The Journal of Mental Health Training, Education and Practice

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Enhancing recovery orientation within mental health services: expanding the utility of values

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Abstract

Purpose – The purpose of this paper is to review the role of values within contemporary mental health recovery services, outlining the rationale and approach for a specific values-focused staff intervention to promote autonomously motivated uptake of recovery-oriented practices.

Design/methodology/approach – Recent advances in understanding of the enduring gap between ideological and applied acceptance of personal recovery within mental health services are outlined, with particular focus on the limited utility of training programmes as a means to promoting implementation. Frequently, mental health service organisations have adopted recovery policies in a primarily "top-down" fashion standing in contrast to the high autonomy approaches espoused for service users. Drawing from the extensive research related to Self-Determination Theory (SDT), a complementary focus on "bottom-up" approaches that enable service-delivery staff to develop a sense of autonomy for changed work practices in order to increase implementation is indicated.

Findings – Application of values-focused interventions for mental health recovery staff parallel to the approaches acknowledged as effective for service participants are likely to be effective in promoting implementation of newly trained recovery-oriented practices.

Research limitations/implications – The paper is conceptual in nature and therefore reflects the priorities and views of the authors but the paper draws together well-established literature to develop a novel approach to a highly relevant issue.

Practical implications – Training transfer and implementation of evidence-based practice are issues with broad relevance and the explication of additional methods to promote employee uptake of new practices is a key priority for organisations and policy makers.

Social implications – Significant social implications include furthering the discussion and insight to the development of effective delivery of mental health services to individuals accessing service.

Originality/value – A novel aspect of this paper is the provision of a theoretical rationale for the application of SDT as a framework for understanding the continuing challenge of recovery operationalisation, which despite the conceptual good-fit, currently stands as an association not well exploited. Moreover, this paper proposes values-clarification and coaching as a specific and reproducible approach to enhancing recovery-oriented service provision.

Keywords Values, Implementation, Recovery-oriented services, Autonomous motivation, Staff

Paper type Conceptual paper

"Recovery" is the journey of an individual with mental illness that reflects a life of purpose and meaning (Farkas and Anthony, 2010). As a movement, recovery grew out of consumer dissatisfaction with a psychiatric system that appeared to not hear the consumers' voice, and at worst, was dehumanising in the use of restrictive treatments (Anthony, 2000; Trivedi, 2010). Three decades on, the possibility of recovery beyond the devastating effects of mental illness is

now well accepted and in many countries formally acknowledged as an expectation and right within government policy and service guidelines (e.g. American Psychiatric Association and American Association of Community Psychiatrists, 2011; Substance Abuse Mental Health Services Administration, 2011).

While recovery is the lived experience of an individual, it does not occur in a vacuum. Though some advocate that recovery should reflect only the consumers' voice, mental health services are generally acknowledged to be an important component of the system of recovery, alongside the individuals' families, other personal support systems, their chosen community, culture and broader society.

Mental health services can impact negatively or positively on recovery. Organisations may believe in, and even intend to live-out the recovery vision, but it is another matter to actually offer services and programmes that are recovery enhancing. The implementation of recovery-oriented practices at the service-delivery level has proved to be an enduring challenge (Jacobson and Greenley, 2001; Glover, 2005; Uppal *et al.*, 2010; Oh *et al.*, 2013).

A number of factors have been identified as potential barriers to the implementation of recovery-oriented service provision, including difficulty identifying exactly how to best determine whether an organisation is delivering recovery-oriented service (Farkas and Anthony, 2010). Clarifying the principles that are considered to be "key ingredients" of recovery-oriented service provision has received rightful attention from various stakeholders. Key to this pursuit is consensus building and explication of models of care based in the growing evidence base surrounding recovery. Foundational to this process is the establishment of benchmarks and perhaps "bottom lines" of what recovery-oriented service provision is, and is not (Spaniol, 2008). The Substance Abuse and Mental Health Services Administration in the USA identified ten key principles of recovery-oriented service. These were; self-direction, individualised and person-centred, empowerment, holistic, non-linear, peer support, strengths-based, respect, responsibility and hope (Substance Abuse and Mental Health Services Administration, 2005). Other research generated at the service-delivery level (e.g. Spaniol, 2008; Oh *et al.*, 2013) has revealed related principles and concepts centred around involvement, choice, flexibility, sharing of information, education and support, and open dialogue, as central to practitioner provision of recovery-consistent support.

