Evaluation of the Mental Health Recovery and WRAP Education Programme

Report to the Irish Mental Health & Recovery Education Consortium

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Executive Summary

Background
Mental health policy in Ireland has emphasized the need for a Recovery orientation to inform all aspects of the design, development and delivery of mental health services and for the education of all staff working in these services. A Recovery-focused approach to care is one of the standards identified in the Quality Framework for Mental Health Services in Ireland (Mental Health Commission, 2007). The provision of high quality education in the philosophy and principles of Recovery that is relevant, accessible and evidence based is thought crucial if the vision for Recovery-oriented mental health services in Ireland is to be realized. To this end, a group of mental health service providers, called The Irish Mental Health & Recovery Education Consortium (IMHREC), came together to develop and deliver a facilitated learning programme on Mental Health Recovery, throughout the Republic of Ireland. The consortium represented stakeholders—families, carers, people with experience of using mental health services and practitioners—and comprised Eastern Vocational Enterprises (EVE), Support, Training, Education, Employment and Research Ireland (S.T.E.E.R), Sli Eile Housing Association, Mayo Mental Health Association and Ballyhoura Development. The education programme was funded by the Department of Justice, Equality and Law Reform under the Enhancing Disability Services Programme.

The education initiative involved a two-day education programme which sought to educate individuals about Recovery and WRAP (Wellness Recovery Action Planning) principles and teach participants strategies to promote mental health recovery. This was followed by a five-day education initiative for a smaller cohort of participants which was aimed at providing its participants with a greater depth of knowledge on recovery and WRAP in addition to the facilitation skills necessary to deliver the two-day WRAP recovery programmes within their own communities. Participants who had attended the two-day programmes were eligible to apply for a place on the five-day programme.

Aim of the evaluation
An independent evaluation of the education programme was commissioned, with the aim of evaluating the impact of the education programme on participants’ knowledge, attitude and skills in mental health recovery.

Methods
The evaluation employed a multi-method approach using quantitative and qualitative approaches. Data on the impact of the programme were collected using pre and post programme questionnaires. Of the 197 people who attended the 2-day programme all
completed the pre course questionnaires and 195 people completed the post course questionnaires. Of the 68 participants who completed the 5-day programme, 67 completed the pre course questionnaire, and 62 completed the post course questionnaire. Overall, the highest number of participants came from the practitioner group, followed by people with self experience and family members/carers. Participants from the family member/carer group were the least well represented group on the 2-day and 5-day programmes. More than 25% of the participants on both the 2-day and 5-day programmes described themselves in more than one category. Participants from all age categories were represented, however the groups categorised 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 female.

In addition, focus group interviews were held with participants who completed the education programme. In total, 33 participants were involved in the focus group interviews. A total of 11 people who attended the two-day programme and 22 people who attended the 5-day programme were interviewed. One focus group was also held with consortium members and telephone interviews were conducted with the 3 education facilitators of the programme.

**Findings from the questionnaires**

The programme increased participants’ knowledge of, and improved their attitudes towards, Recovery and WRAP. However, the increase in knowledge and attitudes was not statistically significant for the 5-day participants. Comparison of reported teaching and facilitation skill levels before and after the 5-day programme also showed statistically significant increases in participants’ perceptions of their ability to teach and facilitate the principles underpinning Recovery and WRAP. Participants reported they had become most skilled at facilitating Wellness Recovery Action Planning, Peer Support, Self Advocacy/Self Agency and Crisis/Post Crisis Planning. Participants were highly satisfied with the content and delivery of the programme. An overwhelming majority of participants agreed or strongly agreed that they would recommend the programme to others. The age and gender of participants, and their identification as a mental health professional or someone with self-experience of mental health problems, had little impact on participants’ experiences of the programme.

**Findings from the focus groups**

Overall, participants spoke very positively and were enthusiastic about the benefits they had achieved personally, professionally and within their broader social circle as a result of their participation in the programme. Many described their experience as inspiring, invigorating, life changing and empowering. Attending the programme exposed participants to new ways of thinking about recovery and they left the programme with a great sense of optimism about the concepts underpinning recovery
and WRAP and with clear messages of hope and personal validation. The emphasis within the programme on wellness, positive mental health and recovery were viewed as a positive move away from the dominant medical and illness paradigms. The focus on self help, self management, and taking responsibility and control was perceived by the participants to be empowering, refreshing and positive. Learning about Recovery and WRAP challenged the assumption that those with self experience of mental distress are passive recipients of mental health care. It also helped the participants to think differently about themselves and view mental distress as a normal reaction to life’s challenges. Participants described how the programme shifted their mindsets and enabled them to open up a different dialogue with themselves and others, around recovery and wellness. For participants who came from a practitioner background the programme also began a process of deep questioning around the values and knowledge base which underpin their practice. One of the most valuable aspects of the programmes appeared to be the mix of people with self experience, family members/carers and practitioners. Participants attributed many of the positive outcomes to the level of interaction, engagement and personal disclosure that was fostered throughout the days. Through the facilitative process of sharing and listening to each others’ experiences, participants were enabled to learn from and support each other. Many commented that the process of shared education helped to equalise relationships, normalise mental distress, and communicated a strong message of partnership. This model of education was seen as essential to all future education endeavours on recovery.

Participants reported that a major challenge to developing a recovery oriented service was overcoming the traditional biomedical approach, and shifting the philosophy of care from the present preoccupation with illness to one of wellness. They expressed concern that current practices might be re-labelled and repackaged as recovery without any fundamental change in philosophy and approach to care. Tied to these concerns were the lack of a national strategy for implementing a recovery oriented service, the uncertainty of IMHREC’s future (IHMREC was perceived as the driver behind the implementation of recovery and WRAP), and the perceived lack of support from medical practitioners. Some participants expressed concern that people with self experience could be exposed to an extra burden if they were continually expected to share their experiences as a means of educating others.

Most of the participants were keen to be involved in either implementing Recovery and WRAP principles into their own practice or educating others about it. For many participants, the core principles associated with recovery and WRAP were more important than the actual action plan itself. Many 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.
Conclusions
Providing mental health practitioners and people with self-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 principles, and their ability to teach and facilitate these changes in others. This education also inspires, invigorates and empowers people, and for many, it is a life changing experience. Mental Health Service Providers and Educators seeking to embed recovery principles into service delivery and education are more likely to do so if they adopt the principles and methods employed in the Recovery and WRAP education programme used in this study.

Recommendations
In light of the findings from this study, the researchers make 14 recommendations:

1. A national mental health recovery network for Ireland is developed. Consideration be given to developing the consortium that formed IMHREC as the network.

2. A national strategy for mental health recovery education be developed, with due consideration of the need to have a wider public focus and expand recovery education outside traditional mental health care environments into general health settings and the wider community, including schools and community networks.

3. Funding is made available to implement a mental health Recovery education programme for all mental health practitioners in Ireland that is inclusive of family members/carers and people with self experience.

4. An identified person/group with autonomy and authority to produce recovery education programmes is appointed.

5. The Mental Health Commission develops a national mental health recovery collaborative to put recovery at the heart of all mental health provision through Local Recovery Implementation Groups.

6. Educational accrediting bodies ensure the inclusion of recovery principles, values and practices is central to undergraduate and postgraduate education curricula that prepare mental health practitioners to work in mental health services in Ireland.

7. Funding be made available for evaluating initiatives developed to promote recovery in people living with mental health problems.
8. The network of recovery facilitators developed as a result of this programme be supported to facilitate the development of locally organised recovery education programmes.

9. Consideration be given to the development of a mentorship programme for facilitators.

10. Those who completed the 2-day programme but did not have access to the five-day facilitation be offered, as a priority, the opportunity to complete the five-day programme.

11. Similar programmes be developed and offered in areas of the country not catered for by the IMHREC project.

12. Future programmes need to address the concerns expressed by participants regarding content, facilitation and issues such as duration and room layout and recruitment of family members/carers and medical practitioners.

13. A follow-up study of participants be undertaken to examine whether the changes reported in this study were maintained over time, and to examine how participants who completed the programme used their knowledge and skills to support their own or others’ mental health. It would also be important to explore what proportion of participants actually formulated a WRAP plan either for themselves or for someone else and facilitated a formal education programme. In addition, a study is required to evaluate the outcomes of education programmes delivered by the facilitators prepared through the IMHREC process.

14. Further evaluation studies are conducted using experimental approaches. In addition, international researchers with an interest in Recovery and WRAP education agree on core outcome measurement tools so that direct comparisons between future Recovery and WRAP education evaluations can be made.
Chapter 1: Background Literature and Context

This chapter provides a brief overview of the literature on Recovery and WRAP. In addition, to set the study in context, the education programme developed by IMHREC which is the focus of evaluation will be described and discussed.

1.1 Recovery and WRAP

A review of the international mental health literature suggests that there is a strong interest in the incorporation of recovery concepts into the organisation and delivery of mental health services in several countries, most notably the United States, New Zealand, Scotland and England. More recently, policy on mental health in Ireland has also emphasised the need for a paradigm shift within mental health services from one largely dominated by a biomedical model to a recovery orientation (Department of Health and Children, 2006). Recovery is based on the idea that people who have mental health problems themselves and specifically those who use mental health services can develop skills and strategies for dealing with mental health problems that promote higher levels of wellness, stability and quality of life. Perhaps most importantly, the concept and ethos of recovery requires health practitioners, people who experience mental health difficulties, family members, and carers to think differently about mental distress/illness and the impact it can have on people’s lives (Higgins and McBennett, 2007).

While 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 in order to live a hopeful and meaningful life (Mental Health Commission (Irl), 2006). In the words of Deegan, “It is a way of life, ... an attitude and a way of approaching the day’s challenges” (Deegan, 1992:8). In a recent Irish study on mental health recovery, the authors described the recovery process as an open-ended, gradual and individual process that involved the reconnection with self, others and time (Kartalova-O’Doherty and Tedstone Doherty, 2010).

1.2 Self Management

Self-help or self-management approaches and programmes are increasingly being recognised as playing a part both within and outside of statutory mental health services. Self-help or self-management programmes have been developed and designed from notions of recovery, and include strategies such as problem solving, goal setting, symptom control, relapse prevention and shared decision making. Such programmes are either guided, as with a workshop or individual sessions, or non-guided, as with a self-help book or Internet resource (Doughty et al., 2008). Although self-management methods are promoted as an integral part of recovery based practices (Social Care Institute for Excellence (SCIE) et al., 2007), an international
review found comparatively little evidence of self-management methods in mental health settings and no real clarity on how self-management could be promoted in mental health services (Singh and Ham, 2006). Hill et al. (2009) pointed out that although self-care and self-management are prominent and valued goals of progressive services, the available models and evidence of successful outcome is partial, provisional and largely anecdotal. They refer to a report by Future Vision Coalition (2009), which recommended that self management tools, such as WRAP, should be much more widely used in everyday practice in mental health services. The need for further research on successful methods of supporting self management and recovery approaches has been identified by the Royal College of Psychiatrists (2008).

### 1.3 Wellness Recovery Action Planning

Wellness Recovery Action Planning (WRAP) was designed by Mary Ellen Copeland, PhD, and further developed by people who have experience of mental health difficulties, struggling to incorporate wellness tools and strategies into their lives (Copeland Center for Wellness & Recovery, 2009b). WRAP is a self-management programme in which participants identify early warning signs or triggers for distress, in addition to identifying internal and external resources to support their ongoing mental health and recovery. People then use this knowledge and tools to create their own, individualised plans for successful living. Such a plan may include strategies for staying well and strategies for eliminating or minimising triggers to distress. The plan also includes an advanced directive on preferences for care and treatment, should the person’s decision making capacity decline. The fundamental principles underpinning this approach are personal responsibility, education, hope, self-advocacy, peer-support and future planning. In other words, people are empowered to take control of their own wellness and control what happens to them within their recovery journey (Copeland Center for Wellness & Recovery, 2009a, 2009b).

Internationally, WRAP is considered to be the most popular self-management tool for maintaining mental health (Slade, 2009). Cook et al. (2009) report that WRAP is now being offered across the USA, with WRAP initiatives ongoing in 50 states and U.S. territories. Others highlight its use in various parts of England (Hill et al., 2009) and New Zealand (McIntyre, 2005).

### 1.4 WRAP Education Programmes: Evaluations of outcomes

Reports which evaluated WRAP education have been documented mainly in English speaking countries, namely the USA (Buffington, 2003, Cook et al., 2009, Cook, Undated [www.mentalhealthrecovery.com](http://www.mentalhealthrecovery.com)), England (Culloty, 2005, Hill et al., 2009), New Zealand (McIntyre, 2005, Doughty et al., 2008), Scotland (Gordon and Cassidy, 2009) and Canada ([www.cultureofrecovery.org](http://www.cultureofrecovery.org)). Anecdotally, it has been reported that WRAP education was introduced in Ireland (Co Clare) in the late 1990s by Mary Ellen Copeland, (McGowan, 2010), and has, more recently, also been introduced...
WRAP is also being used informally by people with self experience of mental distress and by practitioners as part of their work. In 2008 St Patrick’s University Hospital in Dublin established the first dedicated Wellness and Recovery Centre, which is underpinned by WRAP principles, with staff trained in Wellness and Recovery Action Planning (WRAP); no formal evaluations of these could be located for this report.

