strengths Model Leadership Group, Site Strengths Model Leadership Group.
6/04/2018	0	Content reviewed with minor change, completed by MHS Policy Officer. Endorsed by DDDCC.
May 2018	0	Endorsed by MHS Clinical Council with no further amendments.
May 2018	0	Registered by Executive Services and progressed to Draft for Comment.
June 2018	0	No feedback received from Draft for Comment period.
July 2018	0	Processed by Executive Services prior to progression to the Clinical and Quality Council.
July 2018	0	Endorsed by SESLHD Clinical and Quality Council
August 2022	1	Routine review commenced. Links updated. Executive Sponsor updated. Approved by Executive Sponsor.

Appendix 1. Strengths Mentoring Agreement

MENTORING RELATIONSHIP AGREEMENT

The Mentor and Mentee are expected to have read the Strengths Model Mentoring Program SESLHD Mental Health Service Guidelines prior to meeting.

The aim of the Mentoring Relationship Agreement is to document the agreed goals and expectations for the mentor and mentee:

- Maintain confidentiality and respect the other's privacy
- Be respectful, non-judgmental and supportive of each other
- Keep to scheduled meeting times and give adequate notice of change.

1. Expectations

What do we hope to gain from the mentoring experience?	
What are the strengths we bring to this relationship?	
What do we expect from each other for an effective mentoring relationship? e.g. boundaries, confidentiality, time management, communication	
How will we know if the mentoring relationship is going well?	
What signs would suggest we need to change the way we are working and how will we address this?	

2. Goals of the Mentoring Relationship

It is important to set some key goals, specific to the strengths model that will be the focus of mentoring sessions. The most effective goals are those that are shaped as learning goals and guide us to take incremental steps to achieve our desired outcome.

It can sometimes be challenging for people to identify goals, and it's important to remember that need to be flexible, and that it is natural for them to evolve and change.

Ask: Thinking about your strengths practice (e.g. strengths assessments, goal planning and implementation) on a scale of 0-10 how confident do you feel in working in this model?

Goals should consider the following domains:

Identity: Who are you? What do you want to become? What are your aspirations? Having done the strengths training how does this fit with your current practice and what challenges does it raise for you?

Values: What do you care about? Why is this important to you?

Resources: How well supported are you? Who is in your network? What resources would enable you to be more effective in your work?

Thinking about your learning goals are there particular people or resources that you can access?

Purpose: What do you want to contribute? What do you want to achieve?

SMART goals can help with structuring of goals considering the above points.

Goals and why are they important to you?	
1	
2	
3	

3. Mentoring Contact Arrangements

We have discussed our workloads, availability and support requirements to competence in the Strengths Model.

Mentoring agreement will commencement on: / /20

and will finish on: / /20

Contact Frequency (fortnightly, monthly, other)	
Who has primary responsibility for keeping in touch (mentor/mentee)	
Strategies to be utilised (Refer to section 7.2 in Guidelines) e.g. modelling, discussion, observation, role play, feedback	

We have read, understood and agree to these guidelines and procedures.

Mentee Signature: Mentee Name:

Mentor Signature: Mentor Name:

Appendix 2. Quality Review of Strengths Assessment

QUALITY REVIEW OF STRENGTHS ASSESSMENT

Consumer's name _____ **Date reviewed** _____

Case Manager's Name _____

YES	SOMEWHAT	NO	Complete and thorough – each life domain has rich and detailed information
YES	SOMEWHAT	NO	Individualised and specific – gives a clear picture of who the person is. (Here's a good test. Blank out the name and make copies for everyone on the team. Team members should be able to readily identify this person by the information provided)
YES	SOMEWHAT	NO	Clear indication of the person's involvement in the assessment – signature, personal comments, information written by the person, written in the person's own words
YES	SOMEWHAT	NO	Used in an ongoing manner – updated regularly upon meeting with the person (weekly for the first few meetings, at least monthly after that)
YES	SOMEWHAT	NO	Includes natural resources (as opposed to only formal resources) in *each* area
YES	SOMEWHAT	NO	The individual's wants and desires are listed, prioritised and written in the person's own language (vs. unprofessional jargon)
YES	SOMEWHAT	NO	Reflects cultural, spiritual, ethnic and/or racial information that holds meaning for the person
YES	SOMEWHAT	NO	Reflects consumer's skills, talents, accomplishments and abilities – what they know about, care about, have a passion for each life domain

Taken from - The Strengths Model: Case Management with People with Psychiatric Disabilities Second Edition Charles A. Rapp & Richard J. Goscha

RECOMMENDATIONS:

Appendix 3. Quality Review of Personal Recovery Plan

QUALITY REVIEW OF PERSONAL PLAN (Goal Plan)

