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RESEARCH AND EVALUATION

Mental health recovery competencies for mental health workers: A Delphi study

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Abstract
Background: Mental health recovery is a concept that is now widely promoted. Lengthy sets of competency statements have been published to assist mental health workers become more recovery orientated in their work. However, there continues to be a lack of clarity around what constitutes recovery focused practice or which competencies are most helpful to assist people towards recovery.
Aims: To identify the most important or valued mental health worker competencies/practices that are supportive of mental health recovery.
Method: Experts by experience participated in an online Delphi survey to rate the importance of recovery competency statements, to reach consensus on the most important competencies and provide examples of specific practices that demonstrate competent practice.
Results: The top rated competencies emphasized mental health workers listening to and respecting the person's view points, conveying a belief that recovery is possible and recognizing, respecting and promoting the person's resources and capacity for recovery.
Conclusions: These results serve to clarify some boundaries around recovery-focused practices and demark these from other examples of good mental health practice.

Keywords: *Recovery*, *Delphi study*

Introduction

''Mental health recovery'' is now central to the mental health policies of most western countries. However, there is semantic confusion about what ''recovery'' means in the different contexts in which it is used (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). In some policy and discussion documents recovery is varyingly described as a model, an orientation, a process, an outlook, a vision, philosophy and a guiding principle (See: Irish Mental Health Commission, 2005). The development of recovery competencies for the mental health workforce has been proposed as one solution to promote debate about implementation of recovery-focused care (Berzins, 2005) and has been part of an effective strategy to stimulate rapid change towards more recovery orientated services (NZ Mental Health Commission, 2001, 2007). This paper commences with a brief and selective survey of recovery-focused literature, clarifying the origins and meaning of the term and then

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outlines the development to date of recovery competencies for mental health workers. Some of these competencies were included in a Delphi survey in which experts rated the importance of competencies in their own recovery. A brief account of the respondents' views of recovery is provided and then those competencies rated as most important are discussed and illustrated with examples of recovery-focused practice.

Background

The meaning of recovery

Mental health recovery is a concept that has been championed by mental health service users or survivors and has emerged as part of a discourse which counters the dominant bio-medical discourse of chronic, enduring mental illness, through stories of clinical recovery (the absence of overt symptoms of disease), as well as transformation and transcendence despite disease and sometimes perceptions of oppressive treatment. Anthony (1993) at the beginning of the so called ''decade of the brain'' proposed that people with spinal injuries could recover without necessarily healing the spine so too could people recover whilst still having psychiatric symptoms. The appropriation of the term ''recovery'' was in part a political gesture but it was also influenced by the self-help movement, Alcoholics Anonymous (AA) in which people identify as being ''in recovery'' (O'Hagan, 2004), accept they have a problem and struggle to maintain abstinence irrespective of the presence or absence of overt symptoms or impaired functioning. In common with the conception of recovery in AA, early attempts at integrating mental health recovery with mental health care emphasized personal insight or acceptance of mental illness as pivotal to successful recovery (see: Ohio Department of Mental Health, 1999).

The need to accept one's experience as a symptom of illness or disorder has long been contested in the mental health field (see Szasz, 1961) and in relation to mental health recovery (see Barker & Buchanan-Barker, 2008). Nevertheless, there is an intersection between clinical notions of recovery and mental health recovery. For example, proponents of mental health recovery point out that most people diagnosed with schizophrenia achieve clinical recovery (reduction or amelioration of ''symptoms''), or social recovery (improvements in occupational and social functioning) or both (Drake et al., 2006; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Kruger, 2000). Resnick, Rosenheck, and Lehman, (2004) attempted to examine client and service user factors associated with dimensions of recovery and found that there appeared to be a strong relationship between low severity of depressive symptoms and a recovery orientation. However, recovery-orientated care entails more than what might be considered good ''clinical'' or symptom focused care. Many people have argued that the iatrogenic effects of routine psychiatric care and treatment are impediments to mental health recovery (Coleman, 1999; Mancini, Hardiman, & Lawson, 2005; Read, Mosher, & Bentall, 2004). Indeed some have argued that routine practices such as standardization of services (Lakeman, 2004), involuntary treatment (Henwood, 2008) and seclusion and restraint (Ashcraft & Anthony, 2008) may be incompatible with ideas of mental health recovery. Others (Oades et al., 2005) have attempted to identify particular ''evidence-based'' practices that are congruent with a mental health recovery ethos or orientation.