In total, nine evaluative studies of WRAP programmes were located covering a 12 year period (1997–2009). The programmes varied in duration, ranging from 8 hours, delivered over one day (Doughty et al., 2008) to a 20 week programme (40 hours) (Cook undated, www.mentalhealthrecovery.com) and were typically taught by two facilitators, one with experience of mental health difficulties, and one mental health worker. The WRAP Recovery Education programmes were offered to between fifteen and twenty people. The content tended to focus on the following topics: hope, responsibility, self advocacy, education and support; medical care and health management; developing and using various support systems; developing a healthy lifestyle; suicide prevention; beginning steps to dealing with trauma; and the development of a personal Wellness Recovery Action Plan (WRAP). Components of WRAP included within these programmes were: plan for daily maintenance, identification of situations that trigger symptoms and strategies to address these, identification of early warning signs and a plan for how to deal with potential pre-crisis and crisis situations. 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.

Of those studies which clearly identified the programmes’ participants, some focused exclusively on people with self experience (Buffington, 2003, Cook et al., 2009, Gordon and Cassidy, 2009, Hill et al., 2009); others included mental health practitioners and people with self experience (Culloty, 2005, McIntyre, 2005, Doughty et al., 2008), whilst more programmes had representation from people with self experience, practitioners/service providers, peer supporters and family members (Cook, undated www.mentalhealthrecovery.com).

The majority of the programmes were evaluated using a questionnaire distributed at the start and the end of the training programme. One used a structured telephone interview (Cook et al., 2009), whilst two others adopted a qualitative approach; one used semi-structured interviews (Culloty, 2005), and the other a combination of individual and focus group interviews (Gordon and Cassidy, 2009).

Irrespective of the duration of the programmes, the overall results indicated positive changes in levels of knowledge of, attitudes to and skills in recovery and recovery related topics (Doughty et al., 2008, Borkin et al., 2000, www.cultureofrecovery.org Cook, undated www.mentalhealthrecovery.com), with barely any difference in those
results across the four main participant groups (people with self experience, practitioners/providers, peer supporters, family members) (McIntyre, 2005, Doughty et al., 2008). Participants reported better understanding of the broader context of the recovery perspective, as well as a deeper understanding of personal recovery, such as having an increased understanding and appreciation of personal strengths (www.cultureofrecovery.org). Participants also reported increases in their ability to identify early warning signs, develop a crisis plan and use wellness tools in their daily lives (www.cultureofrecovery.org, Cook, undated www.mentalhealthrecovery.com). The majority of participants used the WRAP tools and strategies to proactively prevent or confidently deal with distress, leading to increased feelings of safety. Some of these strategies included taking responsibility for their own wellness, having a lifestyle that promotes recovery, having things to do every day in order to remain well, ensuring a network of supports, and being aware of and having skills to respond to their own early warning signs (Buffington, 2003, www.cultureofrecovery.org, Cook, undated www.mentalhealthrecovery.com).

The realization of hope and increase in confidence featured prominently throughout the findings, with participants feeling more hopeful about their own recovery (Buffington, 2003, Culloty, 2005, Cook et al., 2009, www.cultureofrecovery.org) and having greater confidence in talking about experiences and wishes, in asking questions and getting information, and in using wellness and recovery language (www.cultureofrecovery.org, Cook, undated www.mentalhealthrecovery.com). This increased level in confidence in turn enhanced the participants’ self-advocacy abilities. Interestingly, it was also reported that there was no significant change in participants with self experience feeling comfortable asking a doctor or psychiatrist questions about their medications (Cook, undated www.mentalhealthrecovery.com, www.cultureofrecovery.org).

It was also reported that having the choice and being in control of one’s own recovery plan led to an increased willingness to develop a WRAP, although it was also highlighted that to engage with WRAP not only required belief, time, motivation and an understanding of its usefulness, but also a recognition that engaging with WRAP is best done when someone is reasonably well and able to reflect on their experience in order to appreciate its benefits (Culloty, 2005, Hill et al., 2009).

In some studies participants reported feeling confident in having the knowledge and skills to help others to develop a WRAP. Indeed, in one of the studies those with personal experience of mental health problems had introduced more people to WRAP than those without such experiences (Hill et al., 2009). However, in one of the smaller studies, eight weeks after training only one participant had looked at their WRAP and none of the 7 participants had written anything further in their WRAPs (Gordon and Cassidy, 2009).
Some of the studies also sought information about the programme content and facilitation style. The majority of the participants found the programme content and facilitation very helpful. The most useful positive aspects were peer leadership and facilitation, the experiential and reflective learning approach, the group format, the manual and related materials, and the opportunity to develop a WRAP with those with good insight and understanding about their mental health (Gordon and Cassidy, 2009, www.cultureofrecovery.org,). It was noted in Cook et al.’s (2009) study that those who attended more sessions showed greater improvements overall. Gordon & Cassidy (2009) highlighted that some of the participants in their study were worried about the safety of disclosing issues regarding their mental health, within the context of stigmatised attitudes that participants said they experienced in their communities.

In addition to the above studies, Cook (undated, www.mentalhealthrecovery.com) reported on the outcomes of a WRAP Recovery Educators’ Facilitation workshop, attended by 38 participants. Cook reports that since its completion some of the participants have emerged as leaders and teachers within their community by: teaching recovery workshops; running recovery support groups; giving presentations on recovery to mental health service providers and community members; presenting recovery workshops at conferences; and advocating for recovery services at their local mental health agency and hospital. In addition, four recovery educators gained master’s degrees, and four more were pursuing further education.

1.5 Recovery and WRAP Education Programme Developed by IMHREC
The Recovery and WRAP education programme, which if the focus of this evaluation, was developed by the Irish Mental Health & Recovery Education Consortium (IMHREC). The aim of the education programme was to introduce the concepts of Recovery and Wellness Recovery Action Planning (WRAP) into the lives and practices of people with self experience of mental health problems, family members and mental health practitioners, and teach strategies to promote mental health Recovery. The programme was facilitated in 2 stages: participants first completed a 2-day programme and a smaller cohort subsequently attended a 5-day programme. The programme was facilitated by three facilitators who had extensive recovery facilitation experience.

1.6 Rationale for the Evaluation of the IMHREC Education Programme
It has been recommended that self management methods such as WRAP should be more widely used and promoted as an integral part of recovery based practices in everyday mental health practice; however, there is as yet limited evidence of the value of its use. Although there is some international evidence which has demonstrated some benefits of using WRAP, to date, none of the Irish initiatives mentioned previously appears to have been formally evaluated. In view of the current emphasis on recovery and developing a recovery oriented ethos within Irish health
policy, it seems timely to evaluate the potential benefits of a Recovery and WRAP programme within an Irish context. It is also important that we deepen our understanding of the processes involved in recovery education and its impact on individuals and services, and provide further insights for the planning and implementation of future recovery education programmes.

Only one of the nine WRAP recovery education programmes evaluated to date has used a similar educational design as the one evaluated in this report, with representation from people with self experience, family members, community development workers and mental health care practitioners (Cook, undated www.mentalhealthrecovery.com). In addition, the evaluation of a programme that aimed to develop Recovery and WRAP facilitators is only the second one to be reported on worldwide, and as such will form baseline data for future similar evaluations.

The outcomes of this evaluation will be of interest and relevance to all those with an interest in recovery, from the public at large to people with self experience, family members, practitioners, educators and policy developers. Internationally the outcome of this study is also eagerly awaited (Hill et al., 2009), as it will add to the international body of research in this area.
Chapter 2: Methodology and Field Work

In this chapter the study aims, objectives, study design, methods and ethical procedures will be described. An overview of the profile of participants who participated in each phase of the evaluation is also included.

2.1 Aim of study
The aim of the study was to evaluate the impact of the Mental Health Recovery and Wellness Recovery Action Planning (WRAP) workshops on participants’ knowledge, attitude and skills of mental health Recovery and the WRAP approach.

2.2 Objectives of Study
The objectives of the study were:

- To evaluate participants’ attitudes, knowledge and skills regarding Mental Health Recovery and WRAP education programme pre and post programme delivery
- To describe the level and extent of participants’ application of the Mental Health Recovery and WRAP principles in their own life/practice
- To make recommendations for action and support structures to sustain the further development of the Mental Health Recovery and WRAP education programme nationally and its mainstreaming into mental health services as appropriate.

2.3 Research Design
The evaluation employed a multi-method approach using quantitative and qualitative approaches.

2.4 Data Collection
Data on the impact of the Recovery and WRAP facilitation programmes were collected using pre and post course questionnaires. Questionnaires were completed by participants prior to starting the education programme (pre-course) and immediately after completion (post-course). The information gathered in these questionnaires revolves around opinions on and knowledge of Recovery from mental health problems. In the post-course questionnaire there was an added section on facilitation skills, perceived utility of the course and an overall satisfaction rating. A follow-up, in the form of a series of focus group interviews with a sample of the participants of the two-day and five-day programmes, was also held. In addition telephone interviews were held with the three key people involved in facilitating the programme and a focus group interview was held with members of the consortium.


2.5 Questionnaire Design

The study used a pre-test / post-test questionnaire design. This design has previously been used to evaluate WRAP programmes that were conducted in New Zealand (Doughty et al., 2008). Data were collected in 2 phases: pre and post 2-day programme and pre and post 5-day programme.

2.5.1 Pre-course Questionnaire

The pre-course 2-day questionnaire consisted of four sections.

Section A focused on demographic details, with questions on gender, background and personal objectives for attending the programme. It also invited participants to state what they considered to be the three most important things they wished to achieve by attending the course.

Section B consisted of two 11-point scale questions where participants rated their level of knowledge of both Recovery and WRAP. Possible scores ranged from 0 (No Knowledge) to 10 (Fully Informed), with higher scores indicating better knowledge. This was followed by a Recovery Knowledge Scale (RKS) which comprised 10 True / False items related to knowledge of the key principles that represent key components of the collaborative recovery model. The questions in this section were sourced from an Essential Shared Capabilities (ESC) training booklet prepared by the National Institute for Mental Health in England (NIMHE) (2007). Each item answered correctly was scored as 1, incorrect items were scored at 0, and a sum of correct responses was used in the analysis, with higher scores indicating better knowledge.

Section C comprised the Recovery Attitudes Questionnaire 7 (RAQ-7) which consisted of a 7-item scale developed by Borkin et al. (2000). The RAQ-7 has been used and tested with people with self experience, carers, their families and mental health practitioners. The scale has a Cronbach’s alpha of 0.70 and a test-retest reliability coefficient of 0.67. It is deemed to be appropriate to assess attitudes toward recovery and differentiate between those who are familiar with and positive toward the idea of recovery from those who are not (Borkin et al., 2000). The questions in this section were 5-point Likert scale questions ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

Section D used the beliefs about Recovery and WRAP questionnaire. This WRAP questionnaire has been used by Doughty et al. (2008) to evaluate consumers’ and health professionals’ views of WRAP programmes in New Zealand. The authors reported a Cronbach’s alpha co-efficient of 0.88 for the questionnaire. Participants were asked to rate their agreement with statements about Recovery on a 5-point Likert scale, ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Of the 18 statements in this section, fifteen were phrased positively and three were phrased
negatively. These positively and negatively phrased questions were then analysed separately.

The pre-course 5-day questionnaire had a fifth section. Section E asked participants to rate their skills in facilitating or teaching others about Recovery and WRAP on a 1 to 5 Likert scale, where 1 corresponded to ‘No Skills’ and 5 to ‘Excellent Skills’.

2.5.2 Post-course Questionnaires
For comparative reasons Sections B, C and D of the 2-day post questionnaires repeated all the questions included in the pre course questionnaire, i.e. the RKS, RAQ-7 and the WRAP questionnaires without alteration. In addition the post course questionnaires contained a section E which consisted of a number of new 5-point Likert questions, ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) designed to evaluate the course in terms of participants’ perceptions of the impact of the course on their knowledge, confidence and satisfaction. This was followed by a set of 5 point Likert questions based on how well participants felt that the course was operated.

An 11-point Likert scale item was also added to Section B to elicit participants’ satisfaction with the course as a whole (Satisfaction extremely low=0 to extremely high=10). Participants were also given an opportunity to write free responses to a number of open ended questions, including what they considered were the most and least valuable aspects of the course, how the course might impact on their personal and work lives, and recommendations they would make to improve the programme.

The 5-day post questionnaire repeated all sections from the 2-day post questionnaire and Section E contained one extra set of questions. These were 5-point Likert scale items (No skills=1 to excellent skills=5) regarding participants’ reports of their skill levels in facilitating or teaching others about a WRAP and Recovery.

