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ORIGINAL RESEARCH

Evaluation of mental health recovery and Wellness Recovery Action Planning education in Ireland: a mixed methods pre–postevaluation

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Abstract

Aim. To report a study evaluating the effectiveness of a Wellness Recovery Action Planning education programme.

Background. Internationally, mental health policy is advocating using recovery approaches to care. Underpinning these approaches is investment in education in recovery principles and methods and a need to provide evidence of the impact of this education.

Design. The study design employed a mixed methods approach.

Methods. Using questionnaires and focus groups, we evaluated 2- and 5-day Wellness Recovery Action Planning Education Programmes and assessed participants' attitudes towards recovery, knowledge of recovery and Wellness Recovery Action Planning beliefs. Data were collected between 2009 and 2010. Participants were people with personal experience of mental health problems, practitioners in mental health services and family members/carers of those with mental health problems.

Results. Comparing the pre and postmeasures showed that the programme increased participants' knowledge of and attitudes towards recovery and Wellness Recovery Action Planning. Although this increase was statistically significant for the 2-day programme, it was not so for the 5-day programme. Participants reported being very positive and enthusiastic about the programme and the benefits they had achieved personally and professionally as a result of participating.

Conclusions. This exploratory study shows that providing mental health practitioners and people with personal experience of mental health problems with a systematic education and training in recovery principles using the Wellness Recovery Action Planning approach leads to positive changes in people's knowledge, skills and attitudes towards recovery. This education appeared to inspire, invigorate and empower people, and for many, it was a life changing experience.

Keywords: evaluation, mental health, nurses, personal experience, recovery, recovery education, wellness recovery action plans

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Introduction

International mental health policy literature suggests that there is a strong interest in the incorporation of recovery concepts into the organization and delivery of mental health services (Department of Health UK 2001, Mental Health Commission New Zealand 2001, Department of Health and Children 2006). Although there is no agreed definition of recovery, there is general consensus that recovery is not a linear process, but a personal journey that involves a change in attitudes, beliefs and skills to live a hopeful and meaningful life (Mental Health Commission 2006, Higgins 2008). In a recent Irish study on mental health recovery, Kartalova-O'Doherty and Tedstone Doherty (2010) described the recovery process as an open-ended, gradual and individual process that involved the reconnection with self, others and time. There is, however, limited empirical evidence on recovery education approaches. This article reports the findings of a mixed method study evaluating the effectiveness of a specific recovery education programme: the Wellness Recovery Action Planning (WRAP).

Background

Wellness Recovery Action Planning

In WRAP participants identify early warning signs or 'triggers' for distress, in addition to identifying internal and external resources to support their recovery by creating individualized plans for successful living including strategies for staying well and minimizing triggers to distress. WRAP includes an advanced directive on preferences for care and treatment in the event of a decline in a person's decision-making capacity. Personal responsibility, education, hope, self advocacy, peer support and future planning underpin WRAP. People are empowered to take control of their own wellness and what happens during their recovery journey (Copeland Center For Wellness & Recovery 2009a,b).

The WRAP is considered the most popular self management strategies for maintaining mental health and it is being used in different parts of the world including England, USA and New Zealand (Mcintyre 2005, Cook *et al.* 2009, Hill *et al.* 2010, Slade 2009).

WRAP education programmes: evaluations of outcomes

Reports evaluating WRAP education have been documented in the USA (Buffington 2003, Cook *et al.* 2009, Cook undated), England (Culloty 2005, Hill *et al.* 2010), New Zealand (Mcintyre 2005, Doughty *et al.* 2008), Scotland (Gordon & Cassidy 2009) and Canada (Culture of Recovery Project undated). The programmes evaluated varied in duration, ranging from 1 day (Doughty *et al.* 2008) to a 20-week programme (40 hours) (Cook undated). The content of programmes tended to focus on: hope, responsibility, self advocacy, identification of early warning signs, strategies and supports to address potential precrisis and crisis situations; suicide prevention; and the development of a personal WRAP. Analysis of some of the education programmes indicated an adherence to an illness model of mental distress rather than to a more all embracing and holistic understanding of such distress.

