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**Individual Perspectives on the Wellness Recovery Action Plan (W.R.A.P.) as an
Intervention in Mental Health Care need to edit**

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Abstract

Objective: This study explored the experience of individuals with mental health difficulties who completed the Wellness Recovery Action Plan (W.R.A.P.) intervention. Participant perspectives on the therapeutic elements of the WRAP, its role in recovery and constructive feedback are presented.

Methods: Using descriptive phenomenological methods, in-depth semi-structured interviews were conducted with four individuals with mental health difficulties who attended a WRAP programme in a community mental health centre in Ireland.

Results: Overall, participants felt that completing the WRAP was a therapeutic group experience. The identification of early warning signs and crisis planning proved particularly valuable by individuals who felt more empowered to actively manage their own mental health. Qualitative perspectives from this study point to the importance of introducing the WRAP early in an individual's recovery journey, and providing multiple opportunities to repeat and review the process.

Conclusions and Implications for Practice: Results support the findings of earlier studies in which the WRAP was found to be a self-management programme that contributes to the recovery of individuals with mental health difficulties. Group peer support was valued by participants, but future research should study the effectiveness of the WRAP in comparison to other peer support programmes.

Key words: Wellness Recovery Action Plan, Recovery, Mental Health, Occupational Therapy, Ireland

Introduction

In recent years, the traditional notion that the lives of individuals with mental health difficulties' comprise only of unavoidable decline has been rejected (Bellack, 2006). There is now a widespread understanding that it is possible to reclaim or recover a meaningful life in spite of such difficulties (Jacobson, 2003). There are various definitions of recovery in existence within the literature. Definitions include recovery as an outcome, as a process and as a personal journey (Strauss, 1996; Sheehan, 2002). The existence of such disparate definitions strengthens the stance by Jacobsen (2001, p.15) that "the meaning of recovery will vary, depending on who is asking and interpreting, in what context, to what audience, and for what purpose". Therefore, it is reasonable to infer that the single over-arching feature of recovery is the fact that it is individualised.

Despite the individualised nature of recovery for individuals with mental health difficulties, the fundamental principles upon which the concept is based remain the same. It is upon these principles that mental health services around the world are beginning to base their approach to mental health care (International Mental Health Commission, 2005). Principles such as an individual's right to control their own life and manage their own mental health and the importance of shared decision-making between service user and provider, form the basis of a recovery-orientated approach to care (Wallcraft, 2005; Davidson et al., 2009).

The underlying philosophy of a recovery-orientated approach is similar to that of another approach to mental health care, the self-management perspective. Both are of the view that individuals are active agents and the focus is to empower them with a view to enhancing their self-efficacy (Lorig & Holman, 2003; Davidson et al., 2009). Self-management programmes involve the provision of information by either professionals or

peers (Mueser et al., 2002) and were designed to provide people with the knowledge, skills and supports to self-direct their care (Onken et al., 2007). A variety of self-management programmes have been developed in recent times but the most widely distributed of these is the Wellness Recovery Action Plan (W.R.A.P.) (Slade, 2009).

The W.R.A.P was developed in the United States, in 1997, by a user of mental health services, Mary Ellen Copeland, and further developed by participants in an eight-day recovery skills seminar for psychiatric symptoms (Copeland, 2008). It is now offered in a variety of countries including Ireland (Mental Health Commission, 2005; Cook et al., 2011). It is underpinned by a number of recovery principles including personal responsibility, education, hope, self-advocacy, peer-support and future planning (Copeland, 2008). The idea is to allow individuals to develop an individualised recovery plan in a personal folder, comprising a variety of self-help strategies to improve their ability to take responsibility for their own wellness and manage their symptoms (Copeland 1997, 2004). In practice, individuals may be facilitated to develop their individualised recovery plan in a one-to-one relationship with their therapist, or with a peer facilitator. Conversely, mental health services often design a series of groups with the purpose of facilitating individuals to develop their recovery plan with the support of peers. The number of group sessions may vary, but will be focused on specific components of the WRAP; making a daily maintenance plan, learning strategies to identify and respond to triggers, learning strategies to identify and respond to early warning signs, recognising a crisis and making a post-crisis plan (Copeland, 2004). In the Irish context where this study took place, individuals are assisted by an occupational therapist and a nurse both of whom are certified WRAP facilitators to create a WRAP folder and recovery plan through six sessions on a weekly basis. Usually, the WRAP is facilitated as a group intervention however in cases in which the therapist felt it was more beneficial for the client, it is facilitated on an individual basis.

Literature Review

A paucity of research has investigated individuals with mental health difficulties use of the WRAP. This small body of research has been predominantly quantitative and has focused primarily on measurement of an individual's recovery using a pre-established construct of recovery. The outcome measures used are based on the assertion in the wider literature on recovery that service users often conceptualise common elements of recovery such as hopefulness, acceptance, empowerment and support.

For instance, Starnino et al., (2010) used The Recovery Markers Questionnaire (RMQ) (Ridgeway & Press, 2004) to measure various recovery-related outcomes in their quasi-experimental study. Findings suggested that following the WRAP, there was a significant increase in recovery orientation as indicated by an improvement in mean scores across outcomes such as process factors, goal-oriented thinking, self-agency, self-efficacy, symptoms, social support and basic resources. The RMQ was also used by Fukui et al., (2011), but conflicting results were reported as there were no statistically significant group intervention effects for the treatment group following participation in the WRAP. The use of an outcome measure that has not yet been tested for psychometric validity presents itself as a weakness of these studies. The study by Starnino et al., (2010) also lacked a control group and comprised a small sample size (n=30), further weakening the strength of these findings. Contrastingly, Fukui et al., (2011) made use of a control group. In addition, two-stage least squares regression analysis deduced that selection bias typically associated with a non-equivalent group design was not a problem in this case. A comparison of these studies suggests that the participants who attended the WRAP programme achieved the same level of recovery than those who did not as measured on the RMQ.