2.6 Focus Group Discussion
Focus groups were held with participants who completed the 2-day and 5-day programmes, and were held in three centres nationally: Dublin, Sligo and Cork. Those who completed the two-day training programme had done so approximately 5 – 6 months prior to the focus groups, while the focus groups for the evaluation of the five-day training programme were facilitated immediately on completion of the training. In addition, to gain insight into the thinking involved in the development of the programme and the processes used to roll it out, one focus group was completed with 8 out of the 11 members of the IMHREC consortium. Each focus group was facilitated by two members of the research team, a facilitator and moderator, and was guided by a topic guide. The role of the facilitator was primarily to ensure a flow of discussion and that of the moderator to monitor the focus group and support the facilitator.
2.7 Telephone Interviews
Telephone interviews were used to elicit the three facilitators’ views of the programme as the facilitators resided in the UK. The telephone interviews focused specifically on the facilitators’ experiences of the programme and discussed the values and principles which underpinned the programmes. In total three telephone interviews were conducted. The interviews were guided by a topic guide and lasted between 55 and 75 minutes.

2.8 Data Analysis
All participants were given a numeric code to aid matching of questionnaires. Quantitative data were entered into the Statistical Package for the Social Sciences version 16 (SPSS) for analysis. Both descriptive and inferential statistics were generated. Questionnaires that could not be matched were excluded from this analysis.

All focus groups and telephone interviews were audio recorded and transcribed for analysis using a thematic approach. The overall analytic approach was guided by the Braun and Clarke (2006) thematic template. To enhance the rigor of the analysis, data were analysed by more than one researcher and findings compared. Freeman (2006) argues that a key level of analysis within focus group approaches relates to an analysis of the interaction within the groups. The analysis of the interaction was informed by the field notes which were taken by the group facilitator and moderator. Based on those notes there was evidence of an ongoing interactive flow of conversation throughout the interview process. In each group, participants were willing to share their experiences and opinions freely with considerable evidence of synergy within the groups.

2.9 Ethics and Privacy
Ethical approval to conduct the study was granted from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. Everyone involved in the research was also bound by national and international codes of good practice in research, and by professional standards within their disciplines. The rights and dignity of participants were respected throughout by adherence to models of good practice related to recruitment, voluntary inclusion, informed consent, privacy, confidentiality and withdrawal without prejudice.

Consent was viewed as an ongoing process, which required negotiation throughout all aspects of the study. Potential participants were initially informed about the evaluation at a one-day conference held to raise awareness of the programme. An information brochure outlining the aims and objectives of the study was included with the pre-course questionnaires. Participants were informed that they could return the envelope with an unanswered questionnaire if they so wished. Pre-course
questionnaires were coded with a number and given to participants in envelopes at the commencement and end of both the 2-day and 5-day programmes.

Participants who wished to participate in the focus group interview were recruited through a letter and an opt-in form. Both written and verbal consent was obtained before interviews.

Participants were reassured that information that may identify them would not be used in any presentation or publication resulting from the study. They were also reassured that their non-participation in the evaluation would not jeopardise in any way, their involvement in this or subsequent courses, should they become available.
Chapter 3: IMHREC Recovery and WRAP Programme: Structure and process

In order to set the study and findings in context, the education programme developed by IMHREC is described and discussed in greater detail in this chapter. The discussion presented here is based on the focus group that was held with members of the consortium involved and the education facilitators.

3.1 Background to IMHREC

IMHREC represents the following organizations: Eastern Vocational Enterprises (EVE), Support, Training, Education, Employment and Research Ireland (S.T.E.E.R), Sli Eile Housing Association, Mayo Mental Health Association and Ballyhoura Development. Although members of the consortium had no previous history of working together, collectively they had vast experience of implementing different initiatives within mental health services, and based on their own admission were familiar with attempting to reshape thinking and practices towards a recovery ethos. On the advice of POBAL, they came together to prepare a proposal and seek funding for a recovery education programme, and were successful in securing funding from the Department of Justice, Equality and Law Reform under the Enhancing Disability Services Programme.

Once funding was achieved, the consortium appointed a lead education facilitator from the UK, with responsibility for programme development and facilitation. In addition to the lead facilitator, they appointed two other people (also from the UK), to co-facilitate some aspects of the programme. All three facilitators had extensive recovery facilitation experience.

The programme was designed in 2 phases. Phase one involved a 2-day programme which sought to educate participants about Recovery and WRAP principles and introduce strategies to promote mental health recovery. This was followed by a 5-day programme, for a smaller cohort of participants. The aim of the 5-day programme was to provide participants with a greater depth of knowledge on Recovery and WRAP, as well as the facilitation skills necessary to deliver the two-day WRAP and Recovery programme within their own communities. Participants who had attended the two-day programme were eligible to apply for a place on the five-day programme.

The consortium employed a full-time paid project coordinator and two part-time development officers to co-ordinate the roll out of the education programme. They also convened an advisory group of critical voices. This included representatives from psychiatry, mental health advocacy groups, the Health Service Executive, the Mental Health Commission, and individuals involved in mental health research. Convening this group was considered important as it helped create awareness around the project.
outside the consortium members, and provided a space for reflective and critical commentary from an independent audience.

3.2 Designing the Education Programme: Aim and rationale for actions

The aim of the education programme was to introduce the concepts of Recovery and Wellness Recovery Action Planning (WRAP) into the lives and practices of people with self-experience of mental health problems, family members and mental health practitioners, and teach strategies to promote mental health Recovery. Agreeing this aim and designing the programme involved much discussion within the group. From the outset there was a sense that while each consortium member brought his/her own perspective, “The common thread was the genuine belief in the idea of recovery” (Consortium member). Hence, recovery was quickly identified as the overarching theme of the education programme, and in the words of a member of the consortium, following discussion and a review of literature, “Wellness Recovery Action Planning (WRAP) emerged as a vehicle” to illuminate one recovery-oriented approach.

Initially, members of the consortium had a number of concerns about the inclusion of WRAP. These concerns included the adoption of a prescriptive and standardized approach, the cultural sensitivity of WRAP, the franchised image that may accompany WRAP and the danger of it becoming a kind of cult.

“I suppose I would have had a concern that one size fits all and there’s [WRAP] a solution to your recovery… engaging with models that come from across the Atlantic, that sometimes can be a barrier… The idea of something becoming a mantra… And that rigidity and franchising model didn’t appeal at all… so it was a long hard dialogue” (Consortium member).

After much debate the consortium members agreed that WRAP, if presented within a recovery and mental health framework, had the potential to shift the debate from illness to achieving wellness and positive mental health, and open up a different dialogue with the self and others. Commenting on WRAP and its potential, consortium members said:

“It is compatible with a multi-dimensional model of mental health, and can shift the whole debate to positive mental health promotion … and move the debate to being well... it changes the dialogue for instance between practitioner and client, we are talking about living together rather than talking about your wellness and how you can be treated... It is a model that straddles the common human condition rather than being a treatment model” (Consortium member).

“It’s proactive, it’s positive … It gives an opportunity to have a fresh and different conversation… to shift the frame of reference into more work with an individual around looking to their own internal supports, it’s an opportunity for reflection in a different way…” (Consortium member).
McIntyre (2005) argues that the underlying principle of recovery education is that participants learn through their own experience and the experiences of others with the assumption that no one is any better or has a higher value that anyone else. In keeping with this principle of learning together, the education programme was designed to capture a tripartite audience, and to include an equal spread of service users, family members/carers and practitioners. It was hoped that such participation would be an empowering experience for practitioners, service users and carers and consequently encourage a partnership approach in service provision as outlined in the *Vision For Change* (Department of Health and Children, 2006).

“It [programme] can be very liberating for practitioners as well; they can disclose their own struggles and it can also be very empowering for people who are clients of those services, to recognise that we are all in this together. And I think for the service provider it does have profound implications for the way in which we structure services. The way our services are run, the way we offer services” (consortium member).

In the development stage of the education programme the consortium members also formulated a number of other key objectives. These objectives centred on designing an education programme that would target people around the country, enhance sustainability by harnessing local community involvement and contribute to the evidence base on Recovery and WRAP.

"We wanted to operate from a very clear national perspective, while at the same time harnessing local energy” (consortium member).

"It had to be evaluated ... we had done the literature review ...and it clearly identified that again there’s so little research, ...so we absolutely had to contribute to the evidence base around WRAP but on the broader canvas of recovery” (consortium member).

In an attempt to harness community involvement, the discussion and dialogue around the development and design of the education programme involved members of the organisations which the consortium represented. Decisions about locating the education programme within the three geographic locations of Dublin, Cork and Sligo was also based on the work locations of the consortium’s members and a desire to maximize their capacity to create and harness local energy and knowledge. In this way community engagement was embedded from the outset.

“It was a combination of geography and pragmatics, trying to harness the energy that the individual consortium members could bring to the table. And the idea was that the individual consortium members could take that lead role within their hub to draw in all of that local knowledge” (consortium member).

At the same time the consortium recognised that while it was intended as a national project, due to geographic distance there were certain parts of the country that were
not well catered for, such as the south east and midlands. One member of the consortium explained both the short and long term benefits of building on existing net works in the community to harness local knowledge and energy.

“We would have extremely strong local community links, we looked at the opportunity that was there and the different communities that we work with, we know where the very positive energy is and equally we know where there are challenges. We tried to harness at a community level, ... so that we would have staff and participants along with the local community.... We had to try and take the positive energy that we knew was out there. .. It was a very conscious decision on our part because beyond the lifetime of this project we can effect momentum within those areas, put structures in place to make sure that the energy and the training and all the work and effort that has gone in there that we can now work with it in a community context, and with those people who have done the programme... Like the programme wasn’t advertised, ... people were talking about having to pay for an ad, sure we didn’t advertise anything. I think that was the value, that was the value of the hub, the localised knowledge, and we were maximising what we as a consortium could do” (consortium member).

3.3 Employing the Lead Facilitator: “We had confidence knowing we were in safe hands”

Given the nature of Recovery and WRAP education, where emphasis is on personal sharing, reflection and listening, creating an environment where participants would feel safe to discuss values and share their views and experiences was of central importance. Education in this area needed to provide participants with opportunities to socially transform their world views, develop a sense of agency, and question traditional models and practices within mental health. To be effective, messages needed to be negotiated, questioned and adapted to suit individual needs; hence they could not be absorbed passively by the participants or delivered by the facilitator in some programmatic, didactic manner. Recovery education needed to be underpinned by an educational approach that embraced a variety of participatory and experiential methods and one that viewed participants as agential in the educative process. It was clear that the consortium members gave a lot of consideration to the qualities of the lead facilitator for the programme. The decision to employ the lead facilitator was based on some of the consortium members’ past experiences of working with the person, his reputation in the area of recovery, his facilitative yet challenging approach to teaching/learning and his knowledge of the Irish context.
Commenting on their decision to employ the facilitator, consortium members said:

"When I started questioning things around recovery and the response and his knowledge and insight and flexibility and taking on board people's concerns, it was the whole interaction, and almost immediately he gave you a sense of, 'Yeah I can trust this guy'” (consortium member).

"All the dialogue we've had with him in the preamble that gave us that great confidence. So we never really had to think about that [quality of facilitation]” (consortium member).

"We had been through a process with him previous ... we had a sense of where he’s coming from, his track record, the work he'd been involved in, that gave us a great confidence... I felt personally very comfortable with the manner in which he engaged with us” (consortium member).

"He brought us that kind of community perspective. And I think again that was also a model that was comfortable for people, and I suppose allowed us ... to have a common language, a framework... he also knew the Irish setting and could make things relevant” (consortium member).

During the lifetime of the programme, two other people from the UK, both with extensive recovery facilitation experience, co-facilitated some aspects of the programme with the lead facilitator. The involvement of the same three facilitators across all the hubs ensured a consistency in programme delivery.

3.4 Education Programme: Values and principles

Copeland (2003a) and Copeland and Mead (2004) talk about WRAP as a tool that can be used by people who identify themselves as experiencing a mental health problem, and by practitioners who utilize it within their work context. The consortium members, however, were keen to move beyond a focus on illness to one which viewed Recovery and WRAP as central to all our lives, and not just those who received a diagnosis of mental illness.

Consequently, the Recovery and WRAP education curriculum was to be underpinned with the premise that suggested everyone has experienced trauma and is in the process of recovery. Thus, participants and facilitators in the educational encounter were to be simultaneously helper, helped, facilitator and participant (Copeland Center for Wellness & Recovery, 2009a). Other key values included: an emphasis on personal responsibility, self agency, voluntary participation and shared decision making; respect for the dignity and diversity of people; an unconditional acceptance of people; a focus on people’s strengths and the creation of healing contexts; a move beyond labelling and classification; a belief that difficult feelings and behaviours are normal responses to traumatic events and that crises are opportunities for growth and turning points; and finally, a belief that recovery is possible and without limits (Copeland Center for Wellness & Recovery, 2009a).
All three facilitators emphasised the need to design and deliver an educational programme that was strongly rooted in the practice of these values. In describing their beliefs about the Recovery and WRAP education program they stated:

"It is about the practice of values and not about talking about values” (Facilitator).

"It is around people becoming the subject of their care, not the object” (Facilitator).