Irrespective of the duration of the programmes, the results indicated some positive changes in levels of knowledge of, attitudes towards and skills in recovery and recovery-related topics (Borkin *et al.* 2000, Doughty *et al.* 2008, Cook undated, Culture of Recovery Project undated). Participants reported a deeper understanding of personal recovery, such as having an increased understanding and appreciation of personal strengths (Culture of Recovery Project undated) and an increased ability to identify early warning signs, develop a crisis plan and use wellness tools in their daily lives (Cook undated, Culture of Recovery Project undated). Some of the tools used included: taking responsibility for their own wellness, having a lifestyle that promotes recovery, ensuring a network of supports and being aware of and having skills to respond to early warning signs (Buffington 2003, Cook undated, Culture of Recovery Project undated). Participants reported having greater confidence in talking about their experiences, in asking questions and in using wellness and recovery language (Buffington 2003, Culloty 2005, Cook *et al.* 2009, Culture of Recovery Project undated). In some studies participants reported feeling confident in having the knowledge and skills to help others to develop a WRAP (Hill *et al.* 2010). However, in one of the smaller studies 8 weeks after training, seven of the eight participants had not written anything further in their WRAPs (Gordon & Cassidy 2009).

WRAP education in the current study

The recovery and WRAP education programme was developed by the Irish Mental Health & Recovery Education

Consortium (IMHREC) with the aim of using recovery concepts and WRAP with people with personal experience of mental health problems, family members/carers and mental health practitioners. The programme was facilitated in two stages: participants first completed a 2-day programme and a smaller cohort subsequently attended a 5-day programme. The initial 2-day programme provided participants with an overview of the recovery principles and an introduction to developing individual WRAPs. The 5-day programme focused on giving the participants skills to help other groups learn about recovery and WRAP. Participants to the programmes were recruited through advertising within mental health services, and national and local media.

The study

Aim

The aim of the study was to evaluate the effect of Wellness Recovery Action Planning on participants' knowledge, attitude and skills in using the Wellness Recovery Action Planning approach.

Design

The study employed a mixed methods design using questionnaires and focus groups.

Sample/participants

For the quantitative part of the study, the sample comprised a convenience sample of all participants who attended the WRAP education programmes, drawn from multiple sites around Ireland. Participants were people with personal experience of mental health problems, practitioners in mental health services and family members/carers of those with mental health problems who attended a 2-day WRAP programme [n = 197, 194 (98%) of whom consented to participate in the evaluation] and a 5-day WRAP programme [n = 67, of whom 59 (88%) consented to participate in the evaluation]. A subsample of 33 of the 57 (58%) participants who had attended the 2- and 5-day programmes participated in the qualitative focus groups.

Data collection

Data were collected over 1 year between 2009 – 2010. Data on the impact of the recovery and WRAP facilitation programmes were collected using pre and postcourse questionnaires. The information captured in these questionnaires was opinions on, and knowledge of, recovery from mental health problems. A follow-up, in the form of a series of focus group interviews with a sample of the participants of the 2- and 5-day programmes, was also held.

Measures

The precourse 2-day questionnaire consisted of four sections. Section A focused on demographic details.

Section B consisted of a Recovery Knowledge Questionnaire (RKQ) which comprised 10 True/False items related to knowledge of the key principles that represent the collaborative recovery model. The questions were sourced from an Essential Shared Capabilities training booklet prepared by the National Institute for Mental Health in England (2007). Each item answered correctly was scored as 1. Incorrect items were scored at 0. The sum of correct responses was used in the analysis, with higher scores indicating better knowledge. The RKQ had a Cronbach's alpha of 0·74.

Section C comprised the Recovery Attitudes Questionnaire 7 (RAQ-7) which consisted of a 7-item scale deemed to be appropriate to assess attitudes towards recovery and differentiate between those who are familiar with and positive towards the idea of recovery from those who are not (Borkin *et al.* 2000) The scale has a Cronbach's alpha of 0·70 and a test-retest reliability coefficient of 0·67 (Borkin *et al.* 2000). The questions were 5-point Likert scale questions ranging from 1 (strongly disagree) – 5 (strongly agree).