Cook et al., (2009) utilised The Recovery Assessment Scale (RAS) (Giffort et al., 1995) which comprises five recovery subscales including Personal Confidence and Hope, Willingness to ask for Help, Goal and Success Orientation, Reliance on Others, Not Dominated by Symptoms. There were significant increases observed in the scores for overall recovery following participation in a WRAP programme, and on each of the five subscales, thereby indicating improvement. In the randomised control trials (RCT) by Cook et al., (2012), and Cook et al., (2013), there were similar results found using the RAS. Cook et al., (2012) compared the WRAP with services as usual. The total RAS score and some of the RAS subscales indicated that participants in the treatment group showed significantly greater improvement over time in comparison to participants in the control group. Cook et al., (2013) compared the WRAP with a nutrition education programme and the results suggested that participants in both the intervention and control group improved significantly over time.

The study by Cook et al., (2009) lacked a control group but Cook et al., (2012) and Cook et al., (2013) carried out two single blind randomised control trials. The multisite nature of these studies, data collection at multiple points in time large sample sizes and the use of a valid and reliable outcome measure adds further weight to the findings of these studies. Therefore, there is strong evidence to suggest that WRAP improves recovery outcomes. WRAP improves recovery outcomes more than the usual care provided, but just as much as a nutrition education programme. This leads to the inference that perhaps it is not specifically the content of the WRAP that causes it to be effective, but the support provided by a group intervention.

Psychiatric Symptoms

A reduction in psychiatric symptoms is commonly identified as a recovery outcome in many studies (Bond & Campbell, 1998). Cook et al., (2009) and Cook et al., (2012) found a

statistically significant decrease in global symptom severity using the Brief Symptom Inventory (BSI) (Derogatis, 1993) one month post participation in WRAP compared to beforehand. Scores on several symptom subscales, including psychoticism, depression, phobic anxiety, obsessive compulsive disorder, interpersonal sensitivity, paranoid ideation and general anxiety also decreased significantly; a further indication of improvement.

A summary measure of the BSI, the Global Symptom Severity Index (GSI) was used to provide an overall measure of an individual's level of psychological distress in the study by Cook et al., (2013). Participants in both the intervention and control group improved significantly over time.

Similar results were found on the Modified Colorado Symptom Index (Conrad et al., 2001) which was used by both Fukui et al., (2011) and Starnino et al., (2010). This measure has showed excellence for several types of validity, test-retest reliability and dimensionality. Starnino et al., (2010) on the other hand, reported conflicting results with findings suggesting no decrease in psychiatric symptoms. However, due to the small sample size ($n=30$) of this study, it may have been difficult to find significant relationships from the data, as statistical tests normally require a larger sample size to ensure a representative distribution of the population (Macnee & McCabe, 2008).

Therefore, there is evidence to suggest that the WRAP improves psychiatric symptoms. However, Cook et al., (2013) found that there was an improvement in the intervention group following the WRAP and the control group following a nutrition education course. Again, this could suggest that it is the group support element that results in improvements, rather than the content of the WRAP programme.

Service Utilisation and Need

Service utilisation is considered a recovery outcome in some of the literature with a view that a reduction in the use of services is a measure of an improvement in one's mental health. Cook et al., (2013) assessed the impact of the WRAP on the use of and need for mental health services over time compared with a nutrition and wellness education programme. The Support Service Index or SSI (Heller, Roccoforte & Cook, 1997) was used to measure service utilisation and need. Results indicated that compared with people in the control group, WRAP participants reported a significantly greater reduction over time in service utilisation. Participants also reported a significantly greater decrease over time in the total number of services needed.

The use of telephone interviews may have made it difficult for interviewers in this study to establish their genuineness in seeking sensitive information. Nevertheless, data was collected at multiple points in time and from multiple sites, a single blind RCT design was employed and complete allocation concealment up to the point of assignment was achieved, all of which suggests that this study provides evidence that the WRAP has a sustained effect on both reported mental health service utilisation and self-perceived need for services.

Client Satisfaction

Client satisfaction is an important and commonly used indicator for measuring the quality in health care. Health professionals may benefit from satisfaction surveys that identify potential areas for service improvement through patient-guided planning and evaluation. Client satisfaction with the WRAP was extremely high in the study by Cook et al., (2010) as indicated by the open-ended comments participants left on their evaluation questionnaires. Themes derived from thematic analysis of responses included a view of wellness as attainable and on-going, the influence of and growth of support networks, the increased ability to

recognise and successfully manage stressors and symptoms and pride in new knowledge and skills.

Client satisfaction with the WRAP was also investigated by Wilson et al., (2013). This descriptive cross-sectional survey consisted of quantitative and open-ended narrative or qualitative questions. Participants completed the Mental Health Statistics Improvement Program for which data on reliability is reported (Howard et al., 2003). Factors correlating to client satisfaction with the WRAP included autonomy and services. Length of programme participation was a factor which correlated with client satisfaction with clients who attended the WRAP programme for a longer period of time being more satisfied. Findings also suggested a belief that exposure to the WRAP at a younger age would provide a better opportunity for recovery, a belief that sharing one's story is constructive, there is a need for support and that it is crucial to accept that recovery does not happen overnight.

Cook et al., (2010) used content analysis which is unobtrusive and nonreactive (Lee, 2000). However, few details about the methods of qualitative data collection were provided and so the credibility of the findings is reduced. Wilson et al., (2013) however, used an instrument that is widely used in public mental health systems and has been identified by consumers as addressing important concerns. Furthermore, the use of narration in this study enabled a deeper understanding of participants' perspectives in addition to the quantitative findings.