"It allows people to decide their lives for themselves and we move away from doing to people to doing with people” (Facilitator).

The importance of developing a programme that promoted democratic input, autonomy and individuality was stressed by the facilitators. In addition, the facilitators viewed education about recovery and WRAP as a right and as a means of redistributing power.

"We believe that WRAP is a citizenship right, we believe that people have the right to know, to have the tools and skills to self manage their lives” (Facilitator).

"It’s about taking back control of your life and living your life” (Facilitator).

3.5 Structure of the Education Programme

Although the evaluation only focused on the 2-day and 5-day educational programme, to achieve their aims, the consortium designed four phases to the overall programme:

**Phase One:** This involved the provision of a series of one-day conferences in the three hubs of Dublin, Cork and Sligo. The one-day conferences were set up to raise awareness of Recovery and WRAP. The aim of these conferences was to introduce people to the concept of Recovery and WRAP, and inform delegates of the recovery programmes which had been organised. The conferences involved presentations on recovery delivered by mental health professionals, service users, and family members, with expertise in Recovery and WRAP, from Ireland and the UK.

**Phase Two:** This phase provided a two-day education programme which sought to educate individuals about Recovery and WRAP principles and teach participants strategies to promote mental health recovery. Nine two-day recovery workshops were held around the country (three in each hub).

**Phase Three:** This involved the provision of a five-day education initiative aimed at providing its participants with a greater depth of knowledge on recovery and WRAP in addition to the facilitation skills necessary to deliver the two-day WRAP recovery workshops within their own communities. Participants who had attended the two-day programmes were eligible to apply for a place on the five-day programme. A rigorous
application process was put in place. Interested candidates were required to complete a written application, in which they were asked to give reasons for applying and also to identify how they intended to use the learning in their communities. The emphasis in the selection process for the five-day programme was placed on long-term sustainability and roll out of the learning. Hence, the selection of applicants was based on the criteria that they had "ready-made mechanisms in their organisations and communities, to get the word out about recovery and WRAP, so that there could be sustainability built-in" (Project Co-ordinator).

**Phase Four:** The final phase of the programme involved a one-day recovery "café" where participants came together to bring closure to the programme and address issues regarding sustainability. At this event, a video on recovery *In Our Own Words: An Irish Conversation on Mental Health Recovery* and a Poster *Mental Health Recovery & Me: A New Conversation* compiled by the consortium, were screened and presented. The video included, among others, contributions from participants who attended the education programme. Following the recovery café, the consortium published and distributed two posters; one poster captured what people said recovery meant to them and the second documented wellness tools identified by participants who attended the event.

In addition, the consortium developed a website, [www.imhrec.com](http://www.imhrec.com), which provided potential participants with information on the project and kept people up to date on the progress of the project. All the resources developed were made available on the website.

**3.6 Recruitment to the Events**

Participants were recruited to the events through local advertising with posters, service user networks, Internet and word of mouth. In one area this was augmented with a local radio interview, mainly with a view to spreading the word to services users and carers who may not have been accessing services. The one-day conferences held in Dublin, Charleville (Co Cork), and Sligo also informed delegates of the two-day and five-day education programmes. Participants who attended the five-day education programme had availed of the two-day programme. In all areas, connecting with local communities and networks proved successful as a recruitment strategy.

**3.6.1 Attendance at Events: “We weren’t prepared for the amount of interest”**

Attendance at the conferences far exceeded the expectations of the consortium members, who had hoped for an audience of approximately 400 people. Instead 567 people attended these one-day conferences with 277 people (49%) attending in Dublin, 140 people (25%) attending in Cork, and 150 people (26%) attending in Sligo. Two hundred fifty-six (45%) of the delegates were mental health practitioners, 147 (26%) were community workers, 136 of the delegates (24%) had self experience,
and 28 (5%) were either family members of attending participants or family members of a person with mental health difficulties.

The organisers identified some challenges in coping with the demand for places on both the two-day and five-day courses. A large volume of applicants meant many people with self experience and mental health practitioners who applied could not be provided with a place on the programme.

A total of 345 (160 in Dublin, 84 in Cork and 101 in Sligo) applications for 180 (60 in each hub) available places were received for the two-day programme. Out of the 345 applications, 197 people with self experience, family members, community workers, and mental health care professionals (127 women, 70 men, Mean age: 42.76, age range: 23-70 years) were accepted on to the two-day programme, based on an application form. Thirty four per cent (n=67) of participants were community workers, 31 per cent (n=61) were mental health professionals, 28 per cent (n=55) had self experience of mental health problems, and the remaining 7 per cent (n=14) were family members. Of the 197 participants, 64 attended the course in Dublin, 66 in Cork and 67 in Sligo. Forty percent of participants (n=79) heard about the programme from a friend, 32% (n=63) from the one day conference held in advance, and the remainder from a service user network, the Internet and poster advertisements and other sources.

Sixty places (20 per hub) were available for the five-day programme. Out of the 117 applications received (40 in Dublin, 31 in Cork and 46 in Sligo), 68 people with self experience, family members, community workers, and mental health care professionals (45 women, 23 men, Mean age: 44, age range: 26-70 years) were accepted. Forty-seven percent (n=32) of participants were mental health practitioners, 7.5% (n=5) were family members of people with mental health difficulties, 26.5% (n=18) had self experience of mental health problems, and the remaining 20% (n=13) described themselves as being both mental health practitioners and having self experience of mental health problems.

<table>
<thead>
<tr>
<th></th>
<th>1-day conference</th>
<th>2-day programme</th>
<th>5-day programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Self experience</td>
<td>136</td>
<td>24%</td>
<td>55</td>
</tr>
<tr>
<td>Practitioner</td>
<td>256</td>
<td>45%</td>
<td>61</td>
</tr>
<tr>
<td>Family member</td>
<td>28</td>
<td>5%</td>
<td>14</td>
</tr>
<tr>
<td>Community worker</td>
<td>147</td>
<td>26%</td>
<td>67</td>
</tr>
<tr>
<td>Practitioners and self experience</td>
<td>Not asked</td>
<td>None identified</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>567</td>
<td>100%</td>
<td>197</td>
</tr>
</tbody>
</table>

Table 1: Profile of the participants who attended programme
3.7 Profile of Participants who Participated in the Survey

One hundred ninety seven people who attended the 2-day programme completed the pre-course questionnaires and 195 people completed the post-course questionnaires. Of the 67 participants who completed the 5-day pre questionnaire, 62 also completed the 5-day post course questionnaire. Table 2 below provides a breakdown of participation by location.

<table>
<thead>
<tr>
<th>Location</th>
<th>2-Day Pre</th>
<th>2-Day Post</th>
<th>5-Day Pre</th>
<th>5-Day Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dublin</td>
<td>64</td>
<td>62</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td>Cork</td>
<td>66</td>
<td>66</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Sligo</td>
<td>67</td>
<td>67</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>195</td>
<td>67</td>
<td>62</td>
</tr>
</tbody>
</table>

Table 2: Breakdown of participants who completed questionnaires by location

In total, 194 pre- and post- questionnaires were matched for the 2-day programme and 59 were matched for the five-day programme. Questionnaires that could not be matched were excluded from the analysis.

Overall the highest number of participants came from the practitioner group, followed by people with self experience and family members/carers. Participants from the family member/carer group were the least well represented group on the 2-day and 5-day programmes. More than 25% of the participants on both the 2-day and 5-day programme described themselves in more than one category, with 7-8% describing themselves as belonging to the category of practitioner and a person with self experience. A number of participants who ticked the category other stated they were development officers in mental health, counselling student, community worker, life coach counsellor, mental health advocate, psychotherapist, students, and social care supervisors. Table 3 provides a breakdown of participants’ descriptions of themselves.

<table>
<thead>
<tr>
<th>Self Description</th>
<th>2-Day N</th>
<th>2-Day %</th>
<th>5-Day N</th>
<th>5-Day %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health practitioner only</td>
<td>59</td>
<td>31%</td>
<td>18</td>
<td>31%</td>
</tr>
<tr>
<td>Person with self experience only</td>
<td>47</td>
<td>25%</td>
<td>9</td>
<td>15%</td>
</tr>
<tr>
<td>Family member/carer only</td>
<td>10</td>
<td>5%</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>Mental health practitioner and carer/family member</td>
<td>26</td>
<td>14%</td>
<td>10</td>
<td>17%</td>
</tr>
<tr>
<td>Self experience and Mental Health Practitioner</td>
<td>15</td>
<td>8%</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>Self-experience and carer/family member</td>
<td>15</td>
<td>8%</td>
<td>7</td>
<td>12%</td>
</tr>
<tr>
<td>Self experience, MHP and family member/carer</td>
<td>6</td>
<td>3%</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>8%</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0.5%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>194</td>
<td>100%</td>
<td>59</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 3: Breakdown of participants’ self-description for 2-day and 5-day programme
Participants who completed the questionnaires were from all age categories, however the groups categorised 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 female.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2-Day N</th>
<th>2-Day %</th>
<th>5-Day N</th>
<th>5-Day %</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30 years</td>
<td>37</td>
<td>19</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>31-40 years</td>
<td>48</td>
<td>25</td>
<td>17</td>
<td>29</td>
</tr>
<tr>
<td>41-50 years</td>
<td>62</td>
<td>32</td>
<td>17</td>
<td>29</td>
</tr>
<tr>
<td>51-60 years</td>
<td>33</td>
<td>17</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>61-70 years</td>
<td>13</td>
<td>6.5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0.5</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>194</td>
<td>100</td>
<td>59</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4: Breakdown of participants’ age groups for 2-day and 5-day programme

<table>
<thead>
<tr>
<th>Gender</th>
<th>2-Day N</th>
<th>2-Day %</th>
<th>5-Day N</th>
<th>5-Day %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>68</td>
<td>35</td>
<td>20</td>
<td>34</td>
</tr>
<tr>
<td>Female</td>
<td>126</td>
<td>65</td>
<td>38</td>
<td>64</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>194</td>
<td>100</td>
<td>59</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5: Breakdown of participants’ gender

**3.8 Profile of Participants who Participated in Focus Groups**

In total, 33 participants were involved in the focus groups. Eleven people who attended the two-day training and 22 people who attended the 5-day programme were interviewed. Although 21 people indicated a willingness to participate in the 2-day focus groups, the reduced numbers who attended may be a reflection of a number of issues: the duration of time that had elapsed between attending the programme and the focus group, severe adverse weather condition that occurred at the time of data collection, and possibly disappointment at not having achieved a place on the 5-day programme.

<table>
<thead>
<tr>
<th>Location</th>
<th>2-Day</th>
<th>5-Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dublin</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Sligo</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Cork</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>22</td>
</tr>
</tbody>
</table>

Table 6: Breakdown of participants who engaged in focus groups by location
Gender representation in the focus groups was skewed also, but in contrasting ways. There were more men in the 2-day focus groups (F=4, M=7), but more women in the 5-day focus groups (F=14, M=8).

<table>
<thead>
<tr>
<th></th>
<th>2-Day</th>
<th></th>
<th>5-Day</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>64</td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>36</td>
<td>14</td>
<td>64</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>100</td>
<td>22</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7: Breakdown of participants who engaged in focus groups by gender

The majority of participants who took part in the focus groups were practitioners, followed by people with self experience. No participant identified him/herself as a carer only; however, a small cohort did identify themselves as both having self experience and being a family member/carer and mental health practitioner/family member. The two participants who identified themselves as other were from the categories listed previously. Table 8 provides a breakdown of self descriptions of participants in the focus groups.

<table>
<thead>
<tr>
<th>Self Description</th>
<th>2-Day</th>
<th></th>
<th>5-Day</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health practitioner only</td>
<td>3</td>
<td>27%</td>
<td>8</td>
<td>36%</td>
</tr>
<tr>
<td>Person with self experience only</td>
<td>5</td>
<td>45%</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>Family member/carer only</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Mental health practitioner and carer/family member</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Self experience and Mental Health Practitioner</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Self-experience and carer/family member</td>
<td>1</td>
<td>9%</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Self-experience and other</td>
<td>1</td>
<td>9%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Family member and other</td>
<td>1</td>
<td>9%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Self experience, MHP and family member/carer</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>100%</td>
<td>22</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 8: Breakdown of participants’ self-description for 2-day and 5 focus groups

### 3.9 Participants’ objectives for participating on the programme

In the pre-course questionnaires (2-day and 5-day), participants were asked to write down the three things they wanted to gain most from the programme. Analysis of the responses for similarities identified the following 7 themes. Participants wished to:

- Gain knowledge about Recovery and WRAP;
- Develop their own WRAP;
• Help somebody to develop a WRAP;
• Share experiences with others;
• Gain / maintain control of their own life;
• Obtain skills (for work purposes);
• Engage in networking. In terms of networking, participants stated that they wished to make new friends, meet people in similar positions, and gain contacts. Some simply cited “networking” as an objective.

In addition to the above the five-day participants included responses such as:

• Become a facilitator for WRAP;
• Inform self about alternative therapies;
• Enhance own mental health;
• Understand causes of mental health difficulties.