While identification and clarification of core principles and key ingredients is undoubtedly helpful in translating the recovery vision, consensus building is a process that is by nature reductionist, involving the removal of variability. There is a real risk the essence of personal narratives and individual needs at the heart of recovery become taken over and even lost in this process (Trivedi, 2010). Deegan (1996) highlights recovery fundamentally as a journey of a recovering heart when the perspective of the recovering individual is considered. Deegan (1996) emphasises the deeply human nature of recovery as an attitude or approach to living that involves dignity of hope, inevitable and growth-full risk, where through accessible choice, meaning and capacity are grown by an individual who is active, connected and involved. This perspective gives prominence to holism and individuality in recovery. Mental health policy makers and service providers attempt to balance tension between the need to qualify, quantify and structure translatable core principles of what recovery is, while at the same time honouring the essence of recovery as a variable, self-generated individual journey.

Transforming the recovery vision into practice

Over the past ten to 15 years, attention and progress is reported in the area of operationalising what many argue would otherwise remain simply a "recovery vision" (Jacobson and Greenley, 2001; O'Connell *et al.*, 2005; Glover, 2005; McGregor *et al.*, 2014). This progress has been made in terms of policy, system and service guidelines, and models of care that explicate and guide what operationalised recovery should entail. While lack of clarity and consensus continues, a recent comprehensive qualitative analysis by key recovery researchers identified 30 international documents spanning Europe, US and Australasia with common themes and practice domains aimed at operationalising recovery (Le Boutillier *et al.*, 2011).

The Collaborative Recovery Model (CRM) is one example of a conceptual framework that draws together key principles of recovery as defined by the consumer voice, with evidence-based practices that enable the translation of these into routine practice (Oades *et al.*, 2005, 2009). The CRM has been applied within a number of government and community-managed mental health services as a framework for delivering recovery-oriented support in Australia and Canada (Crowe *et al.*, 2006; Oades *et al.*, 2009; Jambrak *et al.*, 2014). Development of frameworks such as the CRM represent advancement in this operationalisation process, however, translation into practice requires formal communication and uptake of the recovery-based model within services working with individuals. Interventions such as staff training and education are relevant to this pursuit.

Training and its limitations as a means to staff development

Training continues to be a prime method of staff development when knowledge and skill enhancement is required within the workplace (Noe, 1986; Burke and Baldwin, 1999; Burke and Hutchins, 2008). This is despite consistent disappointing results related to transfer and maintenance of newly trained knowledge and skills (Burke and Hutchins, 2008; Baldwin *et al.*, 2009). In the recovery field, a follow-up study investigating transfer of CRM in Australia showed about 37 per cent of staff demonstrated evidence of changed practice via work samples obtained after training (Uppal *et al.*, 2010). This rate of transfer aligns with findings offered consistently in transfer of training research (e.g. Noe, 1986; Burke and Baldwin, 1999; Burke and Hutchins, 2008), indicating that explication of models and training are a first-step at best in changing practice.

Extensive research related to training transfer identifies a range of barriers to uptake and maintenance of new knowledge and skills, including organisational climate factors, (Burke and Baldwin, 1999), unsupportive existing attitude within the organisation (Baldwin and Ford, 1988), poor alignment of new skills and approaches with existing workplace practices (Uppal *et al.*, 2010), and employee factors including motivation, skills and competence (Burke and Hutchins, 2007). This can result in a lack of certainty about organisational imperative and commitment for the newly trained practice. Initiatives may be thwarted or undermined by a perceived lack of commitment and support (Burke and Hutchins, 2007). It is therefore important to create ways of demonstrating that key values embedded within the change are important to the organisation. One way organisations achieve this is by establishing a set of service-values.