Deegan (2001) described mental health recovery as a *self directed process* (emphasis added) of healing and transformation. This is in contrast to some mainstream mental health services in which the process of care is directed by professionals and symptoms are seen as essentially meaningless. Mental health recovery is employed in a number of discourses and social

movements (e.g., the Hearing Voices Network) which have reinvigorated old ideas that ''symptoms'' may have inherent meaning, and which emphasize acceptance of some experiences by both individuals and the wider social group. Whilst, mental health recovery might largely be a personal process it is also, at least in part, a social process. Onken, Craig, Ridgway, Ralph, and Cook (2007) suggest that there is an emerging consensus that this healing and transformation can be promoted or hindered through an interaction between individual factors (e.g., hope), characteristics of the environment (e.g., opportunities) and an exchange between the individual and the environment (e.g., choices). The factors (individual, environmental and interactive) described as being associated with recovery are fairly consistent e.g., living well, finding or maintaining hope, optimism and meaning, taking personal responsibility or maintaining ones autonomy, engaging in meaningful activities, enjoying supportive relationships, having access to a range of services and participating fully in the community (Andresen, Oades, & Caputi, 2003; Jacobson & Greenley, 2001; Mancini et al., 2005; Resnick et al., 2004). These factors imply in one sense ''ordinary living'' but also the possibility to grow, develop and even thrive. They suggest a ''salutogenic'' (Antonovsky, 1996) or ''trephotaxic'' (Barker, 1989) orientation to mental health service delivery that is a concern with promoting the conditions necessary for healing, growth, development and the promotion of positive mental health.

Mental health competencies

One tool to assist in training mental health workers in recovery focused practice and to demarcate particular practices as recovery focused is to identify recovery competencies. Competencies are general descriptions of abilities needed to perform a job or role well. A competency ''involves the ability to meet complex demands, by drawing on and mobilising psychosocial resources (including skills and attitudes) in a particular context'' (Rychen & Salganik, 2001). As Schinkel and Dorrer (2006) note professional competency sets tend to specify clinical knowledge and skills whereas recovery competency sets tend to emphasis values, attitudes and philosophy. The articulation of knowledge, skills and attitudes relating to the performance of roles or tasks can be helpful to inform curricula and training, serve as a source of reflection for self-development, and as a statement regarding the kind of service and relationships that people can expect. Berzins (2005) suggests that the development of competency frameworks can launch debate and dialogue in services and stimulate movement towards more recovery-orientated services.

Several recovery frameworks have been developed that might be considered ''grand'' or whole of workforce competency sets in New Zealand (NZ Mental Health Commission, 2001), Ohio (Ohio Department of Mental Health, 1999) and more recently Scotland (NHS Education for Scotland and Scottish Recovery Network, 2007). To date there has been little critical commentary about the applicability, portability or universality of these competency sets. Additionally middle range competency sets tied to specific recovery-orientated programmes have been developed in Australia (Oades et al., 2005), for particular classes of workers such as the Support Time and Recovery Worker in England (Chadwick, James, & Rigg, 2007), and related to the Tidal Model (Barker & Buchanan-Barker, 2008) .