The most common objective amongst participants on the 2-day programme was to obtain knowledge about Recovery and WRAP, followed by a desire to help someone formulate a WRAP. The developments of skills as well as helping others to develop a WRAP were priorities for the 5-day participants. The desire to build networks increased considerably as participants on the 5-day programme now sought peer support for implementing these ideas in their own practices and lives. Figure 1 provides an outline of participants’ reasons for attending the programmes.

![Participants' Objectives Graph]

Figure 1: Participants’ reasons for attending both the 2-day and 5-day programmes
Chapter 4: Findings from the 2-Day and 5-Day Questionnaires

4.1 Impact of the Programme
This section reports the findings from the pre and post questionnaires for both the 2-day and 5-day programmes. The impact of the programmes on participants’ knowledge, attitudes and beliefs are presented. The final part of this section reports on participants’ perceptions of the impact of the programme on their skills and confidence, and their satisfaction with different aspects of the education programme.

4.2 Self-Rating Knowledge Questions
Main Finding: Participants rated their knowledge of WRAP and Recovery after the programme as higher than before. This increase in self-reported knowledge of both WRAP and Recovery was statistically significant for both the 2-day and 5-day programme participants.

Participants were asked to rate their knowledge of Recovery and their knowledge of WRAP on two 11-point scales, ranking their knowledge from No Knowledge (0) to Fully Informed (10). Prior to the 2-day training programme, participants rated their knowledge of Recovery on average as 5.40 and WRAP as 4.37. Subsequent to completing the programme, these average ratings rose to 8.12 and 8.05, respectively. A paired samples t-test comparing the pre and post means for the 2-day programme resulted in statistically significant increases for both self-reported knowledge of Recovery and WRAP (Recovery: n = 188, t(187) = -19.60, p < 0.0001; WRAP: n = 186, t(185) = -25.04, p < 0.0001).

Prior to the 5-day training programme, participants’ mean rating for their knowledge of Recovery was 6.86 and WRAP 7.04. Subsequent to completing the programme the means rose to 8.72 and 8.78 respectively. A paired sample t-test comparing the pre and post means for the 5-day programme resulted in statistically significant increases for both self reported knowledge of Recovery and WRAP (Recovery: n = 59, t(58) = -8.16, p < 0.0001; WRAP: n = 58, t(57) = -8.73 p < 0.0001). Figure 2 and Table 9 show a summary of these results.
Figure 2: Comparison of mean self reported knowledge of Recovery and WRAP, pre- and post-participation in 2-day and 5-day programme

Table 9: Test of difference in mean self-reported knowledge of Recovery and WRAP, pre- and post-participation in 2-day and 5-day programmes

4.3 Recovery Knowledge Scale (RKS, 10 questions)

**Main Finding:** 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-day 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.
The RKS consists of ten questions each requiring a True/False response. Correct answers were scored with 1 point and incorrect answers were scored 0. Prior to the 2-day programme, participants had on average just over 8 out of 10 correct answers (m = 8.26, SD = 1.74). Having completed the programme, participants had on average almost 9 correct answers, (m = 8.8, SD = 1.56). The increase in mean from pre to post questionnaires for the 2-day participants was statistically significant (n=190, t (189) = -4.59, p < 0.0001).

The mean score for participants prior to the 5-day programme was 8.84 with a standard deviation of 0.98. Having completed the programme, this mean rose to 9.04 and standard deviation fell to 0.79. This increase in mean from pre to post for the 5-day participants was not statistically significant. Figure 3 and Table 10 provide a summary of these results.

![Figure 3: Comparison of mean scores on Recovery Knowledge Scale (RKS), pre- and post-participation in 2-day and 5-day programmes](image)

<table>
<thead>
<tr>
<th>Recovery Knowledge Scale</th>
<th>Pre</th>
<th>Post</th>
<th>Confidence Interval</th>
<th>Paired samples t-test (two-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean S.D.</td>
<td>Mean S.D.</td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>2-day (n = 190)</td>
<td>8.26 1.74</td>
<td>8.80 1.56</td>
<td>-0.78</td>
<td>-0.31</td>
</tr>
<tr>
<td>5-day (n = 56)</td>
<td>8.84 0.98</td>
<td>9.04 0.79</td>
<td>-0.43</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Table 10: Test of difference in mean scores on Recovery Knowledge Scale (RKS), pre- and post participation in the 2-day and 5-day programmes
4.4 Recovery Attitudes Questionnaire (RAQ-7)

**Main Finding:** Participants showed positive attitudes towards the principles of Recovery as measured with the Recovery Attitudes Questionnaire (RAQ-7) before participating in the programme, and demonstrated slightly more positive attitudes towards recovery principles after the 2-day and 5-day programme. This increase was only significant for the 2-day programme.

Using the RAQ-7, participants were asked to rate their agreement with seven statements on Recovery, on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). The total score for the RAQ-7 is the sum of the scores on the 7 questions. With a minimal score of 1 and a maximum of 5 for each item, the range of summated scores for the 7 items is from 7-35. Scores closer to 7 indicate mainly negative attitudes and scores closer to 35 indicate mainly positive attitudes.

Results suggest that participants’ attitudes towards Recovery principles were positive to start with, with a mean RAQ 7 score of 29.8 (SD = 2.8). This increased to 30.5 (SD = 3.27) post the programme. The mean score for participants post the 5-day programme also increased (Pre: m = 30.91, SD = 2.54; Post: m = 31.48, SD = 2.11). Although the increase in participants’ attitudes supporting recovery principles was small, a paired sample t-test of the pre and post means for the two-day programme yielded statistically significant results (n = 173, t(173) = -3.27, p = 0.001). A paired sample t-test of the pre and post means for the five-day programme was not statistically significant. Figure 4 and Table 11 provide a summary of these results.

![Figure 4: Comparison of mean scores on Recovery Attitudes Questionnaire (RAQ-7)](image-url)
Higgins et al 2010 Recovery and WRAP Evaluation Report

### Recovery Attitudes Questionnaire-7

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>S.D.</th>
<th>Post</th>
<th>S.D.</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
<th>p-value</th>
<th>Effect size r</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2-day</strong></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(N=173)</strong></td>
<td>29.80</td>
<td>2.80</td>
<td>30.5</td>
<td>3.27</td>
<td>-1.23</td>
<td>-0.30</td>
<td>173</td>
<td>0.001</td>
<td>0.11</td>
<td></td>
</tr>
<tr>
<td><strong>5-day</strong></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(N = 58)</strong></td>
<td>30.91</td>
<td>2.54</td>
<td>31.48</td>
<td>2.11</td>
<td>-1.20</td>
<td>-0.06</td>
<td>57</td>
<td>ns</td>
<td>0.12</td>
<td></td>
</tr>
</tbody>
</table>

Table 11: Test of difference in mean scores on Recovery Attitudes Questionnaire (RAQ-7), pre- and post-participation in the 2-day and 5-day programmes

### 4.5 WRAP Beliefs Questionnaire

**Main Finding:** Participants in the 2-day and 5-day programmes held beliefs supportive of WRAP and Recovery before they participated in the programmes, as measured by the WRAP questionnaire, and strengthened these beliefs following participation.

The WRAP Beliefs Questionnaire measures participants’ beliefs about Recovery and WRAP. Participants were asked to rate their agreement with 18 statements about Recovery and WRAP on a 5-point Likert scale, ranking from 1 (Strongly Disagree) to 5 (Strongly Agree). 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. With a minimal score of 1 (strongly disagree) and a maximum of 5 (strongly agree) for each item, the range of summated scores for 15 items is from 15-75. Therefore, a mean total of 60.95 (SD = 5.31) before the 2-day programme indicated strong agreement, with an average score of approximately 4 (agree) on the 15 questions (cf. 15 x 4 = 60). This mean increased to 65.01 (SD = 5.35) after the programme. A similar effect took place after the 5-day programme. Prior to the 5-day programme, the mean was 64.19 (SD = 4.50), and this increased to 66.73 (SD = 5.16) post the programme. A paired sample t-test of the pre and post means on the positive questions for the two-day programme yielded statistically significant results (N = 162, t(161) = -11.65, p < 0.0001). A paired sample t-test of the pre and post means for the five-day programme also provided statistically significant results for the
positive items on the questionnaire (N=52, t(51) = -5.59, p < 0.0001). Figure 5 and Table 12 provide a summary of these results.

![Figure 5: Comparison of mean of summated WRAP Positive questions](image)

<table>
<thead>
<tr>
<th>WRAP Positive Questions</th>
<th>Pre</th>
<th>Post</th>
<th>Confidence Interval</th>
<th>Paired samples t-test (two-tailed)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td>Lower</td>
</tr>
<tr>
<td>2-day (N=162)</td>
<td>60.95</td>
<td>5.31</td>
<td>65.01</td>
<td>5.35</td>
<td>-4.74</td>
</tr>
<tr>
<td>5-day (N=52)</td>
<td>64.19</td>
<td>4.50</td>
<td>66.73</td>
<td>5.16</td>
<td>-3.46</td>
</tr>
</tbody>
</table>

Table 12: Test of difference between means of summated WRAP Positive questions

For the three negative questions, the summated mean of 5.93 (SD = 1.98) before the 2-day programme suggested an average score of almost 2 (disagree) for each question. This mean decreased to 5.54 (1.95) post the programme. The mean score for participants prior to the 5-day training programme was 5.18 (SD = 1.45) which decreased to 4.82 (SD = 1.55) post programme, suggesting a change in beliefs more supportive of WRAP principles.

A paired sample t-test of the pre and post means on the negative questions for the two-day programme was statistically significant (N = 180, t(180) = 3.26, p < 0.0001). However a paired sample t-test of the pre and post means for the five-day
programme was not statistically significant. Figure 6 and Table 13 provide a summary of these results.

![Figure 6: Comparison of mean of summated WRAP Negative questions](chart.png)

**Table 13: Test of difference between means of summated WRAP Negative questions**

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>Confidence Interval</th>
<th>Paired samples t-test (two tailed)</th>
<th>Effect size r</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td>Lower</td>
</tr>
<tr>
<td>2-day</td>
<td>5.93</td>
<td>1.98</td>
<td>5.45</td>
<td>1.95</td>
<td>0.19</td>
</tr>
<tr>
<td>(N=180)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-day</td>
<td>5.18</td>
<td>1.45</td>
<td>4.82</td>
<td>1.55</td>
<td>-0.02</td>
</tr>
<tr>
<td>(N=57)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Changes in participants’ beliefs following both the 2-day and 5-day programmes were statistically significant, apart from the negative questions for the 5-day programme, which were not statistically significant.

### 4.6 Facilitation and Teaching Skills

**Main Finding:** Comparison of self-reported teaching and facilitation skill levels before and after the 5-day programme showed statistically significant increases after participating in the 5-day programme for all skills.
One of the principle objectives of the 5-day programme was to educate people to become WRAP facilitators. To evaluate whether participants perceived their teaching and facilitation skills had increased, participants were asked to rate their skill levels both pre and post the 5-day programme, using a 5 point scale ranging from 1 (no skills) to 5 (excellent skills) on 9 areas that underpin Recovery and WRAP education. 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 5 out of the 9 areas identified.

Those areas that participants perceived that they had become most skilled at facilitating after the program were Wellness Recovery Action Planning, Peer Support, Self Advocacy/Self Agency and Crisis/Post Crisis Planning. The greatest increases in facilitation skills came in Hope, Wellness Tools, and Values Based Care with increases of 0.88, 0.82 and 0.8 in means, respectively. Those areas that participants perceived that they were least skilled at facilitating after the programme were the role of Personal Responsibility in Recovery and Advanced Agreements. Participants’ rating for skill in teaching about Advanced Agreements and Personal Responsibility in Recovery were lower than that of other items (m = 3.26). 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 14 and Figure 7 capture these results.

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>Confidence Interval</th>
<th>Paired samples t-test (two tailed)</th>
<th>Effect size</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>Lower</td>
</tr>
<tr>
<td>Wellness Tools</td>
<td>59</td>
<td>3.47</td>
<td>0.70</td>
<td>4.20</td>
<td>0.69</td>
<td>-0.93</td>
</tr>
<tr>
<td>Personal responsibility</td>
<td>57</td>
<td>3.60</td>
<td>0.67</td>
<td>4.15</td>
<td>0.76</td>
<td>-0.77</td>
</tr>
<tr>
<td>Hope</td>
<td>58</td>
<td>3.52</td>
<td>0.70</td>
<td>4.15</td>
<td>0.69</td>
<td>-0.81</td>
</tr>
<tr>
<td>Self Advocacy</td>
<td>59</td>
<td>3.37</td>
<td>0.80</td>
<td>4.10</td>
<td>0.71</td>
<td>-0.93</td>
</tr>
<tr>
<td>Peer Support</td>
<td>58</td>
<td>3.19</td>
<td>0.96</td>
<td>4.00</td>
<td>0.72</td>
<td>-1.03</td>
</tr>
<tr>
<td>WRAP</td>
<td>59</td>
<td>3.12</td>
<td>0.62</td>
<td>3.92</td>
<td>0.68</td>
<td>-0.98</td>
</tr>
<tr>
<td>Crisis Planning</td>
<td>59</td>
<td>2.94</td>
<td>0.69</td>
<td>3.85</td>
<td>0.72</td>
<td>-1.09</td>
</tr>
<tr>
<td>Values Based Care</td>
<td>59</td>
<td>3.08</td>
<td>0.93</td>
<td>3.73</td>
<td>0.83</td>
<td>-0.40</td>
</tr>
<tr>
<td>Advanced Agreements</td>
<td>59</td>
<td>2.67</td>
<td>0.85</td>
<td>3.22</td>
<td>0.81</td>
<td>-0.86</td>
</tr>
</tbody>
</table>

Table 14: Participants’ self rated skill levels pre and post 5-day programme and test of differences
4.7 Additional Measures (Post-programme only)

This section presents the findings on participants’ perception of the impact of the programme on their knowledge, confidence and satisfaction. These results are based on questions only presented to the participants after the programme.