The role of values in recovery-oriented service provision

The "valuing" of key recovery principles can be seen in the actions of governments that mandate the adoption of a recovery orientation at the public-policy level (Slade, 2010). For example, the federal government of Australia has identified the first of its five priority areas to be "Social Inclusion and Recovery", and has stipulated that mental health providers develop cultures that are founded on and reflective of a recovery orientation (Australian Health Ministers, 2009). Indeed, governments across much of the English speaking world have impressed upon service providers the immediacy of the need to operate in recovery enhancing ways by linking provision of funding for community-based organisation to this objective, and by mandating a recovery focus within publically funded health sites in many countries (Slade *et al.*, 2008; Le Boutillier *et al.*, 2011). The recovery values espoused at this public-policy level are derived from and informed by the jointly determined consumer and evidence-based principles cited previously (SAMHSA, Australian Health Ministers, 2009). These high-level strategies are important as they demonstrate overarching support of the recovery vision, and go some way to creating an opportunity and imperative for systems of mental health that incorporate key recovery principles and values.

While there is obvious merit in these high-level practices, there are significant limitations in the capacity of strategic initiatives to shape ground-level uptake of desired workplace practice. When values are espoused at the organisational level, or perhaps even more broadly at the policy level, the risk is that these become distant, generic statements that are "imposed" on

services and their staff. These values statements are unlikely to be experienced as meaningful in terms of translating the "recovery vision" into practice, in some ways mirroring the distancing and depersonalisation from the recovery journey clearly indicated by service users.

Key recovery proponents further argue the point that it is not enough to simply espouse recovery values (e.g. Farkas *et al.*, 2005). Implementation of recovery-oriented service requires both explication of organisational values and beliefs that mirror core recovery principles, and the embodiment of these at all levels of operation. The notion of embodiment of recovery principles necessitates organisations "walk the talk" in not only the kinds of services offered to individuals, but also the way services are established, run and developed. Values are necessarily linked to visions and directions, and they are also inherent in the day-to-day operations of services according to values-based practice. Importantly, in their depiction of values-based practice, Farkas and her colleagues acknowledge the distinct importance of staff in the challenge of implementing recovery-oriented practices (Farkas *et al.*, 2005; Ramon, 2011; Glover, 2005).

The prominence of individual relationships between service users and the employed personnel supporting their journey has also been highlighted by Trivedi (2010), who notes the core role of staff as the enactors of recovery-consistent practice from a service-user's perspective. While high-level adherence to frameworks of service and espousal of recovery-consistent values set an organisational imperative, it is staff members at the coalface of service delivery who are arguably the ultimate gatekeepers of recovery operationalisation. Although services, organisations and governments are definable entities in an operational and legal sense, they are ultimately derived from the interactions and relationships of the people within them (Stacy, 2005).

Individuals in recovery have identified the quality of their interactions to be the most crucial factor in supporting their recovery journeys (Deegan, 1990; Kramer and Gagne, 1997). For example, service-user consultation following staff training in the CRM also reflected the central importance of individual interactions and relationships. Service users who were working with staff trained in the CRM rated relationship qualities such as encouragement to take responsibility, collaboration and assistance in completing personal goals more highly than service users whose recovery worker had not attended training (Marshall *et al.*, 2007). Interestingly, these service-user ratings occurred despite no discernible change in recovery-consistent activity when managers of trained staff provided feedback (Marshall *et al.*, 2007). These findings indicate that relational changes may be evident to service users even prior to detectable changes in practice, further reinforcing the centrality of person to person relationships in recovery operationalisation. With staff members being so central to recovery operationalisation, the issue of mental health worker motivation for transfer of newly trained recovery knowledge, skills and practice emerges as a critical factor.

Enhancing employee motivation for enhanced recovery-consistent practice

Cross-disciplinary research related to transfer and uptake of newly trained practices acknowledges employee factors such as staff motivation and buy in to the change are often overlooked (e.g. Locke, 1986; Noe, 1986). When attempting to bring about increased recovery orientation in a workplace, in essence services are inviting individual staff into a process of behaviour change. Motivation emerges as an important factor in determining whether an individual will or will not enact the desired change. There is an extensive body of research related to the role of "autonomy" – a sense that one's actions are self-determined and aligned with personal values and beliefs – as a human need and driver of purposeful behaviour. Within Self-Determination Theory (SDT; Ryan and Deci, 2000), it is well established that people are both more highly motivated, and more successful in their strivings, when they feel autonomously motivated towards them (Sheldon and Elliot, 1999; Elliot and Sheldon, 1998; Deci *et al.*, 1999; Sheldon and Houser-Marko, 2001; Koestner *et al.*, 2008). Behaviour experienced by the individual as personally meaningful and self-determined is integrated with the individual's values and sense of self, according to SDT. Autonomously motivated acts are more likely to be experienced as valued and self-chosen, resulting in greater purposeful action (Deci and Ryan, 2000).