In conclusion, the sparse amount of research pertaining to the WRAP as an intervention in psychosocial rehabilitation nevertheless provides evidence for a number of outcomes. There is evidence to suggest that WRAP contributes to an individual's recovery outcomes. Evidence also suggests that the WRAP reduces psychiatric symptoms as well as service utilisation and need. However, some research gaps exist. The quantitative

methodologies used in the studies on the WRAP comprised of pre-established constructs of recovery. Therefore, they could fail to accurately capture the individualised nature of recovery. Similarly, individual perspectives on the relationship between the WRAP and psychiatric symptoms and service utilisation and need have not been captured. Client satisfaction with the WRAP was found to strongly correlate to autonomy, services and length of program participation however client perspectives on the different aspects of the programme itself remain unknown. Client perspectives on ways to improve the WRAP have yet to be explored, and the perspective of Irish mental health service users is unknown on this topic.

Aim

This research aimed to capture an in-depth understanding of the value of the WRAP as an intervention in psychosocial rehabilitation from the perspective of individuals who have participated in a WRAP programme. Its primary objective was to explore individual's experience of the WRAP. Its secondary objectives were to elicit the role of the WRAP in individuals' recovery, their perceptions of the therapeutic elements of the WRAP and their use of the WRAP after the programme ended.

Methodology

According to O'Leary (2004), phenomenology is the study of phenomena as they present themselves in direct experiences. The primary focus of phenomenological work is the meaning of lived experience, from the first-person point of view (Husserl, 1970). A descriptive phenomenological approach was used to capture client perspectives on the value of the WRAP as an intervention within mental healthcare. By obtaining this insider view, insight was gained into what the experience of using the WRAP is like. The researcher was required to interact directly with the participants to gather their description of their lived

experiences. The researcher also took steps to bracket her ideas, preconceptions and personal knowledge of the WRAP before interviews were conducted through the use of a personal reflection (Drew, 1999). There are features to any lived experience that are common to all persons who have the experience referred to as universal essences or eidetic structures (Natanson, 1973). For the description of the lived experience to be considered a science, the researcher must have identified commonalities in the experience of the participants, so that a generalized description is possible. In this way, a universal description of the phenomenon, the WRAP, was provided by the lived experience of the participants (Tymieniecka, 2003).

Recruitment Procedure

There was one main recruitment method; a list of all the adults that participated in the previous three WRAP programmes at the participating community mental health centre was compiled by the gatekeeper of the study. The gatekeeper was an occupational therapist who had facilitated the group. An information leaflet was sent to all of the individuals on the list. The leaflet outlined the nature, purpose, duration, possible effects and risks of the study. Interested individuals were invited to contact the researcher (first author) directly. A date and time to conduct the interviews was arranged with individuals who met the inclusion criteria.

Participants

A purposeful homogenous sample was used whereby individuals who had participated in a WRAP programme were purposefully sought out and recruited from the participating community mental health centre. Four participants self-identified to take part. One participant was female and three were male. Their ages ranged from 35 to 61 years old. Each of the participants had different mental health concerns; depression and anxiety (Participant A), psychotic hallucinations (Participant B), schizophrenia (Participant C) and social anxiety disorder and depression (Participant D). The number of times participants had participated in

a WRAP programme varied; once (Participants A and C) twice (Participant B) and three times (Participant D). The time lapse since participants completed a WRAP programme varied from 6 months to 2 years. 3 participants completed WRAP in a group format while one participant completed it on an individual basis.

Procedure

The semi-structured interviews were conducted in the participating community mental health centre over a three week period. An interview schedule was developed by the researcher based on a literature review, the research aims of the study, and had input from an experienced occupational therapy researcher. The schedule covered the following areas; individuals' view of the WRAP, individuals' view of the WRAP in relation to recovery, the therapeutic elements of the WRAP that contributed to recovery and the elements of the WRAP individuals have continued to use since their participation in the WRAP programme. The direction of the interview was lead mainly by what was said by participants however the researcher ensured all the questions were asked and a similar wording was used across all interviews. Each interview was recorded using a password-protected Dictaphone and lasted between twenty and forty minutes. The interviews were transcribed verbatim. All relevant data protection measures were adhered to.

Ethical Considerations

Full ethical approval was sought and received from the Health Service Executive Research Ethics Committee for the region in January 2015. All participants were provided with an information leaflet including the details of the aims and procedures of the research and the participants' right to withdraw at any time without any negative consequences for their future receipt of services. Written consent was obtained from each of the participants. Due to the rich narrative description typically elicited from participants in this study design,

infringements of confidentiality by means of deductive disclosure were of particular concern to the researcher. In order to retain such valuable description and protect the identity of participants the names of participants were replaced with pseudonyms and any other identifying information was removed.

A number of safeguards were in place to reduce any potential distress which might have been caused by the probing nature of the study design. Interviews were conducted in the community mental health centre participants attended regularly and arranged at a time when staff members were available on site. The gatekeeper of the study who was the occupational therapist who facilitated the WRAP programmes was present during the interview. Consequently, this enabled data collection to be conducted within a familiar environment, in the presence of an already established relationship.

Analysis

Thematic analysis was used to analyse the data as it is a method involving the identification, analysis and reporting of patterns in data, which are important to the description of a phenomenon (Aronson, 1994). Specifically, Attride-Stirling's (2001) six step process was used. First, the data was reduced into manageable and meaningful sections by using a coding framework. Once all the text had been coded, themes were derived. The identified themes were organised into thematic networks. The contents of each network were described and the description supported with text segments. The underlying patterns that appeared were explored and noted. The main themes and the patterns characterizing these themes were summarised. The original research questions were re-examined and the patterns that emerged in the exploration of the text were used to address them.

Results

Four themes were identified; the meaning of recovery, the role of the WRAP in recovery, the therapeutic elements of the WRAP, and feedback on the experience of being a WRAP participant.

The Meaning of Recovery

Participants' conceptualisations of recovery illustrated the different meanings it had for each of them. For Participant A, recovery meant "looking forward to things and having an appetite for life". It also meant an improvement in the feelings and symptoms he experiences because of his diagnosis, such as "a little bit more confidence and patience and interest and better concentration". In contrast, Participant C felt that recovery means a peaceful time, "quietness and rest". One participant denoted that recovery means being aware of deterioration in their mental health and having the ability to take action to prevent further decline. For them, recovery was "this thing of being aware when things are slipping and ... to be able to put things in place to stop it escalating" (Participant D).