4.7.1 Impact of Participation on Knowledge of Recovery and WRAP

**Main Finding:** Most participants agreed or strongly agreed that participation in the programme had increased their knowledge of several aspects of Recovery and WRAP.

To evaluate whether participants perceived the programme had increased their knowledge, participants were asked to rate its impact using a 5-point scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) in 9 areas underpinning Recovery and WRAP education. Participants indicated that both the 2-day and 5-day programmes impacted positively on their knowledge, with the mean score for all statements greater than 4 (Agree). The highest mean impact was on Wellness Recovery Action Planning at 4.59 (SD = 0.60) post the 2-day, and 4.85 (SD = 0.37) post the 5-day. The lowest mean ratings for impact, post the 2-day and 5-day programmes, were Values Based Care and Advanced Agreements (see Table 15).
Impact of programme on knowledge

<table>
<thead>
<tr>
<th>The programme increased my knowledge of:</th>
<th>Post 2-Day</th>
<th>Post 5-Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Wellness Recovery Action Planning</td>
<td>191</td>
<td>4.59</td>
</tr>
<tr>
<td>Advanced Agreements</td>
<td>186</td>
<td>4.16</td>
</tr>
<tr>
<td>Crisis/post crisis planning</td>
<td>187</td>
<td>4.40</td>
</tr>
<tr>
<td>Hope</td>
<td>187</td>
<td>4.52</td>
</tr>
<tr>
<td>Personal responsibility in Recovery</td>
<td>188</td>
<td>4.54</td>
</tr>
<tr>
<td>Self advocacy/self agency</td>
<td>189</td>
<td>4.41</td>
</tr>
<tr>
<td>Peer support</td>
<td>188</td>
<td>4.45</td>
</tr>
<tr>
<td>Wellness tools</td>
<td>167</td>
<td>4.56</td>
</tr>
<tr>
<td>Values based care</td>
<td>174</td>
<td>4.15</td>
</tr>
</tbody>
</table>

Table 15: Mean impact on Knowledge, post 2-day and 5-day

4.7.2 Impact of Participation on Confidence in the Ability to Apply Recovery and WRAP Skills

Main Finding: Most participants agreed or strongly agreed that participation in the programme had increased their confidence in their ability to apply Recovery and WRAP skills.

To evaluate whether participants perceived the programme had increased their confidence, participants were asked to rate its impact using a 5 point scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) in three areas.

The mean for each of the three questions was greater than 4.19. 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 (N = 191, mean = 4.46, SD = 0.65). 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 (see Table 16).

<table>
<thead>
<tr>
<th>Impact of programme on Confidence</th>
<th>Post 2-Day</th>
<th>Post 5-Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>The programme increased my confidence to:</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Offer peer support to others</td>
<td>190</td>
<td>4.19</td>
</tr>
<tr>
<td>Help another person develop their own WRAP</td>
<td>191</td>
<td>4.41</td>
</tr>
<tr>
<td>Manage my own mental health and Recovery</td>
<td>191</td>
<td>4.46</td>
</tr>
</tbody>
</table>

Table 16: Mean impact on confidence, post 2-day and 5-day
4.8 Overall satisfaction with the programme

**Main Finding:** Participants rated their overall satisfaction with both the 2-day and the 5-day programme very highly.

The overall satisfaction rating for both the 2-day (N = 176, mean = 8.73, SD = 1.15) and 5-day (N = 61, mean = 8.69, SD = 1.48) programmes was high and almost equally positive. After both programmes, 90% gave a satisfaction rating of between 8 and 10. An overview of the distribution of overall satisfaction ratings can be seen in Figure 8.

![Figure 8: Distribution of Overall Programme satisfaction rating for 2-day and 5-day programmes](image)

4.9 Satisfaction with Process and Structural Aspect of the Programme

**Main Finding:** Participants were highly satisfied with process and structural aspects of the programme.

Participants also rated their satisfaction with various aspects of the programme using a five-point Likert scale, from *Very Dissatisfied* (1) to *Very Satisfied* (5). In total, 9 items that addressed educational process issues were included, such as clarity of
learning objectives and content, learning environment and facilitators style. All mean scores for these questions were positive, returning means greater than 4, reflecting positively on satisfaction with areas such as learning environment, participants’ opinions and knowledge being respected, facilitators’ knowledge, and the clarity of programme objectives. The mode for each question in this section was 5, which means that the most frequently given score for each item was the maximum (very satisfied).

As can be seen in Table 17, participants rated facilitators’ knowledge highest of all, with a mean of 4.8 (N = 191) and 4.9 (N = 56) for the 2-day and 5-day programmes respectively. Of these positively answered questions, participants rated time allocated for discussion lowest (N = 191, m = 4.24; N = 56, m = 4.42). Issues around lack of time for discussion were also reflected in written comments on the questionnaire. Participants expressed a wish for, “more time for sharing and opportunities to work on WRAP for individuals” and it was noted that there “was not enough time for feedback after group work”.

<table>
<thead>
<tr>
<th>Satisfaction with educational process issues</th>
<th>Post 2-Day</th>
<th>Post 5-Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component:</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Objectives of the programme were clear</td>
<td>190</td>
<td>4.42</td>
</tr>
<tr>
<td>Content was clearly presented</td>
<td>190</td>
<td>4.51</td>
</tr>
<tr>
<td>Adequate time for discussion</td>
<td>191</td>
<td>4.24</td>
</tr>
<tr>
<td>Participants’ views and opinions were respected</td>
<td>191</td>
<td>4.68</td>
</tr>
<tr>
<td>Participants’ knowledge was respected</td>
<td>191</td>
<td>4.73</td>
</tr>
<tr>
<td>Facilitator(s) were knowledgeable</td>
<td>191</td>
<td>4.83</td>
</tr>
<tr>
<td>Facilitators shared their own experiences</td>
<td>190</td>
<td>4.81</td>
</tr>
<tr>
<td>Learning environment was positive</td>
<td>188</td>
<td>4.64</td>
</tr>
<tr>
<td>Group work was effective</td>
<td>190</td>
<td>4.54</td>
</tr>
<tr>
<td>Diverse range of participants worked well</td>
<td>189</td>
<td>4.61</td>
</tr>
</tbody>
</table>

Table 17: Overview of satisfaction with process aspects of the 2-day and 5-day programmes

In addition to these process issues, six questions on structural issues were included. Once again, the mean rating for each question was high, returning means greater or equal to 4, bar one question on the 5-day questionnaire. The highest satisfaction level amongst participants was with the learning materials and handouts with a mean of 4.63 (N = 189) for the 2-day programme and 4.81 (N = 57) for the 5-day. Satisfaction rating for rooms was lower, but still positive with a mean of 4.10 (N = 190) for the 2-day programme and 3.96 (N = 57) for the 5-day programme. Some issues regarding rooms and room layout were raised in the qualitative comments.
section of the questionnaire. Participants commented that “the room was too small and cramped” and that the “room temperature was too hot and seating too cramped”. As an alternative seating arrangement, it was proposed by some participants to organise the seating in a U shape so that no participant has his/her back facing another person. The participants’ satisfaction and degree of approval with the programme was reflected in the overwhelming majority who stated that they would recommend the programme to others.

<table>
<thead>
<tr>
<th>Components:</th>
<th>Post 2-Day</th>
<th>Post 5-Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Course Information</td>
<td>N 190</td>
<td>Mean 4.28</td>
</tr>
<tr>
<td>Learning Materials / Handouts</td>
<td>N 189</td>
<td>Mean 4.63</td>
</tr>
<tr>
<td>Rooms</td>
<td>N 190</td>
<td>Mean 4.10</td>
</tr>
<tr>
<td>Arrangements for Breaks / Lunch</td>
<td>N 190</td>
<td>Mean 4.45</td>
</tr>
<tr>
<td>Ease of Access to the Venue</td>
<td>N 190</td>
<td>Mean 4.53</td>
</tr>
<tr>
<td>Time Management</td>
<td>N 189</td>
<td>Mean 4.51</td>
</tr>
<tr>
<td>I would recommend this programme to others</td>
<td>N 189</td>
<td>Mean 4.70</td>
</tr>
</tbody>
</table>

Table 18: Overview of satisfaction with structural aspects of the 2-day and 5-day programmes

4.10 Impact of Self-Description, Age, Gender, and Location of the Programme

Main finding: The predominant result is that there are no major differences between different groupings of participants in the impact that the programmes had and the way in which it was evaluated.

It is important to establish whether the programmes were more or less effective for one group of participants over another. Of particular interest were possible differences between (a) younger and older participants, (b) men and women, (c) participants in the three different locations, and (d) participants who described themselves as having mental health problems and mental health professionals.

To establish whether differences occurred in the impact of the programme on these different groups, Analyses of Variance were performed for the main variables addressed in this chapter. To provide a representation of the overall impact of the programmes on the learning experience of the participants, the following procedure was followed. Where the questions had been presented in a scale (RKS, RAQ-7, WRAP Beliefs) or a thematic cluster (facilitation and teaching skills, impact of programme on knowledge, impact on confidence, satisfaction with process and structural aspects of the programme) the summated total score for all questions in the scale or cluster was used. Analyses of Variance were performed over the differences between pre and post
participation total scores of scales and clusters when both pre and post measures were available. When only post participation measures were available the analysis focused on these.

Because of unequal representation of, for instance men and women in the three locations, it was necessary to enter each of the four factors of interest (age, gender, location, and self-description) simultaneously in the analysis. This way it would be possible to establish whether any differences are attributable to one factor rather than a spurious effect resulting from variations in another factor.

Both categories were included for gender (male, female) and all three locations (Cork, Dublin, Sligo). In regard to the factor self-description, the main interest was in the contrast of participants with self-experience and mental health professionals. Therefore, participants who were in both categories were excluded and so were those who did not fit in either category. Furthermore, to avoid obtaining unreliable results due to empty cells, the number of categories had to be reduced in the analysis for age. Thus, age was reduced to two categories (20-40 and 41-70) with more or less equal numbers of participants. The analyses performed and the outcomes are presented in Table 19.

<table>
<thead>
<tr>
<th>Univariate Analysis of Variance</th>
<th>2-Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign. effect / factor</td>
<td>Category; n, mean, sd</td>
</tr>
<tr>
<td>Difference pre-post Self rating Knowledge of Recovery</td>
<td>Self-descript.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall satisfaction Self-descript.</td>
<td>Self-experience (n=49): m = 9.04; sd = 1.27</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with process Gender</td>
<td>male (n=64); m = 46.10; sd = 4.16</td>
</tr>
<tr>
<td></td>
<td>female (n=119); m = 45.71; sd = 4.77</td>
</tr>
</tbody>
</table>

No significant differences found for: Self rating Knowledge of WRAP; Recovery Knowledge Scale (RKS); Recovery Attitudes Scale (RAQ-7); WRAP beliefs questionnaire (positive questions/negative questions); Impact on Knowledge; Impact on Confidence; Satisfaction with structural aspects.
Univariate Analysis of Variance

Table 19: Univariate Analysis of Variance. Dependent Variables: differences between pre and post summated totals of scales and clusters of measures used in questionnaires plus post measures. Factors: age, gender, self-description and location.

<table>
<thead>
<tr>
<th>Difference pre-post</th>
<th>Sign. effect / factor</th>
<th>Category; n, mean, sd</th>
<th>Location</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>Effect Size Partial Eta 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difference pre-post</td>
<td>Self rating</td>
<td>Knowledge of Recovery</td>
<td>Cork (n=18):</td>
<td>m = 2.61; sd = 1.38</td>
<td>12.88</td>
<td>2</td>
<td>6.44</td>
<td>3.67</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dublin (n=18):</td>
<td>m = 0.94; sd = 1.86</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sligo (n=19):</td>
<td>m = 1.63; sd = 1.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difference pre-post</td>
<td>Self Rating Knowledge</td>
<td>WRAP</td>
<td>Cork (n=17):</td>
<td>m = 2.53; sd = 1.51</td>
<td>17.28</td>
<td>2</td>
<td>8.64</td>
<td>4.61</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dublin (n=18):</td>
<td>m = 1.11; sd = 1.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sligo (n=19):</td>
<td>m = 2.16; sd = 1.39</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact on knowledge</td>
<td>Location</td>
<td>Knowledge of WRAP</td>
<td>Cork (n=17):</td>
<td>m = 41.76; sd = 3.70</td>
<td>97.62</td>
<td>2</td>
<td>48.81</td>
<td>5.14</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dublin (n=18):</td>
<td>m = 39.06; sd = 4.30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sligo (n=20):</td>
<td>m = 42.75; sd = 3.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No significant differences found for:
Recovery Knowledge Scale (RKS); Recovery Attitudes Scale (RAQ-7); WRAP beliefs questionnaire (positive questions and negative questions); Facilitation and Teaching Skills; Impact on confidence; Overall satisfaction; Satisfaction with process; Satisfaction with structural aspects.