Conversely, extensive SDT research indicates external motivators (such as managerial action, pressure and negative evaluation or judgment) can have an adverse impact an individual's motivation for change and purposeful action, particularly in the longer term (Sheldon and Elliot, 1999; Sheldon and Houser-Marko, 2001; Koestner *et al.*, 2008). Behaviour that is externally motivated is not integrated fully with the individual's sense of values, and is experienced as controlled and imposed, according to SDT. In a meta-analysis of eleven studies investigating the impact of motivation on progress towards specified goals, Koestner *et al.* (2008) found that only autonomous motivation had an overall effect on goal progress, and that attempts to change the controlled motivators had little effect on outcome or purposeful striving. Even so-called positive external motivators for behaviour, such as rewards and bonuses, have shown mixed and sometimes counter-beneficial impacts, particularly in socially restricted contexts, such as the workplace (Joussemet *et al.*, 2004; Koestner *et al.*, 2008; Reeve, 1998).

These findings have considerable relevance to the current challenge of promoting recovery-consistent practices within mental health services. In order to increase the likelihood of individual staff members choosing to behave in recovery-enhancing ways in their interactions with individuals, the extent to which they experience the specific work practice as autonomous is likely to be important. In other words, SDT suggests that increased adherence to core recovery principles will occur when staff experience the desired work practice to be integrated with their sense of values, and "what matters" to them as a person.

While the research highlighting the importance of autonomous motivation is considerable, it has focused primarily on the strivings of individuals in their personal life, where the desired behavioural change is not mandated as part of their job requirements (Gagné and Deci, 2005). A paradox emerges as we consider goals towards desired behaviours within a workplace setting, where the extent to which specific goals are experienced as "self determined" by the staff in question is likely to be less. According to SDT, recovery-consistent values that are experienced as more self-determined and autonomous are more likely to be put into practice. The challenge that emerges is how do employers create opportunities for staff to experience key recovery principles as "personally meaningful" or integrated with their own sense of values when the change has been externally imposed. Additionally, individual staff may feel connected and committed to the principles and practices within the recovery-training programme, but perceive a clash with the dominant beliefs and priorities within the organisation (Uppal *et al.*, 2010). The purposeful support of staff autonomy for change complements and extends considerable research establishing the importance of beliefs and attitudes of staff in promoting recovery-oriented service delivery (O'Connell *et al.*, 2005; Crowe *et al.*, 2006).

Purposeful focus on values as a way of increasing autonomy and buy-in of mental health recovery workers appears particularly relevant as previous research related to job selection has indicated those in helping professions tend to be drawn to the work for values-based reasons (e.g. Thorpe and Loo, 2003; Lyons *et al.*, 2006). Specifically, altruism, benevolence and a call to support others have been highlighted as key within helping professions (Thorpe and Loo, 2003), which appear to align with the core principles identified as underpinnings of recovery (McGregor *et al.*, 2014; Le Boutillier *et al.*, 2011; Ramon, 2011). There is also evidence to suggest that individuals in helping professions can lose sight of these core values over time (Taylor and Bentley, 2008), and experience stress, distress and burnout from the demands of supporting others in need (Russinova *et al.*, 2011). In addition to the risks and costs for individual staff, these cumulative demands may result in decreased ability for mental health workers to adopt hopeful and empowering approaches with clients that are acknowledged as central to recovery (Russinova *et al.*, 2011). Key relationship competencies and attributes identified as critical by service users as outlined above would also seem to depend largely on staff being hopeful, enthusiastic and connected to their work (Russinova *et al.*, 2011).

In addition to training in an evidence-based, consumer-informed model of recovery-oriented practice, providing a brief, structured opportunity for mental health workers to identify, connect and possibly re-align with personally held values is proposed as a means of fostering autonomous motivation for change. Previous research related to SDT indicates that autonomous motivation is predictive of increased implementation planning, purposeful striving and personal

well-being (e.g. Koestner *et al.*, 2008; Sheldon and Elliot, 1999). In line with this previous research, it is anticipated that structured, purposeful values-focused intervention for staff will have positive impacts on planned and actual recovery operationalisation over and above traditional methods of education and training.