There was a distinctively different view on recovery expressed by one participant. He described recovery as non-existent. He asserted that recovery is not possible and that there are only mechanisms to help one cope with mental illness. He stated firmly that, "There isn't any [recovery]. There is (*sic*) ways of dealing with it. It's like an addiction, there's no cure, there's just prevention" (Participant B).

The Role of the WRAP in Recovery

Despite the different perspectives held by participants on the meaning of recovery, all participants felt the WRAP contributed to an improvement in their mental health. WRAP

played a role in individual's recovery in a number of ways including the reduction of psychiatric symptoms and the prevention of hospitalisation.

One participant experienced a reduction in psychiatric symptoms, which she accredits to the WRAP. She stated that, "a year or two ago if I got depressed it could last months, now it probably wouldn't even last weeks. I'm able to work with the WRAP and get myself out of it" (Participant D). Linked to this, for two participants, using the WRAP directly affects whether they need hospital admission or not. Participant B said that if he doesn't use the WRAP, "it means the difference between hospital or at home". Specifically, WRAP helps them to "recognise the early warning signals and get help. It stops you from getting so bad that you're hospitalised" (Participant C).

The participants were able to describe clear examples of occasions in which the WRAP played a role in the prevention of hospitalisation. Participant B said that, "the week before last, if I didn't put some of the WRAP into action here with the nurses, I would have been back in hospital". This was similar to Participant C's experience; "last October I started to get a bit unwell and I got in touch with the nurse straight away you know, and the WRAP kind of helped me do that. I got my medication increased and I was grand".

Therapeutic Elements of the WRAP

Participants noted two main beneficial elements of the WRAP. Firstly, participants described the content covered in the WRAP as beneficial, particularly the education on the various tools to incorporate into ones recovery plan. Secondly, participants described the positive impact of the format in which the WRAP programme was facilitated.

During the creation of a WRAP, participants learned about the value of a daily maintenance plan. The daily plan allowed them to identify "certain things that you can do"

(Participant A) and “organise yourself an awful lot better” (Participant B). Participant B also found learning about the personal bill of rights very beneficial, and this knowledge led to him being more self-assured in exercising his rights, as he stated, “You have the right to feel unwell and I didn’t think I had that right. ... Now I know I’ve the right to say no and I’ve been practicing that and if it’s a problem it’s not mine, that’s the WRAP for you”.

Learning how to recognise triggers and warning signs of becoming unwell is an important part of the WRAP, and two participants identified that this content was particularly beneficial. Participant B felt that identifying triggers “plays a big role because I didn’t even know what me (sic) triggers were or what signs to look out for”. Participant C said that “the main thing I got out of the WRAP was recognising the early warning signs of getting unwell so I can get help quick. One of the early warning signs for me is I get all me (sic) possessions and I throw them out in the bin”.

This increase in self knowledge led three participants to comment that the WRAP enables them to put a plan in place when becoming unwell. Participant C recognised the importance of “learning the early warning signs and acting upon it before it got too late. WRAP made me feel more secure that if I was getting unwell that I’d get help quicker rather than let it go too far until I was hospitalised”. Participant B was able to give specific detail of his warning signs and what he would do if he noticed them; “if I’m feeling dirty and I don’t wash or I’m feeling hungry and I don’t eat I’ll go to my WRAP and have a look and think well this is something now that has to be dealt with”. In addition, Participant D noted the importance of being able to “pinpoint who would take over if there was a crisis”.

Participants felt there were certain benefits associated with the facilitation of the WRAP in a group format despite the fact one of the participants had in fact participated in a

WRAP programme on an individual basis. For Participant D, it was actually a new social experience; “I never sat in a group until I did the WRAP the first time”.

Three of the participants commented that an environment comprising individuals with similar experiences fostered a comforting atmosphere and a sense that one was not alone in having a mental illness. Specifically, Participant A stated that “when there are other people that you can familiarise with, I feel more comfortable”. This was similar to Participant D, who felt that the other group participants were “there for the same reason so you feel very comfortable and very safe”. This led to a reduction in the sense of isolation for one participant; “They could say something and you could think I’m not the only one in the world that has this way of mind and thoughts” (Participant B).

One of the participants completed the WRAP programme on an individual basis but he also felt that a group would facilitate a feeling of not being the only person with mental illness. He felt that the sharing of ideas within a group would provide access to otherwise unknown information; “You’d learn that not having a wash or a bath in two weeks was one of their early warning signs and would say, that happens to me too whereas if they didn’t say it you mightn’t think of it” (Participant C.)

One participant described how hearing individuals’ personal accounts of recovery evoked the idea that their own was possible. She described how “you hear other people and how bad they were and how it is possible to recover and think to yourself well, you know, I could get better” (Participant D.)

Two participants emphasized the supportiveness of the group, and the respect and understanding shown between all involved. It was “a really good group who stuck together” (Participant B) and there was “respect, everybody understands each other” (Participant D). There was also a sense that the group built some lasting relationships. Participant D felt that

the group members are “still friends”, and described meeting group members socially for coffee or to go to the cinema. She felt that the social benefits of the group continued after the formal intervention was completed; “*afterwards when it’s finished there’s support*”.

The Overall Experience and Suggested Improvements to the WRAP

Participants described their overall experience of the WRAP. In doing so, a number of potential ways to improve the WRAP were identified. The overall experience of the WRAP was referred to with it being described by some as a pleasant experience; “I enjoyed it” (Participant A) and others as a mediocre experience; “doing it was alright” (Participant C).