Results show first and foremost that effects for the four factors do not play a significant part in the responses to the questionnaires pre and post participation in the two programmes. No effects for age are found. A small gender effect is found, only for satisfaction with the process after the 2-day programme. Men show slightly higher appreciation (m = 46.10) than women (mean = 45.71). Furthermore, only two small self-description effects emerged in the evaluation of the 2-day programme. Firstly, participants with self-experience experienced a higher increase in their self rating of knowledge of recovery (m = 2.90) than mental health practitioners (m = 2.36).
Secondly, those with self-experience reported a slightly higher overall satisfaction \((m = 9.04)\) than mental health practitioners \((m = 8.49)\).

For the 5-day programme, only the factor location showed any significant effects. Differences in self rating of knowledge of recovery and WRAP and impact of participation on knowledge suggest that participants in the Dublin programme increased their knowledge less than those in the other two locations. A look at the ratings themselves (rather than the differences between pre and post shown in Table 3.18) demonstrates that the Dublin participants started out with higher self-reported knowledge of WRAP and recovery than the other two \((\text{Dublin: } m = 7.36 \text{ (WRAP) and } m = 7.23 \text{ (recovery)}; \text{Cork: } m = 6.57 \text{ (WRAP) and } m = 6.45 \text{ (recovery)}; \text{Sligo: } m = 7.17 \text{ (WRAP) and } m = 6.87 \text{ (recovery)})\). They ended up with lower means than the participants in the other hubs \((\text{Dublin: } m = 8.39 \text{ (WRAP) and } m = 8.28 \text{ (recovery)}; \text{Cork: } m = 9.05 \text{ (WRAP) and } m = 9.11 \text{ (recovery)}; \text{Sligo: } m = 8.90 \text{ (WRAP) and } m = 8.75 \text{ (recovery)})\). This difference is validated by the fact that the Dublin participants of the 5-day programme also demonstrated slightly less impact of the course on their knowledge \((\text{Dublin: } m = 39.06; \text{Cork: } m = 41.76; \text{Sligo: } m = 42.75)\).

Finally, it is of particular relevance that mental health professionals and participants with self experience of mental health problems showed no significant differences in the impact of the 5-day programme and its evaluation. This demonstrates that based on the quantitative measures used here, the programme seems to have been equally valid for both groups.

4.11 Summary

Each of the measures employed in this evaluation demonstrated that before participating in the 2-day and 5-day programmes, participants were supportive of beliefs around WRAP and Recovery and showed positive attitudes towards the concept and its implementation. Comparison of the pre and post questionnaires indicated that the programme had a positive impact and increased participants’ knowledge of, and attitudes towards Recovery and WRAP. However, the increase in knowledge and attitudes was not statistically significant for the 5-day participants.

Comparison of reported teaching and facilitation skill levels before and after the 5-day programme also showed statistically significant increases in participants’ perceptions of their ability to teach and facilitate the principles underpinning Recovery and WRAP. Those areas that participants perceived that they had become most skilled at facilitating after the program were Wellness Recovery Action Planning, Peer Support, Self Advocacy/Self Agency and Crisis/Post Crisis Planning. Those areas that participants perceived that they were least skilled at facilitating after the programme were the Role of Personal Responsibility in Recovery and Advanced Agreements.
Although some issues were raised around structural matters such as room lay out, the results also show consistently that participants were highly satisfied with the content and delivery of the programme. The results support the overall conclusion that the programme was received well, with an overwhelming majority agreeing or strongly agreeing that they would recommend it to others.

An integrated comparison of groups within the participant body through Analysis of Variance, with age, gender, self-description and location as independent variables and all measures in the evaluation as dependent variables showed very few significant differences. It follows that on the whole it can be concluded that, overall, the different groupings did not have a significantly different response to the questionnaires before or following their participation in the programmes. This suggests that the effectiveness of the programme was not significantly different in the three locations, nor was it different for men or women, for younger or older participants, or for those with self-experience of mental health problems or mental health practitioners.
Chapter 5: Findings from the Focus Groups with 2-Day and 5-Day Participants

5.1 Introduction
This section presents the emerging themes from the focus groups held with the participants of the two-day and five-day programmes. Although the focus groups were facilitated for participants on the two-day and five-day training programmes separately, they are presented together as there was a significant overlap between the issues and themes.

The findings from the analysis are presented under the following themes:

- Recovery and WRAP: An inspiring and invigorating experience
- Recovery and WRAP: Shifting the paradigm of mental health care
- Putting Recovery and WRAP into Practice: A simple and practical toolkit
- Learning Together: Diversity of perspective and leveling the playing field
- Structure and Delivery of the Programme: Mixed reactions
- Mainstreaming Recovery and WRAP: Obstacles and concerns
- Forward Movement and Sustaining Progress: Strategies for consideration

5.2 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” (FG 2).

“For me it has just been a life experience that I could never praise enough” (FG 5).

The above comments were also strongly reflected in the qualitative comments made by participants at the end of the questionnaires. Participants attributed many of the positive outcomes to the level of interaction, engagement and personal disclosure that was fostered throughout the days. In particular, participants valued how the values of recovery were modelled by the facilitators, from the outset, and integrated throughout the programme.

“I felt that the whole philosophy of recovery was embodied from day one, from the facilitators to everyone” (FG 5).

Having time to agree boundaries and values was welcomed by several participants and identified as important in creating trust and safety within the groups. This level of trust enabled participants to speak openly and honestly about their experiences.
"The honesty and openness of everybody was quite striking" (FG 2).

"I had no problem sharing around my own personal experiences, and I felt that others in the group shared their experiences as well" (FG 5).

"Telling our story and being listened to, that really was a big part of it for me" (FG 5).

Participants welcomed and valued the opportunity to share their own story and hear other peoples’ stories. Listening to peoples’ stories in an environment that was non-judgmental and supportive acted as an enabling medium, facilitating some participants to talk about issues that they had not previously spoken about.

"I thought it was excellent because I actually started talking about stuff that I actually didn’t know was bottled up inside me for years and I’d never actually spoken about before... And the reason I was able to do it is because there was other people talking about their stories“ (FG 2).

Sharing personal experiences was also considered an important means of validation. Using personal experiences to help others appeared to heighten participants’ sense of achievement and personal satisfaction. For many, this was the first time their personal experience was acknowledged as a valuable source of learning and help for others.

"I work with mental health services and I also use mental health services. So there’s two angles for me. ...It’s in fact the only occasion I’ve had where I can draw on my experience as a service user and speak about it and use it. I think that was the best thing for me. The validation, ... the validation of my own personal experience and that’s really what I take away from it, was the respect and the sense of the value of my personal experience and I think that’s probably the best thing I can communicate to anybody. This program is a kind of facilitation based on a value of personal experience and that has been most beneficial” (FG 5).

For others, especially those who attended the five-day programme, there was a strong sense that the programme promoted confidence and self esteem; as illustrated by one participant:

"I found it a very confidence building course, my confidence built up more as it went on” (FG 5).

5.3 Recovery and WRAP: Shifting the paradigm of mental health care

The concepts of Recovery and WRAP were initially unfamiliar to a number of the participants. When participants spoke about WRAP they were often talking about the values, beliefs and attitudes associated with Recovery and not the Wellness Recovery Action Plan per se. Nonetheless, the two concepts are closely related and were
perceived as central to wellness and a move away from the medical and illness paradigms that tend to dominate mental health care.

Prior to attending the programme, some participants viewed recovery in a traditional “medical” manner, seeing it as the absence of symptoms, or as illness remission. Attending the programme exposed the participants to new ways of thinking about Recovery. Specifically, the emphasis on taking greater control of one’s own destiny, through accepting greater levels of self responsibility, was embraced and viewed as the foundation of Recovery and the WRAP approach. This focus on self help, self management, and taking responsibility was perceived by the participants to be empowering, refreshing and positive.

"What WRAP does is empowers people, …it gives them a voice to demand their choice” (FG 5).

"This allows people to be empowered to take control, and tell others what they want” (FG 5).

"It gave me power to help myself, something that was never discussed with me ever as a mental health patient” (FG 2).

"My experience of WRAP means you are responsible for yourself” (FG 2).

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 was more positive, it was more focused on getting well rather than the sickness” (FG 2).

“It was just completely different [from hospital], the focus was more positive” (FG 5).

The focus on wellness and not just illness also offered a sense of hope to many participants.

"I would have felt that WRAP was more positive …Just the basic words that would have been used, you know like hope and words like that” (FG2).

"Well it’s a lifeline, I was actually sick a few weeks ago and at least it’s not this never ending you know negative, you sort of know, if I can get myself back to this level you know I’ll continue. It’s giving hope, gives you a reason…. things will change ….you’ll get control back into your own life you know” (FG2).

"It gives people hope and gives you hope in your work. It’s like a vision for a future” (FG 5).

Learning about recovery and WRAP challenged the assumption that those with self experience of mental distress are (or perhaps should be) passive recipients of mental
health care. A number of participants contrasted the active and participative message of Recovery with their experience of traditional mental health services where people are treated as passive recipients within their own recovery journey.

“It was just completely different.... I was like attending the day hospital, ...the emphasis is more medication and once you’re doing that [taking medication] everything else was fine, it didn’t matter what else you did” (FG2).

“You can recover from alcoholism, you can recover from drug addiction but I’ve never once been told I can recover from mental illness” (FG 5).

“WRAP is giving you the control you know, you decide how to live your life and whatever. Whereas you know the traditional approach is just being handed down” (FG2).

Being able to develop one’s own wellness plan and retain the WRAP, as opposed to the traditional model where medical notes and care plans are frequently developed and kept by health professionals, was seen as another way of shifting the paradigm and taking control of one’s life.

“One of the things that impressed me most about WRAP was the whole thing about ownership, that the person takes ownership and will have their own file” (FG 2).

For some participants, the concept of recovery allowed them the freedom to view their individual mental health as a continuum that fluctuated between wellness and ill health. It also promoted a sense of belief in the capacity for wellness and recovery, across all participants. The philosophy that recovery and WRAP is applicable in all areas of life and to all people, and not just the “unfortunate few” was spoken about as an empowering and leveling idea. This philosophy was viewed as a way of assisting the normalisation of mental distress as a natural response to life’s challenges.

“WRAP is really a tool for the future, it’s a tool to help you live...whether people have a mental health [problem] or not” (FG2).

“My whole understanding of the WRAP is that we are all recovering from something. So basically we all bring something to the table” (FG5).

In addition, the concepts and message of Recovery and WRAP was perceived as a means of reducing the stigma associated with mental illness, and seen as instrumental in sending out a message that people can successfully live with and recover from mental illness.

“As well as giving people the tools to empower ...bringing that out [message of recovery] to the general public I think will ultimately have a positive impact and reduce stigma” (FG 5).
For participants who came from a practitioner background, the values that underpin the Recovery and WRAP approach were viewed as more democratic and respectful than the current philosophy underpinning mental health services.

"I also think it’s much more respectful than what we do at the moment in our service.... WRAP for me is about somebody actually saying this is mine. This is what I want to do, rather than me saying what you are doing. If I’m the person being discharged I have real choice and real power....For me that’s the reality of what this [Recovery and WRAP] is about as opposed to some kind of a veneer of participative democracy” (FG 5).

For other practitioners, the programme began a process of deep questioning around their beliefs, values and knowledge base.

"My background is [names discipline] so I suppose I could say after 26 years I know nothing. Because our whole training has been always on the illness side. So it’s been a complete restructuring and a re-training and examining the whole philosophy and what we are about. The course opened that can of worms for us....Questioning particularly people from a professional background, ...what's our understanding of recovery. So...quite challenging... We were certainly asked to think about what are the values that underpin practice” (FG 2).

5.4 Putting Recovery and WRAP into Practice: A simple and practical toolkit
Participants expressed enthusiastic views concerning their use of WRAP and the benefits they had achieved personally, professionally and within their broader social circle as a result of their participation in the programme at each level. There was a strong sense that the participants valued the WRAP approach because of its simplicity and practicality. In essence, the WRAP approach was experienced as a systematic and structured self management approach which helped participants make sense of experiences as well as normalising distress. Participants spoke of WRAP as a simple and practical toolkit that placed a certain structure or order on what many were doing already to cope with distress and manage their health. The structure of the WRAP approach was perceived as one which made eminent common sense, was logical and achievable. Many participants, both people with self experience and practitioners, spoke of the accessibility of the language of recovery and WRAP, which they found helpful.