Summary and proposed processes in values-based recovery enhancement

Values play a critical role in determining an imperative for recovery-oriented service provision at a strategic level, assisting systems, organisations and services in determining what recovery is, and is not (Farkas *et al.*, 2005). In this sense, values at the core of consensus-based recovery statements and guidelines become anchors, upon which frameworks and models of practice that seek to operationalise recovery have been built (Le Boutillier *et al.*, 2011; Slade *et al.*, 2008; Oades *et al.*, 2005). These top-down interventions are an important part of the current approach to enhancing recovery-oriented service delivery, though may have limited utility in directly influencing the iterative interactions of frontline recovery staff, whose day-to-day relational experiences are commonly endorsed as the most critical element of the recovery journey by service users (Deegan, 1996; Kramer and Gagne, 1997; McGregor *et al.*, 2014). Here, SDT has been identified as a theory of motivation that highlights the importance of staff autonomy for a change in recovery-oriented practice, emphasising that autonomy is experienced by individuals when their actions feel connected to personally held values (Deci *et al.*, 1999; Koestner *et al.*, 2008). Trivedi (2010) notes that day-to-day "functionalisation" of recovery is most likely to occur in those organisations that enable staff to live out their personally held recovery values in what would be a shift in power-relations away from the dominant process of following organisational norms. By enabling staff to work out how to express personally important recovery values amongst the competing organisational imperatives, Trivedi (2010) argues that opportunity for recovery operationalisation as a bottom-up, individual-to-individual process of change also exists.

A number of proposed means by which staff-level values intervention may lead to increased uptake of a newly trained set of recovery practices have been outlined. All of these emphasise the centrality of staff service-user relational interactions in the operationalisation of recovery. These various hypothesised processes of change are highlighted, as follows:

1. increased sense of autonomy for the otherwise imposed change resulting in increased motivation to implement within individual staff flowing on to increased uptake of recovery-oriented service delivery;

2. connection and re-alignment of a "new" work practice with personally held values for recovery work, in addition to formalised opportunity to commit to and live-out personally rewarding recovery-consistent values in work;

3. increased acknowledgement of centrality of individual relationships as the arena for recovery operationalisation, and purposeful shift of power from valuing at an organisational level to values-enactment by individual staff in day-to-day interactions with service users; and

4. mental health recovery workers gaining personal experience of working with values and having their own individual experiences and needs acknowledged and worked with, which provides opportunity for experiential learning of the desired parallel process the staff are being encouraged to undertake with service users.

The potential of experiential learning and use of parallel processes as a means to enhancing recovery-oriented service delivery (outlined in four above) has not been detailed thus far in the current discussion. For a full discussion of the relevance and utility of parallel processes as a method of mental health recovery worker development refer to Crowe *et al.*, 2011. Being involved in an experience that parallels that in which an individual is expected to later perform or guide another has been highlighted as a key method of learning (e.g. Kolb, 1984) and is a process that is acknowledged as a means to teaching otherwise difficult to teach relational skills and attributes in counselling and other supportive work (Miller, 2004; Crowe *et al.*, 2011). It is anticipated that these processes will also be relevant to the mental health recovery workers who will experience first-hand a values-focused, person-centred intervention for desired behaviour change, which aligns with many of the key features of recovery desired by service users. Furthermore, applied,

first person experience of working from specific tools and approaches comprised within the CRM will enable mental health staff to capitalise on developmental learning opportunities acknowledged within the experiential learning cycle (Kolb, 1984).

Current plans for research

Application of staff-focused values intervention will take place across five non-government organisations across 22 sites in the Australian states of New South Wales, Queensland and Victoria involved in the provision of community-based support services to individuals in recovery. Full protocol of this research can be accessed at Williams *et al.* (2013). Mental health recovery workers will be randomised into either a "values" or "implementation" condition to explore the relative utility of each approach to enhancing recovery-oriented service delivery. The staff in the values condition will be invited to participate in two forms of values-focused intervention: first, values-clarification process focusing on personal values and work values; second, values-focused coaching in the form of monthly coaching sessions targeting their values for 12 months (maximum of 12 sessions in 12 months). The findings related to implementation and staff autonomous motivation for recovery-consistent practices within community-based mental health services in this study will be reported as they become evident.