Section D consisted of the Beliefs about Recovery and WRAP questionnaire. This questionnaire was used by Doughty *et al.* (2008) to evaluate consumers' and health professionals' views of WRAP programmes in New Zealand and had a Cronbach's alpha of 0·88. Participants were asked to rate their agreement with statements about recovery on a 5-point Likert scale, ranging from 1 (strongly disagree) – 5 (strongly agree). Of the 18 statements in this section, 15 were phrased positively and 3 were phrased negatively. These positively and negatively phrased questions were analysed separately.

The precourse 5-day questionnaire had a fifth section, which asked participants to rate their skills in facilitating or teaching others about recovery and WRAP on a 1–5 Likert scale, where 1 corresponded to 'No Skills' and 5 to 'Excellent Skills'.

Postcourse questionnaires

For comparative reasons Sections B, C, D and E of the 2-day postquestionnaires repeated the questions included in the precourse questionnaire.

Focus groups

Focus groups were held with participants who completed the 2- and 5-day programmes, and were held in three centres nationally. Each focus group was facilitated by two members of the research team, a facilitator and moderator, using a topic guide which prompted participants to discuss their personal experiences of the programmes, its impact on their life and work, comparisons with other mental health programmes, their confidence in facilitating WRAP programmes themselves in the future (only for 5-day participants) and the further development of WRAP in Ireland.

Ethical considerations

Ethical approval to conduct the study was granted from the Research Ethics Committee of the Faculty of Health Sciences at the university from which the study was run. All participants who attended the programme were given detailed information (written and verbal) about the evaluation. Participants who wished to participate in the focus group interview were recruited through a letter and an opt-in form. Written and verbal consent was obtained prior to interviews. Return of questionnaires was taken as consent for this aspect of the study.

Data analysis

All participants were given a numerical code to aid matching of questionnaires. Quantitative data were entered into the Statistical Package for the Social Sciences version 16 (SPSS, SPSS Inc., Chicago, IL, USA) for analysis. Questionnaires that could not be matched were excluded from this analysis. Both descriptive and inferential statistics were generated. These included means, standard deviations and *t*-tests used mainly for comparing the pre and postmeans for each scale.

All focus groups were audio recorded and transcribed for analysis. Prior to analysis transcriptions were cleaned of any identifying information and compared with audio recordings for accuracy. The overall analytic approach was guided by the Braun and Clarke (2006) thematic approach. Data were analysed by coding for key ideas, concepts and patterns, which were then compared for similarities and difference and merged into higher order themes.

Rigour of data analysis

To ensure accuracy and completeness of quantitative data one person entered the data into SPSS and another person confirmed correct entry by comparing data with the survey forms. The researchers eschewed the use of the Bonferroni adjustment as we were interested in assessing the effect of the WRAP programme on each variable independently, something which the Bonferroni adjustment would be unable to reveal as it simply shows the possible effect on the significance level when accounting for the multiple tests. Also, the Bonferroni has little practical value in determining the practical significance of the intervention, which was of more interest to the researchers. Finally, the Bonferroni adjustment also increases the likelihood of a type 2 error with the result of potentially denying people with mental health problems the WRAP programme when we have shown it is helpful to their recovery (Perneger 1998). The researchers recognize, however, that the use of the Bonferroni correction is a controversial topic in the statistical literature.

To enhance the rigour of the qualitative analysis, all transcripts were analysed by two researchers, who compared and agreed codes and themes. The analysis was also informed by the field notes which were taken by the group facilitator and moderator. Other methods used to enhance the trustworthiness of qualitative data included the collection of data from participants who attended the three centres and the use of participants' narratives to substantiate claims made about the data.

Results

Quantitative findings

In total, 194 pre and postquestionnaires were matched for the 2-day programme and 59 were matched for the 5-day

Table 1 Breakdown of participants' self description for 2- and 5-day programme.