The content of the WRAP was referred to by participants in both a positive and a negative way. There were indications that there was a lot of information to take in, and that this meant that individuals needed to revise and re-read their workbooks. While Participant A indicated it “was all positive stuff”, he also mentioned that “I just didn’t abide by it much at all really. It went out of my head”. Participant B felt that “there’s too much for one time” but also that he has “used it a few times since I’ve come out (of hospital)”. He indicated that he continues to look at his workbook; “I still read it. It’s nice to remind myself every so often”. In contrast, Participant C stated that he has “lost the information now”.

Participants shared their perspectives of the individuals to whom they would recommend the use of the WRAP, the people the WRAP is suitable for, the ways in which the WRAP could be improved and the future of one’s personal WRAP. These are all important to consider within the context of the facilitation of WRAP programme in the future.

Participants A, B and C declared that they “would recommend” the WRAP to other individuals with mental health difficulties, and Participant B noted “if they want something

that's really helpful to them, I'd recommend them doing it". Two participants noted that the WRAP is suitable "regardless of how well or unwell someone was" (Participant A) and that "you can use it anytime" (Participant C). One participant noted that the WRAP is useful even "if you never had a mental illness" (Participant D).

Directly or indirectly, the participants described possible ways of improving the WRAP. Two participants felt that it was necessary to complete the WRAP a number of times because different things are learned each time. Participant B stated that; "there is always something in it that'll pop up and it mightn't have been something that popped up either of the other times". Similarly, Participant D felt that doing the WRAP more than once was important because "it was the second WRAP in particular I became more aware of things that affect me. It took me that long for things to just click".

Two participants felt that WRAP would be more beneficial if it was introduced into one's life earlier. Participant B indicated that it could have played a role in preventing ill-health; "if I knew then what I know now, through WRAP, it may not have got out of hand as much as it did". So, as Participant D mentioned, "it was a pity that WRAP didn't come around an awful lot sooner".

Discussion

Results of this study highlight the individualised nature of recovery, the role of the WRAP in recovery, the therapeutic elements of the group and the ways in which the WRAP could be improved.

The Meaning of Recovery

Conflicting views were expressed among participants regarding belief in the concept of recovery. One participant noted that recovery means an improvement in the feelings and

symptoms he experiences because of his mental health condition. Reduction of psychiatric symptoms is a commonly identified outcome in much of the recovery literature (Bond & Campbell, 2008; Lloyd et al., 2008). For another participant recovery means a quiet and peaceful time. Similarly, in a previous personal narrative, the quiet life was identified as indicative of recovery (Rudnick, 2012). To a different participant, recovery means awareness that one's mental health is deteriorating and having the ability to put a plan into action to prevent further deterioration. This perception of recovery strongly correlates to section two of the WRAP entitled early warning signs. This section comprises the identification of the signs that may indicate if a situation is beginning to worsen and the development of a plan of how to respond to these signs (Copeland, 2001). Therefore, it is reasonable to surmise that the philosophy of the WRAP is embedded within the meaning this participant attributes to recovery.

Previous research comprising personal narratives of mental illness support the range of meanings associated with recovery by participants. For instance, Stocks (1995) denotes recovery as living a worthy and healthy life despite disability while Caras (1999) describes it as trusting that the bad times will pass. The participant in this study who expressed non-belief in recovery compared mental illness to an addiction, in that there is no cure. The term 'recovery' is often mistakenly understood to be synonymous with the word 'cure' (Davidson et al., 2006). Unlike studies conducted on the WRAP to date, this study obtained participants' perspectives on the meaning of recovery. Consequently, this enabled the intricacy and profundity of recovery to be captured (Belleck & Drapalski, 2012). Participants' views of recovery further illustrated the individualised nature of recovery. In doing so, the argument that recovery defies simplistic measurement is further substantiated (Anthony, 1993).

The Role of WRAP in Recovery

The WRAP in its entirety was found by participants to foster recovery in three ways; alleviating symptoms, preventing hospitalisation and reducing service utilisation. This supports the findings of previous research on the WRAP. Cook et al., (2009) reported a statistically significant decrease in global symptom severity one month post WRAP while Cook et al., (2012) reported a significantly greater reduction in the symptoms of depression and anxiety in participants following participation in the WRAP in comparison to the control group who received services as usual. In addition, service utilisation including admittance to hospital was reduced among WRAP participants in the study by Cook et al., (2013) when compared to participants in a nutrition education programme.

The above-described improvements in mental health are all regarded as aspects of recovery for individuals with mental health difficulties (Torrey et al., 2005; Mueser et al., 2006; Bond & Campbell, 2008). Hence, the findings of this study add support to previous findings demonstrating that WRAP can contribute to the recovery of individuals with mental health difficulties. This study however adds to the literature by reporting first-person accounts of the role of certain therapeutic elements of the WRAP in recovery. Thereby, the study has contributed new insights into the potential elements of the WRAP that may make it effective. Future research is warranted to further substantiate these findings.

Therapeutic Elements of the WRAP

Participants indicated that there were certain elements of the WRAP that fostered improvements; the content of the WRAP and the group format. The section of the WRAP on recognising triggers was described as one of the most beneficial elements of the WRAP with most of the participants describing its usefulness. Participants noted that it created an awareness of triggers, which has similarly been noted in previous research on the WRAP carried out by Cook et al., (2010). According to participants, an awareness of their triggers

improved their mental health by underscoring the importance of daily measures to sustain wellness. In addition, participants attributed the prevention of relapse to this section of the WRAP. The section on early warning signs was also identified by participants to have contributed to the prevention of relapse. This is consistent with previous findings related to the use of early warning signs which suggests that positive outcomes were experienced including the prevention of relapse (Novacek & Raskin, 1998; Pitschel-Walz et al., 2001).