Conclusion

While organisational factors are important, the day-to-day interactions of staff and individuals they seek to support are arguably most crucial to determining whether the recovery journey of the individual is enhanced or stifled. We have identified here that values can and do play a critical role in establishing organisational and systemic environs that are facilitative of recovery-oriented service. The potential applicability of values-focused interventions that fully capitalise on the central role of staff-service user relationships have remained relatively unexplored, both as a specific approach in organisations, and within the literature on promoting recovery-consistency within services. This paper has explored the various roles that values currently have in organisational practice to enhance the extent to which individuals are supported in their recovery journeys, proposing a specific, structured values-based intervention for staff as an additional means to capitalising on bottom-up processes of change that have been emphasised as key by service users. It is anticipated that research investigating the impact of values-focused interventions for mental health recovery may impact positively on operationalisation of the recovery vision by empowering capacity for core recovery values to be enacted in the day-to-day interactions between service users and their key supports. Furthermore, the approach and methods will be structured and reproducible, thereby presenting opportunity for application broadly in the mental health recovery field, and in other organisational contexts where increasing training transfer and uptake is a focus.

References

American Psychiatric Association and American Association of Community Psychiatrists (2011), "Psychiatry and recovery oriented practice: a situational analysis", available at: www.psychiatry.org/practice/professional-interests/recovery-oriented-care (accessed 10 August 2015).

Anthony, W.A. (2000), "A recovery-oriented service system: setting some system level standards", *Psychiatric Rehabilitation Journal*, Vol. 24 No. 2, p. 159.

Australian Health Ministers (2009), *Fourth National Mental Health Plan – An Agenda for Collaborative Government Action in Mental Health 2009-2014*, Australian Government, Canberra.

Baldwin, T.T. and Ford, J.K. (1988), "Transfer of training: a review and directions for future research", *Personnel Psychology*, Vol. 41 No. 1, pp. 63-105.

Baldwin, T.T., Ford, J.K. and Blume, B.D. (2009), "Transfer of training 1988-2008: an updated review and agenda for future research", *International Review of Industrial and Organizational Psychology*, Vol. 24, pp. 41-70.

Burke, L.A. and Baldwin, T.T. (1999), "Workforce training transfer: a study of the effect of relapse prevention training and transfer climate", *Human Resource Management*, Vol. 38 No. 3, pp. 227-41.

Burke, L.A. and Hutchins, H.M. (2007), "Training transfer: an integrative literature review", *Human Resource Development Review*, Vol. 6 No. 3, pp. 263-96.

Burke, L.A. and Hutchins, H.M. (2008), "A study of best practices in training transfer and proposed model of transfer", *Human Resource Development Quarterly*, Vol. 19 No. 2, pp. 107-28.

Crowe, T.P., Deane, F.P., Oades, L.G., Caputi, P. and Morland, K.G. (2006), "Effectiveness of a collaborative recovery training program in Australia in promoting positive views about recovery", *Psychiatric Services*, Vol. 57 No. 10, pp. 1-5.

Crowe, T.P., Oades, L.O., Deane, F.P., Ciarrochi, J. and Williams, V. (2011), "Parallel processes in clinical supervision: implications for coaching mental health practitioners", *International Journal of Evidence Based Coaching and Mentoring*, Vol. 9 No. 2, pp. 56-66.

Deci, E.L. and Ryan, R.M. (2000), "A The 'what' and 'why' of goal pursuits: human needs and the self-determination of behavior", *Psychological Inquiry*, Vol. 11 No. 4, pp. 227-68.

Deci, E.L., Koestner, R. and Ryan, R.M. (1999), "A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation", *Psychological Bulletin*, Vol. 125 No. 6, pp. 627-68.

Deegan, P. (1996), "Recovery as a journey of the heart", *Psychiatric Rehabilitation Journal*, Vol. 19 No. 3, p. 91.

Deegan, P.E. (1990), "Spirit breaking: when the helping professions hurt", *Humanistic Psychologist*, Vol. 18 No. 3, pp. 301-13.

Elliot, A.J. and Sheldon, K.M. (1998), "Avoidance personal goals ands the personality-illness relationship", *Journal of Personality and Social Psychology*, Vol. 75 No. 5, p. 1282.

Farkas, M. and Anthony, W.A. (2010), "Psychiatric rehabilitation interventions: a review", *International Review of Psychiatry*, Vol. 22 No. 2, pp. 114-29.