	2-Day		5-Day	
Self description	*N*	%	*N*	%
Mental health practitioner only	59	31	18	31
Person with self experience only	47	25	9	15
Family member/carer only	10	5	4	7
Mental health practitioner and carer/family member	26	14	10	17
Self experience and mental health practitioner	15	8	4	7
Self experience and carer/family member	15	8	7	12
Self experience, MHP and family member/carer	6	3	1	2
Other	15	8	6	10
Missing	1	0·5	0	0
Total	194	100	59	100

programme. Table 1 provides a breakdown of participants' descriptions of themselves. It is noteworthy that there is considerable overlap in the roles participants describe themselves as having.

Participants who completed the questionnaires were from all age categories, however, the groups categorized as younger than 30, and over 60, were the least represented. Approximately two-thirds of the participants at the 2-day (F = 126, M = 68) and 5-day (F = 38, M = 20) education programme were women (Table 2).

Knowledge of recovery

Participants showed high degrees of knowledge of recovery prior to participation in the programmes, but still demonstrated increased knowledge as measured with the Recovery Knowledge Scale (RKS) after the 2- and 5-day programmes. This increase in knowledge was statistically significant for the participants who attended the 2-day programme, but not for the 5-day participants. These results are shown in Table 3.

Recovery attitudes

Participants showed positive attitudes towards the principles of recovery as measured with the RAQ-7 before participating in the programme, and demonstrated slightly more positive attitudes towards recovery principles after the 2- and 5-day programme. This increase was only important for the 2-day programme. These results are shown in Table 4.

WRAP beliefs

The WRAP Beliefs Questionnaire measures participants' beliefs about recovery and WRAP. The way in which 15 of the 18 questions were worded suggests that when participants were in agreement, they expressed support for WRAP-related beliefs (positive questions). For 3 of the 18 questions, the opposite was the case, and agreement with the questions meant holding beliefs contrary to the WRAP principles (negative questions). The two types of questions were analysed separately. The summated scores for the 15 positive questions indicated that before participating in the programme, participants were already in agreement with most of the WRAP beliefs, and participation enhanced significantly those beliefs for both the 2- and 5-day participants. For the three negative questions, a change in beliefs more supportive of WRAP principles was only statistically significant for the 2-day participants (Table 5).

Table 2 Breakdown of participants' age.

Age group	*N* = 194 (2-day)	%	*N* = 59 (5-day)	%
20–30 years	37	19	6	10
31–40 years	48	25	17	29
41–50 years	62	32	17	29
51–60 years	33	17	12	20
61–70 years	13	6·5	2	3
Missing	1	0·5	5	8
Total	194	100	59	100

Confidence in ability to apply recovery and WRAP Skills

To evaluate whether or not participants perceived that the programme had increased their confidence, participants were asked to rate its impact using a 5 point scale ranging from 1 (strongly disagree) – 5 (strongly agree) in three areas. The greatest increase in confidence for participants who completed the 2-day programme came in their ability to manage their own mental health and recovery. In comparison, the ability to help another person to develop his/her own WRAP plan had the highest mean score (*N* = 57, mean = 4·63 SD = 0·59) after the 5-day programme. The higher means after the 5-day programmes suggest that confidence kept growing (Table 6).

Teaching and facilitation skills

One of the principle objectives of the 5-day programme was to educate people to become WRAP facilitators. On average, participants considered themselves having 'some skills' (3) before participating in the 5-day programme. After participation they considered themselves 'very skilled' (4) or better at facilitating the learning of others on five of the nine areas identified. Paired samples *t*-tests indicated that participants' perceptions that their teaching and facilitation skill levels had improved on all items, from pre to post, were statistically significant (Table 7).

Qualitative results

This section presents some of the core issues from the focus groups held with the participants of the 2- and 5-day programmes. The themes identified from these analyses are summarized in Table 8.

The programme was viewed as an empowering experience in that it promoted a sense of self belief and capacity for wellness and recovery among all participants and was instrumental in sending out a message that people can live well with and recover from mental illness. The shift in emphasis from an illness model to the promotion and nurturing of positive mental health was viewed by participants as a core message of recovery. The focus on self help, self management and taking responsibility was perceived by the participants to be empowering, refreshing and a contrast to the biomedical model that emphasized medication. Par-

Table 3 Mean scores on Recovery Knowledge Questionnaire (RKQ), pre and postparticipation in the 2- and 5-day programmes.