Other content covered appeared to empower participants. Empowerment has previously been identified as an important factor in recovery (Campbell, 1997; Cohen, 2005). Firstly, the personal bill of rights provided participants with information regarding their human rights. Subsequently, one participant began to exercise his rights and felt self-assured in his decision to do so. The crisis planning element of the WRAP also proved empowering as it facilitated a participant to formulate plans for who would take over if there was a crisis. Thereby, it can be construed that participants referred to empowerment as an outcome (by the outcomes of decisions) and as a process (being an active participant in the decision-making process), a previously noted viewpoint in the literature (Mc Lean, 1995; Salzer, 1997).

There were also certain benefits associated with the facilitation of WRAP in a group format. Previous research supports the stipulation that there are specific therapeutic benefits of group-work; cohesiveness, universality, instilling hope, interpersonal learning and imparting of information (Yalom, 1995). In this study, participants felt that the group fostered a comforting atmosphere and a sense that one was not alone in the experience of mental illness. This shared experience led to the removal of a sense of isolation (Yalom, 1995). Hearing group members' personal accounts of recovery evoked in participants a sense that recovery is possible, demonstrating the role of WRAP in instilling hope. An emphasis was placed by participants on the supportiveness of the group, and friendships had emanated from it (Yalom, 1995). This finding is consistent with previous research on the WRAP in which

participants noted a growth in their support networks following the WRAP (Cook et al., 2010).

As aforementioned, self-management programmes tend to be delivered by either a peer or a professional facilitator (Mueser et al., 2002). A recent study suggests that there are different benefits associated with each of these types of facilitators (Pallaveshi et al., 2014). For example, Cook et al., (2010) elucidated that peer facilitators were especially powerful in instilling hope. Some authors contend that there are more benefits associated with a peer facilitator than with a professional facilitator such as an occupational therapist, a nurse or a counsellor (Foster et al., 2008; Druss et al., 2010). Despite this fact, previous research on the WRAP has failed to determine the impact of a peer-facilitator or professional facilitator on the outcomes of programmes. In this study, the participants valued the support of their peers, but also the professional support of a facilitator. Therefore, perhaps, it is a possibility that professional-led WRAP programmes are just as beneficial as peer-led programmes once facilitated in a group format. Future research is warranted to explore this possibility.

Overall Experience and Improvements

Participants found the WRAP programme enjoyable as an overall experience. However, there were a number of ways suggested to improve the WRAP. Some participants felt that there was too much information provided, and one had forgotten much of the material. Taking into account the personal journey of recovery, perhaps the WRAP needs to be completed more than once and for sessions to be more frequent. There may also be benefits to introducing WRAP to individuals much earlier on in their recovery journey. This small scale study provides initial insights from participants in an Irish context into what could be considered with regards to the WRAP programme. Further research could examine how the WRAP could be used as a mental health promotion intervention before individuals reach

a crisis. There may also be benefits in examining how individuals may repeat the WRAP at different stages of their lives or at different points in their recovery journey.

Limitations

There are a number of limitations pertaining to this study. Participants had varying degrees of the experience being studied as some had participated in the WRAP programme more than once. Individuals can self-refer to the WRAP group and so repeating it may be a sign that they enjoyed it, or that they had forgotten it and wanted to revise or they may have been referred by someone else on the multidisciplinary team. The reason for some of the participants participating in the programme more than once is unknown.

Participants were required to self-identify to take part in the study. Thereby, there may be an element of bias secondary to the client's willingness to participate. Participants may have had a particular viewpoint of the WRAP they wished to convey (Olsen, 2008). This may have resulted in participants under or over exaggerating perspectives pertaining to the WRAP. In addition, the presence of the gatekeeper during the interviews may have caused participants to feel obliged to speak of the WRAP in a positive manner, as the gatekeeper was the occupational therapist who facilitated some of the WRAP programmes attended by participants. However, this was a condition of the ethical approval for the research.

This study has a small number of participants, similar to many exploratory qualitative studies. However, the researcher included description of how the study was conducted, making it possible to apply the findings of the study to another similar context, group or setting (Mc Daniel & Bach, 1996). A physical audit trail comprising the stages of the research study, from the identification of the research problem to the key research methodology decisions was kept by the researcher. In this way, the research process was clearly documented in a logical and observable manner (Kock, 2006). Failure to reach data

saturation is also identified by some authors as a limitation (Francis et al., 2010). To counteract this limitation however, thick description was utilised when presenting the results of the study; conveying the complexities and richness of the experience of using the WRAP (Silverman, 1997).

Implications for Future Research and Practice

An understanding of recovery as a personal process is increasingly underpinning the policy of the Irish mental health system (Department of Health & Children, 2006). This study contributes to raising awareness of the individualised nature of recovery and the misconception that all individuals believe in the concept of recovery.

This study supports the earlier findings of the WRAP as a self-management programme which contributes to the recovery of individuals with mental health difficulties (Cook et al., 2012). It confirms and complements results from outcome studies with regard to the significant effects of the WRAP on recovery outcomes (Cook et al., 2009; Cook et al., 2010), psychiatric symptoms (Cook et al., 2009; Cook et al., 2010; Doughty et al., 2008; Fukui et al., 2011) and reduced use and need for services (Cook et al., 2013). Hence, this study adds to and supports the existing body of knowledge. It is a further indication that WRAP should be offered as part of standard treatment for service users with mental health difficulties.

This study provided some insights into the therapeutic elements of the WRAP that may contribute to its effectiveness, particularly the identification of personal triggers and early warning signs. This should encourage mental health professionals to explore these concepts with those they work with. The study contributes to literature about the therapeutic benefits of group-work, but future research should seek to examine whether peer-led or professional-led groups are more effective. Since the participants in this study found that the

WRAP helped them to reduce their symptoms and avoid hospitalisation, it indicates that the WRAP could lead to cost-efficiencies for mental health services, but this warrants future investigation.