Farkas, M., Gagne, C., Anthony, W. and Chamberlain, J. (2005), "Implementing recovery oriented evidence based programs: identifying the critical dimensions", *Community Mental Health Journal*, Vol. 41 No. 2, pp. 141-57.

Gagné, M. and Deci, E.L. (2005), "Self-determination theory and work motivation", *Journal of Organizational Behavior*, Vol. 26 No. 4, pp. 331-62.

Glover, H. (2005), "Recovery based service delivery: are we ready to transform the words into a paradigm shift?", *Australian E-Journal for the Advancement of Mental Health*, Vol. 4 No. 3, pp. 1-3.

Jacobson, N. and Greenley, D. (2001), "A conceptual model and explication", *Psychiatric Services*, Vol. 52 No. 4, pp. 482-85.

Jambrak, J., Deane, F.P. and Williams, V. (2014), "Value motivations predict burnout and intentions to leave among mental health professionals", *Journal of Mental Health*, Vol. 23 No. 3, pp. 120-4.

Joussemet, M., Koestner, R., Lekes, N. and Houlfort, N. (2004), "Introducing uninteresting tasks to children: a comparison of the effects of rewards and autonomy support", *Journal of Personality*, Vol. 72 No. 1, pp. 139-66.

Koestner, R., Otis, N., Power, T.A., Pelletier, L. and Gagnon, H. (2008), "Autonomous motivation, controlled motivation, and goal progress", *Journal of Personality*, Vol. 76 No. 5, pp. 1201-30.

Kolb, D.A. (1984), *Experiential Learning: Experience as the Source of Learning and Development*, Prentice Hall, Englewood Cliffs, NJ.

Kramer, P.J. and Gagne, C.A. (1997), "Barriers to recovery and empowerment for people with psychiatric disabilities", in Spaniol, L., Gagne, C. and Koehler, M. (Eds), *The Psychological and Social Aspects of Psychiatric Disability*, Center for Psychiatric Rehabilitation, Boston University, Boston, MA, pp. 467-76.

Le Boutillier, C., Leamy, M., Bird, V.J., Davidson, L., Williams, J. and Slade, M. (2011), "What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance", *Psychiatric Services*, Vol. 62 No. 12, pp. 1470-6.

Locke, E.A. (1986), *Generalizing from Laboratory to Field Settings: Research Findings from Industrial-Organizational Psychology, Organizational Behavior, and Human Resource Management*, Free Press.

Lyons, S.T., Duxbury, L.E. and Higgins, C.A. (2006), "A comparison of the values and commitment of private sector, public sector, and parapublic sector employees", *Public Administration Review*, Vol. 66 No. 4, pp. 605-18.

McGregor, J., Repper, J. and Brown, H. (2014), "The college is so different from anything I have done. A study of the characteristics of Nottingham recovery college", *The Journal of Mental Health Training, Education and Practice*, Vol. 9 No. 1, pp. 3-15.

Marshall, S., Oades, L.G., Crowe, T.P., Deane, F.P. and Kavanagh, D.J. (2007), "A review of consumer involvement in case management: consistency with a recovery paradigm", *Psychiatric Services*, Vol. 58 No. 3, pp. 396-401.

Miller, S. (2004), "'What's going on? Parallel process and reflective practice in teaching", *Reflective Practice*, Vol. 5 No. 3, pp. 383-93.

Noe, R.A. (1986), "Trainees' attributes and attitudes: neglected influences on training effectiveness", *The Academy of Management Review*, Vol. 11 No. 4, pp. 736-49.

Oades, L., Deane, F., Crowe, T., Lambert, W.G., Kavanagh, D. and Lloyd, C. (2005), "Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness", *Psychiatric Services*, Vol. 13 No. 3, pp. 279-84.

Oades, L.G., Crowe, T.P. and Nguyen, M. (2009), "Leadership coaching transforming mental health systems from the inside out: the collaborative recovery model as person-centred strengths based coaching psychology", *International Coaching Psychology Review*, Vol. 4 No. 1, pp. 64-75.

O'Connell, M., Tondora, J., Croog, G., Evans, A. and Davidson, L. (2005), "From rhetoric to routine: assessing perceptions of recovery-oriented practices in a state mental health and addiction system", *Psychiatric Rehabilitation Journal*, Vol. 28 No. 4, pp. 378-86.