	Pre		Post		Confidence interval		Paired samples *t*-test (two-tailed)		
Programmes	Mean	SD	Mean	SD	Lower	Upper	*t*	d.f.	*P* value
2-Day (*n* = 190)	8·26	1·74	8·80	1·56	−0·78	−0·31	−4·59	189	< 0·0001
5-Day (*n* = 56)	8·84	0·98	9·04	0·79	−0·43	0·04	−1·67	55	ns

Table 4 Mean scores on Recovery Attitudes Questionnaire (RAQ-7), pre and postparticipation in the 2- and 5-day programmes.

	Pre		Post		Confidence interval		Paired samples *t*-test (two-tailed)		
Programmes	Mean	SD	Mean	SD	Lower	Upper	*t*	d.f.	*P* value
2-Day (*N* = 173)	29·80	2·80	30·5	3·27	−1·23	−0·30	−3·27	173	0·001
5-Day (*N* = 58)	30·91	2·54	31·48	2·11	−1·20	−0·06	−1·81	57	ns

Table 5 Comparison of pre and post-test WRAP beliefs.

	Pre		Post		Confidence interval		Paired samples *t*-test (two-tailed)		
Programmes	Mean	SD	Mean	SD	Lower	Upper	*t*	d.f.	*P* value
2-Day									
N = 162 (Positive statements)	60·95	5·31	65·01	5·35	−4·74	−3·37	−11·65	161	< 0·0001
N = 180 (Negative statements)	5·93	1·98	5·45	1·95	0·19	0·77	3·26	180	< 0·0001
5-Day									
N = 52 (Positive statements)	64·19	4·50	66·73	5·16	−3·46	−1·62	−5·59	51	< 0·0001
N = 57 (Negative statements)	5·18	1·45	4·82	1·55	−0·02	0·72	1·90	56	ns

Table 6 Mean impact on confidence, post 2- and 5-day programmes.

Impact of programme on confidence						
The programme increased my confidence to	Post 2-day			Post 5-day		
	N	Mean	SD	*N*	Mean	SD
Offer peer support to others	190	4·19	0. 74	57	4·49	0·74
Help another person develop their own Wellness Recovery Action Plan	191	4·41	0·63	57	4·63	0·59
Manage my own mental health and recovery	191	4·46	0·65	56	4·59	0·57

ticipants reported learning new techniques and strategies to promote their own recovery and left the programme with a greater sense of hope, a belief in the capacity for their own and others' wellness and recovery, a greater belief in the importance of people being enabled to regain control of the own lives and recovery, and a greater sense of empowerment and agency. All the participants spoke of the supportive, educational and affirmative value of sharing and listening to each others' experiences, in an environment where their humanity was respected and their experiences valued. Participants attributed the majority of their learning to the storytelling, disclosure and dialogue that was fostered throughout the education programmes.

Some difficulties and challenges were highlighted. The difficulties with WRAP mainly consisted of the personal time required to complete it and the impact of people's distress on their ability to work through a WRAP. Similar challenges have also been documented previously, and concerns around the impact of heavy caseloads and heavy administrative tasks on practitioners' time to facilitate the people to develop a WRAP (Culloty 2005). Many participants offered suggestions on how recovery and WRAP could be implemented and sustained. Examples of these included having an apprenticeship model of facilitation, developing a support network for facilitators, and extending education outside traditional health services.

Discussion

Study limitations

The study did not include a control group for comparison. Participants volunteered to take part in the programme and

Table 7 Participants' self-rated skill levels pre and post 5-day programme and test of differences.