Consumer's name _____ **Date reviewed** _____

Case Manager's Name _____

LONG - TERM GOAL

YES	NO	Goal is taken from the "wants" section of the strengths assessment, that is, long-term goal clearly reflects what the person wants, what motivates him/her, not what others think they need to do
YES	NO	Goal is written in the person's own words

SHORT - TERM GOALS (action steps/tasks)

YES	SOMETIMES	NO	Date is recorded that the action step is written
YES	SOMETIMES	NO	Goals are measureable (outcomes oriented)
YES	SOMETIMES	NO	Goals are achievable (broken down into small steps)
YES	SOMETIMES	NO	Goals are positive (what *will* be done rather than what *will not* be done)
YES	SOMETIMES	NO	Dates to be achieved are recovered (no ongoing)?
YES	SOMETIMES	NO	Are tasks being achieved and target dates recorded?
YES	SOMETIMES	NO	Is goal progress reflected in comments section?
YES	SOMETIMES	NO	Resources/information from the strengths assessment are reflected in the goal plan
YES		NO	The consumer has signed the plan

Taken from - The Strengths Model: Case Management with People with Psychiatric Disabilities Second Edition Charles A. Rapp & Richard J. Goscha

RECOMMENDATIONS:

Appendix 4. Field Mentoring – Strengths Manual Excerpt

Field Mentoring (From Strengths Manual Appendix)

Field mentoring is a supervisory tool used to help staff further develop and refine their use of skills and/or tools in actual practice. The environment for field mentoring should be one of mutual learning and professional development rather than micro-management. There should be an expectation that all staff continue in their professional development throughout the year, and the role of the mentor is to support the enhancement of their professional skills.

Purposes of Field Mentoring

- Observe Skills of Staff
- Provide Feedback on Skills
    - e.g. Assessing strengths, formulating goals, building relationships, processing decisional uncertainty, motivational interviewing, etc.
- Modeling Skills
- Prompting of Skills

Benefits of Field Mentoring

- Reinforce Strengths of Staff
- Enhance Transfer of Training
- Build Skills
- Build Confidence
- Better assist staff in areas they identify that they struggle with

Format for Field Mentoring

- Agree on the goal of the field mentoring session (using the SA with clients who are reticent to speak, breaking down the goal on the RGW, etc.)
- Choose a client that will best help the case manager learn the skill
- Agree on the role each of you will play in the field mentoring session
- Plan for time afterwards to process

Processing After Field Mentoring

- Restate the purpose of the particular field mentoring session
- Point out specific strengths of the case manager observed during field mentoring
- Point out specific words, behaviours or actions that might have been obstacles to the case manager reaching his or her desired outcomes
- Make a plan for follow-up

The Power of Positive Reinforcement

- Reinforce Specific Behaviour
- Use Immediate Reinforcement
- Reward Small, Incremental Achievements
- Use Intermittent Reinforcement

Types of Rewards

- Verbal Praise
- Written Praise
- Symbolic Rewards

Factors in Implementing a Reward-based Environment

- Diversity in Rewards
- Amount of Rewards
- Specificity
- Sources
- Individualise

Field mentoring focuses on enhancing the strengths of the case manager rather than focusing on their deficits

The following are some examples of ways to provide field mentoring.

Field Mentoring Interventions

Intervention #1 Observe ↓ Provide Feedback ↓ Role Play ↓ Discuss	Intervention #2 Model ↓ Discuss ↓ Observe ↓ Provide Feedback
Intervention #3 Observe ↓ Prompt Skills ↓ Model Skills ↓ Discuss/Provide Feedback	Intervention #4 Role Play ↓ Provide Feedback ↓ Observe ↓ Provide Feedback

Intervention #1 – Here the case manager takes the lead role in working with the client with minimal involvement from the mentor. After the session, the mentor and case manager discuss what worked well and what did not. Using role play, the mentor models as the case manager and presents alternative ways the session might have been conducted. The role play is discussed, along with possible switching of roles for further practice.

Intervention #2 – Here the mentor takes the lead role in working with the client for the purpose of modelling how to use a specific skill or tool. The mentor and case manager discuss the session afterwards. On a subsequent session, the mentor observes the case manager using the skill or tool. Afterwards, they discuss the session.

Intervention #3 – Here the case manager takes the lead role in working with the client and will try using a new skill or tool. If needed the mentor might intervene during the session and assist by modelling the skill or tool. Afterwards the mentor and case manager discuss the session.

Intervention #4 – Here the mentor and case manager role play using a new skill or tool prior to meeting with the client. The mentor gives the case manager feedback on using the skill or tool. The mentor then goes out with the case manager to observe him/her using the skill or tool with an actual consumer. Afterwards, the mentor provides feedback to the case manager.