Oh, H., Noorsdy, D. and Robert, G. (2013), "Eight steps toward recovery oriented psychiatry education", *The Journal of Mental Health Training, Education and Practice*, Vol. 8 No. 3, pp. 126-33.

Ramon, S. (2011), "Organisational change in the context of recovery-oriented services", *The Journal of Mental Health Training, Education and Practice*, Vol. 6 No. 1, pp. 38-46.

Reeve, J. (1998), "Autonomy support as an interpersonal motivating style: is it teachable?", *Contemporary Educational Psychology*, Vol. 23 No. 3, pp. 312-30.

Russinova, Z., Rogers, E.S., Ellison, M.L. and Lyass, A. (2011), "Recovery-promoting professional competencies: perspectives of mental health consumers, consumer-providers and providers", *Psychiatric Rehabilitation Journal*, Vol. 34 No. 3, p. 177.

Ryan, R.M. and Deci, E.L. (2000), "Self-determination theory and the facilitation of intrinsic motivation, social development and well-being", *American Psychologist*, Vol. 55 No. 1, p. 68.

Sheldon, K.M. and Elliot, A.J. (1999), "Goal striving, need satisfaction, and longitudinal well-being: the self-concordance model", *Journal of Personality and Social Psychology*, Vol. 76 No. 3, p. 482.

Sheldon, K.M. and Houser-Marko, L. (2001), "Self-concordance, goal attainment, and the pursuit of happiness: can there be an upward spiral?", *Journal of Personality and Social Psychology*, Vol. 80 No. 1, pp. 152-65.

Slade, M. (2010), "Mental illness and wellbeing: the central importance of positive psychology and recovery approaches", *BMC Health Services Research*, Vol. 10 No. 1, p. 26.

Slade, M., Amering, M. and Oades, L.G. (2008), "Recovery: an international perspective", *Epidemiologia e Psiachiatria Sociale*, Vol. 17 No. 2, pp. 128-37.

Spaniol, L. (2008), "What would a recovery-oriented program look like?", *International Journal of Psychosocial Rehabilitation*, Vol. 13 No. 1, pp. 57-66.

Stacy, R. (2005), "Organisational identity: the paradox of continuity and potential transformation at the same time", *Group Analysis*, Vol. 38 No. 4, pp. 477-98.

Substance Abuse and Mental Health Services Administration (2005), *National Consensus Conference on Mental Health Recovery and Systems Transformation*, Department of Health and Human Services, Rockville, MD.

Substance Abuse Mental Health Services Administration (2011), "Frequently asked questions about recovery and recovery-oriented practice", available at: www.psychiatry.org/practice/professional-interests/recovery-oriented care (accessed 8 August 2015).

Taylor, M.F. and Bentley, K.J. (2005), "Professional dissonance: colliding values and job tasks in mental health practice", *Community Mental Health Journal*, Vol. 41 No. 4, pp. 469-80.

Thorpe, K. and Loo, R. (2003), "The values profile of nursing undergraduate students: implications for education and professional development", *Journal of Nursing Education*, Vol. 42 No. 2, pp. 83-90.

Trivedi, P. (2010), "A recovery approach in mental health services: transformation, tokenism or tyranny?", in Basset, T. and Stickley, T. (Eds), *Voices of Experience: Narratives of Mental Health Survivors*, John Wiley and Sons, pp. 152-64.

Uppal, S., Oades, L.G., Crowe, T.P. and Deane, F.P. (2010), "Barriers to the transfer of collaborative recovery training into into Australian mental health services: implications for the development of evidence-based services", *Journal of Evaluation in Clinical Practice*, Vol. 16 No. 3, pp. 451-5.

Williams, V., Oades, L.G., Deane, F.P., Crowe, T.P., Ciarrochi, J. and Andresen, R. (2013), "Improving implementation of evidence-based practice in mental health service delivery: protocol for a cluster-randomised quasi-experimental investigation of staff-focused values interventions", *Implementation Science*, Vol. 8, p. 75.

Further reading

Locke, E.A. (1976), "The motivation sequence, the motivation hub and the motivation core", *Organisational Behavior and Human Decision Processes*, Vol. 50, pp. 288-99.

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