		Pre		Post		Confidence interval		Paired samples *t*-test (two-tailed)		
	N	Mean	SD	Mean	SD	Lower	Upper	*t*	d.f.	*P*
Wellness tools	59	3·47	0·70	4·20	0·69	−0·93	−0·52	−7·14	58	< 0·0001
Personal responsibility	57	3·60	0·67	4·15	0·76	−0·77	−0·37	−5·76	56	< 0·0001
Hope	58	3·52	0·70	4·15	0·69	−0·81	−0·44	−6·72	57	< 0·0001
Self advocacy	59	3·37	0·80	4·10	0·71	−0·93	−0·53	−7·35	58	< 0·0001
Peer support	58	3·19	0·96	4·00	0·72	−1·03	−0·60	−7·44	57	< 0·0001
WRAP	59	3·12	0·62	3·92	0·68	−0·98	−0·62	−8·87	58	< 0·0001
Crisis planning	59	2·94	0·69	3·85	0·72	−1·09	−0·66	−8·19	58	< 0·0001
Values based care	59	3·08	0·93	3·73	0·83	−0·40	−0·89	−5·25	58	< 0·0001
Advanced agreements	59	2·67	0·85	3·22	0·81	−0·86	−0·33	−4·52	58	< 0·0001

this possibly attracted people motivated to change. Questionnaires were administrated at the beginning and end of the 2- and 5-day programmes. As a result, participants' enthusiasm about the programme may have been enhanced from their experience and the collegial atmosphere generated by meeting other people. Although the evaluation demonstrated improvements in the participants' attitudes, knowledge and perceived skills, longer term outcomes were not considered in the evaluation.

Discussion of results

The study involved a large sample, drawn from three sites around the Republic of Ireland and used a pre and post-test design with focus group interviews. Findings indicated that the programme impacted positively on participants' knowledge, attitudes and beliefs about recovery and WRAP, in line with the changes reported by others who have evaluated recovery and WRAP education programmes (Culloty 2005, Doughty *et al.* 2008, Hill *et al.* 2010, Culture of Recovery Project undated). Although findings from the quantitative measures indicated that participants already had considerable knowledge of WRAP and recovery prior to participation, and held positive attitudes towards recovery and WRAP, participation in the programme further strengthened their attitudes and knowledge, and increased the participants' own belief in their knowledge of WRAP and recovery. Results were consistently statistically significant on all measures for the 2-day participants; however, a ceiling effect seemed to have occurred on the RKS and RAQ7 for the 5-day participants. This could be due to the fact that the participants had already completed the 2-day programme, thus the vast majority of participants were familiar with the questions and concepts, making it unlikely their scores could increase much further. In addition, participants held quite positive attitudes towards recovery prior to participation in the 2-day programme, and were more in agreement with recovery principles than the participants used for the validation of the RAQ7 in Borkin *et al.*'s (2000) study. The mean scores for the present study prior to participation was around 30, whereas Borkin *et al.* (2000) found mean scores of around 22 for their sample.

Quantitative findings also indicated that there were increases in participants' self-rated ability to manage their own mental health and recovery. These findings were supported within the focus group interviews, with participants expressing positive views about the WRAP structure and welcoming the simplicity of its approach and language. They reported a greater awareness and ability to manage and cope with negative experiences, including increased awareness of factors/triggers that influence stress levels and ability to access internal resources. Similar positive outcomes have been reported in other evaluations. These included an important perceived increase in knowledge of tools for coping with early warning signs and distress; increased understanding of how to create a crisis plan/WRAP, express needs and wishes and explain early warning signs; and finding it easier to engage in recovery-promoting activities (Buffington 2003, Culloty 2005, Doughty *et al.* 2008, Culture of Recovery Project undated).

One of the most valuable aspects of the programme was the bringing together of people with personal experience, mental health practitioners and to a lesser extent family members/carers. Findings from this study suggest that involvement of people with personal experience, family and practitioners increased partnership skills and served to challenge professional orthodoxies and power. There is some suggestion in the literature that taking on a valued role in education can have positive outcomes for people with personal experience, such as increased self esteem, empowerment and gaining new insight into their lives (Walters *et al.*

Table 8 Themes identified from the focus groups.