References

- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16 (4), 11–23.
- Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report*, 2 (1). Retrieved from <http://nsuworks.nova.edu/tqr/vol/iss1/3>
- Attride-Stirling, J. A. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, 1 (3), 385-405.
- Bellack A. & Drapalski, A. (2012). Issues and developments of the consumer recovery construct. *World Psychiatry*, 11 (3), 156-160.
- Bond, G. & Campbell, K. (2008). Evidenced-based practices for individuals with severe mental illness. *Journal of Rehabilitation*, 74 (2), 33-44.
- Campbell, J. (1997). How consumers/survivors are evaluating the quality of psychiatric care. *Evaluation Review*, 21 (3), 357-363.
- Caras, S. (1999). *Reflections on the recovery model*. Unpublished paper.
- Cohen, O. (2005). How do we recover? An analysis of psychiatric survivor oral histories. *Journal of Humanistic Psychology*, 25 (3), 333-354.

Conrad, K. J., Yagelka, J. R., Matters, M. D., Rich, A. R., Williams, V. & Buchanan, M.

(2001). Reliability and validity of a modified Colorado Symptom Index in a national homeless sample. *Mental Health Services Research*, 3 (3), 141-53.

Cook, J., Copeland, M. E., Corey, L., Buffington, E., Jonikas, J., Curtis, L. & Nichols, W.

(2010). Developing the evidence-base for peer-led services: Changes among participants following Wellness Recovery Action Planning (WRAP) education in two state-wide initiatives. *Psychiatric Rehabilitation Journal*, 34 (2), 113-120.

Cook, J., Copeland, M. E., Floyd, C. B., Jonikas, J. A., Hamilton, M. M., Razzano, L., Carter,

T. M., Hudson, W. B., Grey, D. D. & Boyd, S. (2012). A randomized controlled trial of effects of Wellness Recovery Action Planning on depression, anxiety, and recovery. *Psychiatric Services*, 63 (6), 541-547.

Cook, J. A., Copeland, M. E., Hamilton, M. M., Jonikas, J. A., Razzano, L. A., Floyd, C. B.,

Hudson, W. B., Macfarlane, R. T. & Grey, D. D. (2009). Initial outcomes of a mental illness self-management program based on Wellness Recovery Action Planning. *Psychiatric Services*, 60 (2), 246-249.

Cook, J. A., Copeland, M. E., Jonikas, J. A., Hamilton, M. M., Razzano, L.A., Grey, D. D. &

Boyd, S. (2011). Results of a randomized controlled trial of effects of mental illness self-management using Wellness Recovery Action Planning. *Schizophrenia Bulletin*, 38 (4), 881-891.

Cook, J., Jonikas, J., Hamilton, M., Goldrick, V., Steigman, P., Grey, D., Burke, L., Carter,

T., Razzano, L. & Copeland, M. (2013). Impact of Wellness Recovery Action Planning on Service Utilization and Need in a Randomized Controlled Trial. *Psychiatric Rehabilitation Journal*, 36 (4), 250-257.

Copeland, M. E. (1997). *Wellness recovery action plan*. Dummerston, VT: Peach Press.

Copeland, M. E. (2001). Wellness Recovery Action Plan: A system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings. *Occupational Therapy in Mental Health*, 17, (3/4), 127-150.

Copeland, M. E. (2004). *Leading a mental health recovery and WRAP facilitator training*. Brattleboro, VT: Peach Press.

Copeland, M. E. (2008). *The WRAP Story: First Person Accounts of Personal and System Recovery and Transformation*. Peach Press.

Davidson, L., O'Connell, M., Tondora, J., Styron, T. & Kangas, K. (2006). The top ten concerns about recovery encountered in the mental health system transformation. *Psychiatric Services*, 57, (5), 640-645.

Davidson, L., Tondora, J., Lawless, M. S. O'Connell, M. J. & Rowe, M. (2009). *A practical guide to recovery-oriented practice: Tools for transforming practice*. New York: Oxford University Press.

Department of Health & Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationary Office. Retrieved from http://www.dohc.ie/publications/vision_for_change.html

Derogatis, L. R. (1993). *Brief Symptom Inventory: Administration, procedures and scoring manual* (4th ed.). Minneapolis, MN: NCS Pearson Incorporated.

Doughty, C., Tse, S., Duncan, N. & Mc Intyre, L. (2008). The Wellness Recovery Action Plan (WRAP): Workshop evaluation. *Australian Psychiatry*, 16 (6), 450-456.

- Drew, N. (1999). A return to Husserl and researcher self-awareness. In: Polifroni, E. C. & Welch, M. (eds.) *Perspectives on philosophy of science in nursing: An historical and contemporary anthology*. Philadelphia: Lippincott Williams & Wilkins, pp. 263-272.
- Druss, B. G., Zhao, L., von Esenwein, S. A., Bona, J. R., Fricks, L., Jenkins-Tucker, S., Sterling, E., DiClemente, R. & Lorig, K. (2010). The health and recovery peer (HARP) program: A peer-led intervention to improve medical self-management for persons with serious mental illness. *Schizophrenia Research*, 118 (1-3), 264-70.
- Foster, G., Taylor, S. J., Eldridge, S. E., Ramsay, J., & Griffiths, C. J. (2007). Self-management education programmes by lay leaders for people with chronic conditions. *Cochrane Database Syst Rev*, 4(4).
- Fukui, S., Starnino, V., Susana, M., Davidson, L., Cook, K., Rapp, C. & Gowdy, E. (2011). Effect of Wellness Recovery Action Plan (WRAP) participation on psychiatric symptoms, sense of hope and recovery. *Psychiatric Rehabilitation Journal*, 34 (3), 214-222.
- Giffort, D., Schmook, A., Woody, C., Vollendorf, C. & Gervain, M. (1995). *Recovery Assessment Scale*. Chicago, IL: Illinois Department of Mental Health.
- Heller, T. Roccoforte, J. A. & Cook, J. A. (1997). Predictors of support group participation among families of people with mental illness. *Family Relations: An Interdisciplinary Journal of Applied Family Studies*, 46 (4), 437-442.
- Howard, P. B., El-Mallakh, P., Rayens, M. K. & Clark, J. J. (2003). Consumer perspectives on quality of inpatient mental health services. *Archives of Psychiatric Nursing*, 17 (5), 205–217.