There is considerable overlap amongst many competency indicators. Many are highly generic and similar to discipline specific practice standards or the United Kingdoms, National Health Services' ''Ten Essential Capabilities'' (Brabban, McGonagle, & Brooker, 2006) e.g., ''Working in partnership ... promoting recovery ... identifying people's needs and strengths ...'' etc. This congruency with wider policy or general notions of ''good practice'' is reassuring. However, the lack of specificity or concrete indicators mean that

there is a dissonance between the rhetoric of policy and what is delivered in practice. Mental health recovery practice becomes associated with all things good (thus reinforcing an unhelpful dichotomy between recovery-focused practice and other necessary practices). Most competency frameworks lack specific indicators or examples of practice that might usefully guide training or reflection in or on practice. Early in the adoption of recovery-orientated practices concrete examples of a competency being realised in practice might greatly assist people move from rhetoric of recovery to tangible improvements in practice.

Aim

This project aimed to:

(1) Identify a mental health recovery worker competency set through consensus by people with first hand personal experience of recovery;
(2) Develop brief exemplars/narrative illustrations of recovery competencies in action.

Methods

An on-line Delphi study was used to reach consensus between a panel of ''experts by experience'' on mental health worker competencies. Linstone and Turoff (1975, p. 3) described the Delphi as ''... a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem''. These authors suggest that a major application of Delphi is to gather expert opinions among a nationwide ''advice community''.

The Delphi technique involves an iterative process in which respondents anonymously provide responses to questions or items in an attempt to reach group consensus. The group may initially generate a list of items, reflect on an item list provided by the researcher, or a mixture of both. This method is ideally suited for using electronic forms or e-mail to gauge responses. The Delphi technique has been used to develop performance or clinical indicators (Nieuwenhuijsen, Verbeek, de Boer, Blonk, & van Dijk, 2005; O'Brien, Boddy, Hardy, & O'Brien, 2004), statements regarding priorities (Downie, Henderson, Juliff, Munns, & Wichmann, 2006) and consensus statements on best practice in mental health (Baker, Lovell, Harris, & Campbell, 2007; Hopkins & Niemiec, 2007). The Delphi methodology is a useful method for generating consensus around priority competency statements and indicators.

Recruitment/sample

After obtaining institutional ethics approval, an expert panel in mental health recovery was recruited using a ''snowballing'' method whereby members of the Irish Institute for Mental Health Recovery were asked to invite people whom they knew with ''expertise by experience'' in recovery to visit the project web site. The web site provided detailed information about the project including discussion documents, researcher and ethics committee contacts and information about what participation entailed. Those people who choose to participate completed an on-line registration and consent form which gathered some basic demographic information and concluded with participants choosing a login name and password to access the site in future. On completing registration participants were invited to recommend participation to others. This gave rise to a panel who-self identified as

being in or having achieved mental health recovery and who were identified by peers as having expertise in recovery or having recovered well.

The web portal

A secure web portal was developed by the researcher (written as active server pagers). Participants were notified by e-mail when competencies were ready to be rated. When they logged on they were notified of the stage of the project, invited to provide a personal definition of recovery and to rate competencies. Participant details, competencies and ratings were stored in a secure Microsoft access database. Descriptive statistics were generated via web based scripts. Textual data (comments or examples of recovery practices) was imported directly into QSR Nvivo 8 for latter content analysis. The aim of this analysis was to reduce the text to a parsimonious but complete representation of the main themes in the text, particularly in order to provide an outline of the respondents' views of recovery.

The competencies/instrument

One hundred and three competency statements all purportedly related to mental health recovery formed the competency set. These included six statements from Oades et al. (2005), 10 statements from the New Zealand Mental Health Commission (2001), 20 statements from Barker and Buchanan-Barker (2008) and the remainder from NHS Education for Scotland and Scottish Recovery Network (2007) (25 statements relating to knowledge, 22 to skills, and 20 to values). Competency statements were presented with a stem e.g., ''A competent mental health worker . . .'' or ''To work in a recovery focused way mental health workers need to . . .'' but otherwise un-amended form their published form. A likert scale was used to rate the importance of each competency from not important (1) to very important (7).