Theme	Meaning	Illustrative example
Recovery and WRAP: An inspiring and invigorating experience	Participants described the programme in a positive way and spoke of it as being an inspiring, invigorating and life changing experience that promoted self confidence	'For me this has been the most amazing, beneficial personal experience' 'I found it a very confidence building course, my confidence built up more as it went on'
Recovery and WRAP: Shifting the paradigm of mental health care	A move away from medical and illness paradigms towards a more positive recovery orientated view of mental health	'The focus was more positive, it focused on getting well rather than sickness'
Putting Recovery and WRAP into Practice: A simple and practical toolkit consideration	Participants valued WRAP due to its simplicity and practicality, they also found it to be logical and achievable	'What WRAP does is it brings them all together [ideas previously come across] in a simple, systematic straightforward way, into a very useable package'
Learning Together: Diversity of perspective and levelling the playing field	Participants reported positive feedback learning with people with self experience, practitioners and family/carers due to hearing different perspectives and feeling accepted and equal	'The thing I found most useful was hearing different perspectives from the different people' 'It was the first time I had a strong sense of it [being equal] in any connecting group'
Structure and Delivery of the Programme: Mixed reactions	There were mixed opinions on group size, spacing of the training days, and preparation for the presentations	'I think [the group was] far too big. You ended up sticking to your own group too much; I think a smaller group would have allowed freer dis cussion and much more time for it' 'To give more people a chance to actually do one [recovery plan] and get feedback on it like…it's getting other people's perspectives on it as well'
Mainstreaming Recovery and WRAP: Obstacles and concerns	The perceived obstacles and concerns that might impact negatively on the future of recovery and WRAP revolved around personal confidence, current biomedical philosophy of services, lack of leadership, maintaining the philosophy of recovery and WRAP, and burdening people with self experience	'I felt a lot of the focus of the group was about recovery and the ethos and very inspirational, but it wasn't so practical in terms of how you'd deliver' 'When I was at my lowest point I wouldn't have done a WRAP program…you have to be in a well enough state even to just stay for the 2-days'
Forward Movement and Sustaining Progress: Strategies for consideration	Most of the participants were keen either to implement WRAP into their own practice or educate others about it	'It should be unwrapped long before you hit the mental health services. You know, parenting courses, I don't care where you start but it should be an ethos of life'

2003, Barnes *et al.* 2006, Repper & Breeze 2007). Findings obtained in this study add weight to these views. Participating in the programme gave some participants a palpable sense of personal validation, equality and affirmation of the contribution that people with personal experience can make to the education of others. Through their involvement as equals in the learning process, some participants began the process of reconstructing a more positive and valued sense of their identity, one that transcended the label of illness and the stereotypes associated with illness roles.

All the participants spoke of the supportive, educational and affirmative value of sharing and listening to each others' experiences, in an environment where their humanity was respected and their experiences valued. Participants attributed many of the positive outcomes to the level of interaction, engagement and personal disclosure that was fostered throughout the days.

The content of the programme under evaluation was similar to other education programmes documented in the literature, although there was a concerted effort made by the facilitators to move away from the medicalization of recovery and WRAP, hence the language of 'diagnosis', 'symptom', 'relapse' and 'compliance' was avoided and WRAP was spoken of as a 'life plan' for all as opposed to an 'illness recovery plan'. Similar to other programmes evaluated, participants were highly satisfied with the content and delivery of the programme, with an overwhelming majority agreeing or strongly agreeing that they would recommend the course to others.

One of the main objectives of the 5-day programme was to develop people's skills in facilitating a 2-day recovery and WRAP programme. Comparison of reported teaching and facilitation skill levels before and after the 5-day programme showed statistically significant increases in participants'

What is already known about this topic

- International mental health policy is adopting a recovery-oriented approach to practice.
- Wellness Recovery Action Planning is a popular self management educational strategy for maintaining mental health that is recovery-oriented.
- There are limited evaluations of Wellness Recovery Action Planning, that include people with personal experience, mental health practitioners and family members/carers.

What this paper adds

- Systematic education and training in recovery principles using the Wellness Recovery Action Planning approach leads to positive changes in participants knowledge, skills and attitudes towards recovery principles.
- Wellness Recovery Action Planning education delivered using a tripartite model transforms people's world views around mental distress and illness, and provides people with strategies to support mental health.
- Although Wellness Recovery Action Planning education increases reported skill in teaching and facilitating the Wellness Recovery Action Planning approach, participants still experience a lack of confidence in their ability to teach and facilitate these changes in others.