Husserl, E. (1970). *Logical investigations* (J. N. Findlay, Trans.). New York: Humanities Press.

Jacobsen, N. (2001). Experiencing recovery: a dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal*, 24 (3), 248-256.

Jacobson, N. (2003). Defining recovery: An interactionist analysis of mental health policy developments. *Qualitative Health Research*, 13 (3), 378-393.

Koch, T. (2006). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, 53 (1), 91-103.

Lee, R.M. (2000). *Unobtrusive methods in social research*. Buckingham, Open University Press.

Lloyd, C., Waghorn, G. & Williams, P. (2008). Conceptualising recovery in mental health rehabilitation. *British Journal of Occupational Therapy*, 71 (8), 321-328.

Lorig, K. Holman, H. (2003). Self-management education: History, definition, outcomes and mechanisms. *Annals of Behavioural Medicine*, 26 (1), 1-7.

Macnee, C. & McCabe, S. (2008). *Understanding nursing research: Reading and using research in evidence-based practice (2nd ed.)*. Philadelphia: Wolters Kluwer and Lippincott Williams and Wilkins.

McDaniel, R. W. & Bach, C.A. (1996). Focus group research: The question of scientific rigor. *Rehabilitation Nursing Research*, 5 (2), 53-59.

McLean, A. (1995). Empowerment and the psychiatric/ex-patient movement in the United States: contradictions, crisis, and change. *Social Science in Medicine*, 40 (8), 1053-1071.

Mental Health Commission (2005a). *A vision for a recovery model in Irish mental health*

Services. Dublin: Mental Health Commission. Retrieved from

<http://www.mhcirl.ie/file/discpapvforarecmod.pdf>

Mueser, K., Corrigan, P., Hilton, D., Tanzman, B., Schaub, A., Gingerich, S., Essock, S. M.,

Tarrier, N., Morey, B., Vogel-Scibilia, S. & Herz, M. I. (2002). Illness management and recovery: a review of the literature. *Psychiatric Services*, 53 (10), 1271-1284

Natanson, M. (1973). *Edmund Husserl: Philosophy of infinite tasks*. Evanston, IL:

Northwestern University Press.

Novacek, J., & Raskin, R. (1998). Recognition of warning signs: a consideration for cost-

effective treatment of severe mental illness. *Psychiatric Services*, 49 (3), 376–378.

O'Leary, Z. (2004). *The essential guide to doing research*. London: Sage Publications.

Olsen, R. (2008) 'Self-selection bias'. In: P. J. Lavrakas (Ed.) *Encyclopaedia of survey*

research methods, (pp. 809-811). Thousand Oaks, CA: Sage Publications.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R.O. & Cook, J.A. (2007). An analysis of the

definitions and elements of recovery: a review of the literature. *Psychiatric Rehabilitation Journal*, 31 (1), 9- 22.

Pallaveshi, L., Balachandra, K., Subramanian, P. & Rudnick, A. (2014). Peer-led and

professional-led group interventions for people with co-occurring disorders: A qualitative study. *Community Mental Health Journal*, 50 (4), 388-394.

Pitschel-Walz, G., Leucht, S., Bauml, J., Kissling, W. & Engel, R. R. (2001). The effect of

family interventions on relapse and re-hospitalization in schizophrenia—a meta-analysis. *Schizophrenia Bulletin*, 27 (1), 73–92.

Ridgeway, P. & Press, A. (2004). *Assessing the Recovery-orientation of your mental health program: A User's guide for the Recovery-Enhancing Environment Scale (REE)*.

Kansas: University of Kansas

Rudnick, A. (Ed.). (2012). *Recovery of people with mental illness philosophical and related perspectives*. London: Oxford University Press.

Salzer, M. S. (1997). Consumer empowerment in mental health organisations: concept, benefits, and impediments. *Administration and Policy in Mental Health*, 24 (5), 425–434.

Sheehan, A. (2002). *Inspirations: A photographic record of recovery*. London: NIMHE.

Silverman, D. (1997). *Discourses of Counselling: HIV Counselling as Social Interaction*. London: Sage Publications.

Slade, M. (2009). *Personal recovery and mental illness. A guide for mental health professionals*. Cambridge: Cambridge University Press.

Starnino, V. R., Mariscal, S., Holter, M. C., Davidson, L. J., Cook, K., S. Fukui, S. & Rapp, C. A. (2010). Outcomes of an illness self-management group using wellness recovery action planning. *Psychiatric Rehabilitation Journal*, 34 (1), 57-60.

Stocks, M. L. (1995). In the eye of the beholder. *Psychiatric Rehabilitation Journal*, 19 (1), 89-91.

Strauss, J. S. (1996). Subjectivity. *Journal of Nervous and Mental Disease*, 184 (4), 205-212.

Torrey, W., Rapp, C., Van Tosh, L., McNabb, C. & Ralph, R. (2005). Recovery principles and evidenced-based practice: Essential ingredients of service improvement. *Community Mental Health Journal*, 41 (1), 91-100.

Tymieniecka, M. T. (2003). Introduction: Phenomenology as the inspirational force of our

times. In: Tymieniecka, M. T. (ed.) *Phenomenology world-wide: foundations-*

expanding dynamics-life-engagements: A guide for research and study. London:

Kluwer Academic, pp. 1-10.

Wallcraft, J. (2005). Recovery from mental breakdown. In: J. Tew (Ed.). *Social perspectives*

in mental health (pp.200-227). Philadelphia: Jessica Kingsley Publishers.

Wiles, R. (2013). *What are qualitative research ethics?* London: Bloomsbury Academic.

Wilson, J. M., Hutson, S. P. & Holston, E. C. (2013). Participant satisfaction with Wellness

Recovery Action Plan (WRAP). *Issues in Mental Health Nursing*, 34 (12), 846-854.