Data collection

There were two rating rounds. In the first round participants were presented with competency statements in a random sequence, invited to rate them and to offer a comment or rationale for their rating. Participants were able to log out and return at a later time to finish the rating process. In the second round participants were presented with the competencies in mean rank order (calculated from the first round ratings) and invited to change their ratings if they wished and to offer an example to illustrate the competency. Further rating rounds were not undertaken as there was a strong level of agreement (near consensus) on the top rated items.

Results

The respondents

Thirty one people formed the expert panel comprised of 13 males and 18 females. Nine people came from Ireland, 7 from Scotland, 9 from other parts of the United Kingdom, one each from New Zealand and Germany, and two each from Australia and the United States. Twenty three reported living in an urban setting and eight in rural regions. Three respondents identified as having attained no post secondary school qualifications. The

majority ($n = 19$) had attained a higher degree, e.g., bachelors ($n = 4$), honors ($n = 4$), post graduate diploma ($n = 5$), masters ($n = 4$) or doctoral degree ($n = 2$) with the remainder having attained certificates or diplomas. Most people reported being diagnosed with a mental illness including schizophrenia or schizoaffective disorder ($n = 9$), bipolar affective disorder ($n = 4$), depression ($n = 7$), puerperal psychosis ($n = 2$), and post traumatic stress disorder ($n = 1$). Twelve people had never been hospitalized. Of the remainder, seven people had been hospitalized more than ten times and people had spent between 3 weeks and 13 years in hospital. Of those who spent less than 10 years in hospital ($n = 17$) the mean length of hospitalization was 24 weeks.

Respondents were asked to describe the main people who had supported them in their recovery. Family were cited most frequently (21 occasions including spouse/partners = 6, parents = 2, and siblings = 3), followed by mental health professionals (19 occasions including psychiatrists = 5, nurses = 4, general practitioners = 3 and social workers = 2). Friends were cited as supportive of recovery by 12 people, peers and other service users by 9 and groups/organizations, e.g., GROW by 3 people.

The meaning of mental health recovery

Respondents proffered their own definitions of mental health recovery. The most dominant themes embodied in these definitions were transcending the need for psychiatric services, living with one-self and finding personal meaning:

> Recovery is the process of getting off medication and unlearning the psychiatric interpretation imposed on oneself. It is about understanding the reasons for and the mechanisms of breakdown and finding the meaning in it.

Several respondents stated that not taking or being reliant on medications (some also mentioned illicit drugs) was important to their recovery. Others suggested that developing tools to manage mental health and to resist being engulfed by discourses of mental illness or stigma that positioned them as ''... helpless, deficient, hopeless or chronic''. Living with oneself and deriving satisfaction from life, relationships and activities was described by most:

> For me recovery is about discovering who I truly am and want to be. To feel happy in my own skin and, despite having changes in mood and thoughts occasionally, having the strength to remember and return to a norm I choose and a life I want to live.

For many living well was framed in ordinary terms with people stating e.g. ''... having more good days than bad days ... living at home ... socialising and feeling hopeful some or even most of the time''. Most respondents spoke of recovery involving some form of personal discovery, ongoing learning and/or finding meaning and worth in everyday activities, e.g., ''Finding meaning, purpose and a sense of belonging''. For some having choices, being ''self-determining'' or taking control of one's life was crucial. Others spoke of recovery in terms of reclaiming something that had been diminished or lost through their experience of distress, e.g., hope, humour, joy, enthusiasm, stability, strength or balance:

> Personally it means getting back to being 'me' with a sense of humour, reflective capacity, making decisions, an ability to say 'no', in control and requiring no medication or support from services, and overall enjoying life.

Scoring the recovery competencies

Table I outlines the competency statements in rank order according to their mean rating from the second round (top ten). There was substantial agreement between round one and two ratings ($r = 0.98$) and near consensus around those statements that were rated most important (consequently additional rating rounds were not undertaken). The mean average ratings in round two ($M = 6.15$) were slightly less than in round one (Mean difference was -0.06). Individuals were positive in their ratings (range of Mean individual ratings = 4.88–6.95). All competencies received at least one rating of 7 (i.e., extremely important). The 18 top ten ranked competencies all received a mean rating of 6.6 or above and a high level of agreement (Mean standard deviation = 0.6). In contrast there was less agreement (Mean standard deviation = 1.9) regarding the nine lowest ranked competencies.