Implications for practice and/or policy

- Providers and educators seeking to embed recovery principles into service delivery and education should consider adopting, as one approach, the principles and methods of the Wellness Recovery Action Planning programme.
- Further evaluations of Wellness Recovery Action Planning should consider testing its effectiveness against other approaches.
- Future researchers should agree on core outcome measures to allow for direct comparisons between studies.

perceptions of their ability to teach and facilitate the principles underpinning recovery and WRAP. However, the increase in reported skill in teaching and facilitation did not transfer to all participants' confidence to do so. Within the 5-day focus groups, participants (especially those who had little previous experience of teaching and facilitating groups), expressed a lack of confidence in their ability. Indeed, expecting a more positive outcome may have been overly ambitious on the Consortium's behalf, as the development of facilitation and teaching skills requires time, practice, support and reflection. What is important as an outcome in this study is the overwhelming desire of all the participants (both the 2- and 5-day) to become involved in spreading the message of recovery and WRAP. In addition, the 5-day participants were very positive about becoming involved in developing and facilitating similar education programmes, and many spoke of their plans to work with mentors to build confidence and skills.

In contrast, to Borkin *et al.* (2000) who reported some differences in attitudes to recovery among the various groups included in their study, the current study found no important differences in quantitative outcomes between people with personal experience, family members and practitioners. Doughty *et al.* (2008) who reported similar results suggest that this is an indication that recovery and WRAP may have not been included to a large extent in the training of mental health professionals in New Zealand. However, in the present study, it is difficult to draw a similar conclusion as both groups were supportive of beliefs around WRAP and recovery and showed positive attitudes towards the concept and its implementation before participating in the 2-day programme. This suggests that they had been exposed equally to some of the ideas.

One of the key elements contributing to the success of this programme was the facilitators' knowledge of the area of recovery and WRAP and their ability to create a non-judgmental, supporting and facilitative learning environment that enabled participants to actively engage with learning and transform their world views. In presenting a similar programme, future facilitators need to be adequately prepared for their role, otherwise the potential of recovery and WRAP education may be lost, with it becoming just another tool that is integrated within what appears to many people as the benign paternalistic and illness-oriented paradigm of current mental health care.

Conclusion

Mental health literature suggests that there is a strong interest in the incorporation of recovery concepts into the organization and delivery of mental health services from service users and service providers. This represents an important challenge for service users, family/carers, mental health practitioners and providers, who must work together in partnership if this paradigm shift is to be realized.

Findings from this exploratory study indicate that the recovery and WRAP education programme has the potential to engage people in collaborative discussion and increase

people's knowledge, promote positive attitudes and beliefs about recovery and WRAP. This education also inspires, invigorates and empowers people, and for many, it is a life changing experience. The study clearly demonstrated the importance and power of a tripartite model of education, if facilitated with skill and empathy. One of the main objectives of the 5-day programme was to develop people's skills in facilitating a 2-day recovery and WRAP programme. Although participants reported increased skill in teaching and facilitating the WRAP approach, they still experience a lack of confidence in their ability to teach and facilitate these changes in others.

This study has a number of implications for policy, practice and research. There is a need for a national strategy for mental health recovery education, with due consideration given to expanding recovery education outside traditional mental healthcare environments into the wider community. Providers and educators seeking to embed recovery principles into service delivery and education should consider adopting, the principles and methods of the WRAP programme used in this study, including using the tripartite model of education. In view of participants' lack of confidence in facilitating future training, consideration needs to be given to developing an apprenticeship or mentorships model of facilitation, for new trainers. Although we have demonstrated the effectiveness of the WRAP approach; further evaluations of WRAP should consider testing its effectiveness against other approaches on longer term outcomes. We also suggest that future researchers agree on core outcome measures to allow for direct comparisons between studies.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

AH and PC were not only responsible for the study conception and design but also obtained funding. AH, JDV, BK, JM and DR performed the data collection. AH, PC, JDV, BK, JM, MN, DR and HG performed the data analysis. PC and TC were responsible for the drafting of the manuscript. AH, PC, JDV, BK, JM, MN, DR, HG and TC made critical revisions to the article for important intellectual content. PC and JDV provided statistical expertise.

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