Only six competencies did not receive an unequivocally positive average rating (>5) and only three received an average negative rating (<4). The three negatively rated competency statements were drawn from Oades et al. (2005) paper and included statements regarding using ''Collaborative Goal Technology'', the ''Camberwell-Assessment of Need'' and assigning ''homework'' tasks. Respondents commented in relation to these and other lesser rated competencies that they reflected jargon and alluded to the recovery worker directing the person in recovery, whereas the higher rated competency statements emphasized respecting and supporting the autonomy of the individual.

Eighteen competency statements were ranked 6.6 or above (the ten highest ratings). Of these 8 addressed respecting and promoting the person's autonomy in some way, seven addressed recognizing the capacity of the individual, four addressed some aspect of communication and only one could be said to address technical knowledge, e.g., ''To work in a recovery focused way mental health workers need to have knowledge of the relationship between traumatic experiences and mental health problems'' (NHS Education for Scotland and Scottish Recovery Network, 2007).

The top five recovery competencies

The first ranked competency statement was ''A competent mental health worker recognises and supports the personal resourcefulness of people with mental illness'' (NZ Mental Health Commission, 2001). Some panel members stated that it reflected the fundamental attitude and skill to assist people to recover, that mental health workers needed to see, acknowledge and work with people's strengths and abilities rather than their limitations. Some commented that recognizing the resources that people possess, e.g., supportive relationships, untapped skills, dreams and aspirations is the first step in mobilizing those resources. Some also said that taking the time to really know and understand the person was necessary to realize the competency and described individuals, e.g., workers, other service users and mental health workers who (as one person suggested) ''know when to push and when to hold''. Some respondents provided examples of small practical gestures that made a difference to them:

> My mental health social worker encouraged me to plan my own weekly activities with my young baby when recovering from puerperal psychosis. Further down the line of recovery, she also gave me the WRAP (Wellness Recovery Action Plan) for my husband and I to fill in for ourselves.

Table I. The top ranked recovery competencies.

Competency	Rank	Mean	Low	High	Dif[1]
A competent mental health worker recognizes and supports the personal resourcefulness of people with mental illness (NZ Mental Health Commission., 2001)	1	6.89	6	7	−0.11
To work in a recovery focused way mental health workers need to reflect a belief that recovery is possible (NHS Education for Scotland and Scottish Recovery Network, 2007)	2	6.82	6	7	−0.07
To work in a recovery focused way mental health workers need to be able to listen to what service users are actually saying and respect their views (NHS Education for Scotland and Scottish Recovery Network, 2007)	3	6.81	5	7	0.03
To work in a recovery focused way mental health workers need to reflect respect for the expertise and unique knowledge gained as a result of having experienced mental health problems (NHS Education for Scotland and Scottish Recovery Network, 2007)	4	6.76	6	7	0.01
A competent mental health worker helps the person develop self-belief, therefore promoting their ability to help themselves. (Barker and Buchanan-Barker, 2008)	5	6.75	6	7	0
A competent mental health worker has the self-awareness and skills to communicate respectfully and develop good relationships with service users (NZ Mental Health Commission, 2001)	5	6.75	6	7	−0.14
To work in a recovery focused way mental health workers need to be able to maximize opportunities for all service users including those subject to compulsory powers, to make choices about how they live their lives and have these choices respected and acted upon wherever possible (NHS Education for Scotland and Scottish Recovery Network, 2007)	6	6.71	6	7	−0.07
To work in a recovery focused way mental health workers need to reflect a recognition and appreciation of the potential impact of the power imbalance between mental health workers and service users particularly in situations involving compulsory powers (NHS Education for Scotland and Scottish Recovery Network., 2007)	7	6.69	4	7	−0.31
To work in a recovery focused way mental health workers need to have knowledge of the relationship between traumatic experiences and mental health problems (NHS Education for Scotland and Scottish Recovery Network, 2007)	8	6.64	6	7	−0.03
A competent mental health worker understands and actively protects service users' rights (NZ Mental Health Commission, 2001)	8	6.64	5	7	−0.03
To work in a recovery focused way mental health workers need to reflect a recognition and appreciation of the role of non-mental health resources in relation to recovery (NHS Education for Scotland and Scottish Recovery Network, 2007)	8	6.64	6	7	0.08
To work in a recovery focused way mental health workers need to reflect an appreciation of the benefits of informal and formal peer support (NHS Education for Scotland and Scottish Recovery Network, 2007)	9	6.62	5	7	−0.16
To work in a recovery focused way mental health workers need to have knowledge of an understanding of the importance of	9	6.62	5	7	−0.16

(*continued*)

Table I. (*Continued*).

Competency	Rank	Mean	Low	High	Dif[1]
self determination and ownership of the recovery journey (NHS Education for Scotland and Scottish Recovery Network, 2007)					
To work in a recovery focused way mental health workers need to have knowledge of the rights of service users and named persons and relevant safeguards in relation to all aspects of compulsory care and treatment (NHS Education for Scotland and Scottish Recovery Network, 2007)	10	6.6	4	7	0.04
To work in a recovery focused way mental health workers need to be able to support service users to identify and make use of community resources (NHS Education for Scotland and Scottish Recovery Network, 2007)	10	6.6	5	7	0.04
To work in a recovery focused way mental health workers need to have knowledge of the central role of hope in recovery (NHS Education for Scotland and Scottish Recovery Network, 2007)	10	6.6	5	7	0.04
To work in a recovery focused way mental health workers need to be able to develop links with local community resources beyond traditional mental health services (NHS Education for Scotland and Scottish Recovery Network, 2007)	10	6.6	4	7	0.04
To work in a recovery focused way mental health workers need to be able to convey hope sensitively at times of distress (NHS Education for Scotland and Scottish Recovery Network, 2007)	10	6.6	5	7	0.04

[1]The difference in mean scores between first round and second round.

> A worker from The Community Resource Team recognised my enjoyment with participating with line dancing whilst in recovery and made a point of ringing and inviting me to sessions of 'Keep Fit' to participate in whilst I was in recovery.

The second most highly rated competency was ''To work in a recovery focused way mental health workers need to reflect a belief that recovery is possible'' (NHS Education for Scotland and Scottish Recovery Network, 2007). Several people pointed out that workers needed to be mindful of what is meant by recovery, ''That recovery does not mean being free from 'symptoms', but in most cases learning to live with certain experiences and being comfortable with who we are''. This competency was deemed important to engender hope. People spoke of mental health professionals who communicated their belief that recovery would happen, sometimes despite feeling pessimistic themselves:

> I always remember a conversation I had with a nurse where he had so much belief in recovery for me, I had a home, a job to return to, and that has remained with me. His belief in me and recovery helped to so much.

The third and fourth highest rated competencies were closely related. ''To work in a recovery focused way mental health workers need to be able to listen to what service users are actually saying and respect their views'' and ''To work in a recovery focused way mental health workers need to reflect respect for the expertise and unique knowledge gained as a result of having experienced mental health problems'' (NHS Education for

Scotland and Scottish Recovery Network., 2007). Respondents provided examples of health professionals listening to them, sometimes disagreeing but acquiescing to their wishes (e.g., to stop or reduce medication) or negotiating a course of action that reflected a compromise in relation to the person's wishes and the mental health worker's recommendations. Several people acknowledged that they might be considered ''experts by experience'' and that this expertise needed to be tapped. It is unclear to what extent mental health workers ought to lead or follow the service user and how the stance is related to the person's stage of recovery. One respondent stated ''My CPN has stated she is guided by me at the moment . . . as I would class myself as recovered currently and I feel my voice is very much heard''.

The fifth rated competency was ''A competent mental health worker helps the person develop self-belief, therefore promoting their ability to help themselves'' (Barker & Buchanan-Barker, 2008). Respondents suggested that using ''strengths based approaches'' or simply being encouraging demonstrated this competency. Another suggested that ''. . . providing opportunities for the individual to help/support others in distress and/or contribute to a group or organisation'' helps a person to develop self-confidence.

Discussion

The anonymity afforded to participants in this Delphi study served to reduce the impact of social pressures on responses. That is, people were free to rate and comment as they wished without fear of any kind of sanctions. It also ensured that all participants were able to contribute in an equitable way rather than some individuals being influenced by dominant individuals or acquiescing to a dominant viewpoint. The competency statements were presented to participants in random order which reduced the likelihood of bias due to the ordering of items. The experience of the expert panel as former or current mental health service users, being identified by peers and self-identifying as being in recovery adds credibility to the study. That so many respondents identified mental health professionals as helpful or important in their recovery adds credibility to their expertise being applied to considering the competencies of mental health workers. However, respondents cannot be said to be representative of service users or people who identify with recovery. Rather, participants were technologically literate, well educated and well-networked within international service user/mental health advocacy movements. The relatively small number of respondents might also be considered a weakness of this study.

Only the top ranked competency statements have been presented (see Table I) but this may not diminish the actual importance of other competencies in some contexts which were also mostly rated positively. Some perhaps are more applicable in particular cultural contexts and make more sense when considered in the context in which they were originally presented. For example, some competencies derived from the New Zealand Mental Health Commission (2001) relating to whanau (family) may have needed some explanation for this audience. Similarly some Oades et al. (2005) competencies (whilst perhaps not as universally applicable as the competencies rated most highly in this study) were more specific (arguably more measurable) and the panel may have benefited from reading the rationale for their choice and selection).

With only a few exceptions respondents rated the competencies positively, i.e., as important or very important in assisting people in recovery. This may be seen as an endorsement of the competency sets themselves. However, it might also be seen that there is little to discriminate between competency statements or between some principles of good practice and recovery-focused practice. Recovery-focused competencies and practices (like

non-specific factors in psychotherapy) may be subject to the ''Dodo bird verdict'', that is that ''Everybody has won and all must have prizes''. Further critical reflection and debate is also warranted on the congruency of competency statements (derived as they are from a positivistic paradigm) with the more post-modern notion of mental health recovery. Similar tensions exists between ''evidenced-based practice'' and recovery and some might reasonably ask whether mental health workers who demonstrate the competencies described really make a difference to people's recovery and how can this be demonstrated? This study asked individuals to consider what made a difference to them rather than conflating various ideas of ''objective'' clinical or functional recovery with subjective notions of personal recovery (described by the respondents).

The top ranking competencies did especially emphasize recognition and promotion of an individual's capacities, strengths, resourcefulness, and autonomy. This suggests that coercive or controlling practices may sit uncomfortably alongside or in some cases may be incompatible with recovery-focused practice (at least as recognized by this panel of experts). For example, it would be hard to argue that forcibly restraining someone and administering medication to them against their will is a recovery-focused practice, despite whatever beliefs might be held by the mental health workers involved about the individuals capacity and likelihood to recover, or whatever moral or legal justification might be offered. The kind of directive stance that might be needed of a helper in a crisis or emergency situation may not be incongruent with recovery-focused care but it is something different from it. Thus recovery focused and competent care may be a subset of good care but it does not subsume all that is good. Many people will need good quality, time limited crisis intervention or to consult with technical experts in medication management. These may be needed and provided in a mental health system but these in themselves may not be recovery-focused practices.

The Delphi results suggest some tentative boundaries around the concept of recovery and recovery-focused practice which might be explored in further research, concept analysis or clarification exercises. These high rated competency statements may also be of use for auditing educational programmes, seeking to promote recovery-focused practice and developed further as service indicators of recovery focused care. (1)

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