“People were speaking a language that you could relate to, rather than with professionals you were just like doing what you’re told, it was nearly a relief like, it was something that you could relate to” (FG2).

"I found for the two days in WRAP that the language that was being used we all could understand it regardless if we had been through the journey of the mental health services or looking at it from people who are being delivering the care” (FG 2).
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“There’s no intellectualisation of words and messages…it’s just more real and non-academic” (FG 5).

Several participants described how, prior to completing the programme, they were already inadvertently practicing some of the approaches that WRAP advocated. For them, attending the programme provided a structure while simultaneously validating what they were already doing to manage their mental health. Participants stated:

“What WRAP does is it brings them all together [ideas that person had previously come across] in a simple, systematic straightforward way, ... into a very useable package....WRAP ticked all my boxes,... I haven’t come across its equal” (FG 5).

“When I went to do it [WRAP] myself there were so many things I was doing without seeing it. It gave me a bit of a feeling that you are not doing so bad” (FG 5).

“The training for me I think was important from the point of view of I’d have had my own system that would keep me well, I’d know when things are stressing me out, I’d know when I’m trying to do too much ...what it done was just confirmed for me and whether it’s called WRAP or whatever name you’d put on it, it just confirmed, I was on the right track and had a system myself” (FG 2).

“I actually realised that I had been doing a lot of stuff myself... wellness and action planning. So it’s exactly what it says on the tin, ... identify all the different things that keep you well and then follow on ...having a planned, systemised way” (FG 2).

“I would have been kind of doing it myself but I didn’t feel that I was doing anything, because there was no structure .... WRAP has given me that kind of structure” (FG2).

Practitioners commented on how it provided them with “valuable information and a good positive model to work from” (FG 5).

The value of having a structured and practical tool to assist individuals to reflect on, explore and learn from past experiences was something the participants valued and recognised as important. One of the participants described WRAP as a manual that helped to develop strategies to “surf the waves” of distress:

“I would see it as a manual where it teaches you to surf really, surf through the waves, you are not going to stop the waves but you are going to be taught though this process how to surf the waves. It’s not going to stop them, but you are going to teach yourself how to surf them” (FG 5).
Others commented on how the programme made them more self-aware and as a consequence gave them an opportunity to commence a different conversation with themselves.

“You run into the doctor, ‘How are you?’ And you say, ‘I’m not too bad’, and out the door. Whereas with WRAP you sit down and you start thinking about yourself, and when I actually did it, I explored things that I’d never actually explored before, nor had I been asked to explore before. When I started to put it down, I could start to see solutions and triggers and things that worked for me...all I could say is it worked for me...I’m not saying I’m going to be perfect for the rest of my life, not at all, but I mean I’ve already experienced where I was sliding but I took myself out before I hit a crisis. That’s success for me” (FG5).

“I found that it gave me an ability to have a continuation because [previously] I might do something in my life and it doesn’t work and I’d say, ‘Ah defeat isn’t retreat and failure isn’t final’. And that sort of is the end of the story... there was no continuation... Where WRAP would give me the idea of saying, ‘Okay, we all make mistakes and we’ve got a right to be wrong ... nobody’s perfect’. But before it was just full stop. But with WRAP again there’s continuation. Saying, ‘Okay what do I do next time’, you know work out a formula” (FG 2).

While acknowledging that life was about continual challenges, many participants commented on how the programme helped them to become more aware of factors/triggers that influence their stress levels. As a consequence they felt more in control of their mental health, with a greater awareness and ability to manage and cope with negative experiences.

“It has kind of made me aware, more aware of my triggers, because you know you might know your triggers but you mightn’t be aware of them, ...there is things that can set it off, or things like a change about myself, whether it be drinking too much or not getting enough exercise, like they’re all kind of common sense things, but they’re only common sense if you know them” (FG 2).

“You become aware of the triggers that might lead you back to negative thinking and getting on the path of the poor me and that leads to depression ... leads totally to negative [thinking] which nothing good comes out of. WRAP will say ‘be self aware’ ... you instantly recognise that [negative thinking] and move to something positive...whereas if I say, ‘Okay, that happened, what do I do now, that I can avoid that’, well WRAP gives you a programme that you can do exactly that and that’s what I found was good” (FG 5).

“It explains your bad days,...okay now what do you do to prevent your bad days. This is what I had out of it...Do something...take one of your hobbies or one your interests ...but one thing you don’t do, you don’t go to bed. That’s what I got out of the days” (FG 2).
"You are still going to get your bad days, but it’s to accept them and get on and be responsible for yourself, and try and find some kind of positive thinking for getting out of yourself“ (FG 2).

In addition, several spoke about learning new techniques and strategies to promote their recovery. These included learning new techniques and strategies from using the facilitator’s resource pack, using the “little green” WRAP book and, above all, listening to the wealth of knowledge and experiences within the group. Participants stated:

"You have techniques now to use,...I picked up a lot of things, little techniques that you can use” (FG 2).

"I think the small booklet is fantastic, you can have it in your handbag, you can have it anywhere, so you will refer to it a lot” (FG 2).

"The experience of listening to other people, and how they approached problems or how they solved problems...did things differently...that was a huge part of the five-day” (FG 5).

Participants spoke of applying WRAP in a number of different ways and at a number of levels. Some commented on the length of time it took to complete an action plan and indicated that they were still working on its completion. Some used it in an elective fashion, dipping into various aspects to suit their own individual needs or to complement other mental health approaches. For others, there was total immersion into the principles and practices including designing their individual WRAP plans and utilising the core principles.

"As I operated the plan myself and I found it seeped into me, it’s actually in my mind now. Without me being consciously thinking about it, it’s operating in my mind I don’t have to go back to the book. Everything has changed - how I do things. It’s also changed my language. And it’s had a knock on effect... I’m a much more positive person, but also it’s having a positive effect on people around me, in work and in my own family” (FG 2).

Those who had self experience tended to view WRAP as something that they could use and apply to their own lives or to the lives of peers. Participants who were health practitioners spoke of using the ideas to open up a dialogue on recovery with those with self experience and other practitioners that they were working with. Others who were involved in the education of other practitioners spoke of introducing the concepts and principles into education programmes.

"It’s changed how I approach assessing somebody... initially you’d be looking at their illness, their negatives, whereas this has allowed me to broach it from a different angle completely... look at what keeps them well” ( FG 5).

However, it was not merely seen as an additional tool for practice, as practitioners also spoke of applying the approach within their own lives, with one participant
applying it within her own family to help manage a crisis situation. In this sense the uniqueness of its applicability emerged, demonstrating its potential use as a life tool and not merely a strategy for people with a diagnosis of mental illness.

5.5 Learning Together: Diversity of perspective and leveling the playing field

Participants of the two-day and the five-day programmes stated that having the opportunity to learn about WRAP with people with self experience, practitioners and family/carers was very positive. One of the main benefits of learning in a mixed group was hearing the diversity of views and opinions. Through the process of sharing, participants were enabled to learn about different perspectives and what worked for others. Participants commented:

“There was so much insight and expertise in that room from people who have been on both sides of the table, if you like” (FG 5).

“The thing I found most useful was hearing different perspectives from the different people” (FG 5).

“There was a great learning...both from people that had been through the system and people who had not been or be it from family’s perspective or carers we had a very mixed group” (FG 2).

“The combination of people, I think that was very important” (FG 2).

“Just getting everybody involved you know...showing them [practitioners] that maybe there’s a different way of approaching the whole issue” (FG 2).

Having the opportunity to learn together was a new experience for many practitioners, family members and people with self experience. Not surprisingly, some participants with self experience came to the group with fears about being accepted, but their experience within the group from day one allayed these fears, as one participant stated:

“Coming down I was apprehensive - where do I fit into this and am I out of my league, I didn’t know but yet from day one, everyone was on the same level playing field” (FG 5).

For some participants with self experience, this was the first time they felt as an equal in a group, and as a result it created a sense of belongingness for them; as one participant described:

“It was the first time I had that strong sense if it [being equal], in any connecting group” (FG 5).

There was widespread consensus that the training was experienced as one which both normalised experiences of mental distress and equalised the relationships between...
those with self experience, family/carers and practitioners. It was widely agreed that participation in the programme fostered a sense of togetherness and participants did not feel that there were any obvious distinctions made between them. Participants commented on how the mixed group communicated a strong message of partnership and helped level the field.

"I think there was real partnership and that’s something that came out of that training, it strips away all those badges... it doesn’t matter what grade you are or what badges you have – it’s about people. And I think that was something very important and there was a real, a real change... And I think that was very important and I think the partnership of it was the strong part of it, it wasn’t the service provider coming and saying this is a good idea it was all the stakeholders” (FG 2).

"Everyone had to learn from the beginning, it just brings everybody to the same level, nobody was over or under you” (FG 2).

"Like people have said they didn’t know who was who, like as regards who was a professional and who wasn’t, which was amazing” (FG 5).

For others, having people with self experience, family/carers and practitioners all learning together was viewed as central to shifting the power agenda in mental health.

"The recovery approach demands the power that is traditionally held by professionals be handed over to the user and for them to take it on board. And that means there’s a leveling of the table and when we go into WRAP we are a group of people who are working together and our personal experience is as relevant and as valid ...I think it’s that leveling of the playing field at the table, that’s the challenge” (FG 5).

Others viewed this way of learning as an important and necessary factor for the successful implementation of a recovery-oriented mental health service, as one participant stated:

"I think by having a mixture of people there’s a chance of mental health changing, you need to have everybody involved in the process to change it” (FG 5).

5.6 Structure and Delivery of the Programme: Mixed reactions

In terms of the course structure and delivery, several participants stated that there was a good balance between the theory of Recovery and WRAP and putting it into practice. Although the course addressed a lot of information, participants did not feel overloaded or that the content was too technical. For many, the length of time allocated to the two-day programme was “just right”. Others, however, thought that
they needed more time to complete their Wellness Recovery Action Plans and get other peoples’ perspectives and feedback.

"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 like you know” (FG 2).

Similarly, the structure of the five-day training received mixed responses. For some participants the group size was “too big” and restricted the amount of time available for discussion; as stated by one participant:

"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 discussion and much more time for it” (FG 5).

Although the participants believed that having a smaller group would facilitate freer discussion as well as more time to accommodate the diversity of opinions within the group, they appreciated the external pressures the facilitators were under to accept twenty participants for each cohort. Several stated that having the break between days was not beneficial and they would have preferred to have the five-days together. As one participant stated:

"One thing I found negative is that there was a break between the first and second day and then the third day....the break seemed to be too long for me” (FG 5).

Conversely, others appreciated having the gap between each study day as it allowed them time to apply their learning to practice. The length of the programme also evoked different responses; some participants suggested that the length of the programme be extended to seven days, however others believed that five days was sufficient. As one participant commented:

"Seven days is a lot, I think for, don’t get me wrong I think the information is really good and why I say seven is because obviously you have to do the two to get to the five, I think that’s a lot of days. I do think there’s a need for a lot of the things that were done and I do think there’s a lot of benefit but I do think there’s overlaps in it” (FG 5).

Interestingly, many participants believed that the amount of time allocated for the individual groups to prepare for the presentation on the third day was too long. Furthermore, having one day solely for presentations was difficult for many participants in terms of sustaining their enthusiasm. As one participant stated:

"On the fourth day the presentations all going on the same day, I think by the end of that day and it’s not because I was on the last presentation, but it was
Participants recommended that for future courses, the presentations take place over two different periods.

In one cohort, several participants expressed disappointment about the lack of clear goals for the presentations, particularly concerning the focus of the presentation and the different teaching and learning strategies to be used. As one participant stated:

"For me the brief that we got at the beginning of one day was different from what was expected of us, when we actually gave our presentations. So the objectives weren’t clear for me” (FG 5).

Notwithstanding this, the participants did acknowledge that they had enjoyed being a member within their learning group and had learnt a lot from listening to the other presentations.

Some five-day participants in one focus group expressed some dissatisfaction with the composition of the group, particularly since they expected that each cohort would have an equal number of service users, practitioners and family members/carers. On commencing the course, they were then disappointed to discover that there appeared to be an unequal representation of service users as one participant stated:

"The service user or person with self experience of mental illness, they were the lowest number in the group” (FG 5).

Others within the group did not appear to notice this until a discussion on implementing learning took place, as one participant commented:

"Everyone in the room talked about a crisis, they got emotional around it...so it was only when we got into how we would roll it out did it become obvious [who were practitioners and who were people with self experience]” (FG 5).

For some, the fact that a number of practitioners also identified themselves as people with self experience challenged the assumption that people fell into “neat categories of them and us”.

For some of the 2-day participants there were varied responses when they did not succeed in securing a place on the five-day programme. The response ranged from being happy as the person did not feel “ready at that point” to being “bitterly disappointed” at not having gained a place. Some of the participants thought that not being able to do the five-day programme constituted “a lost opportunity” in their ability to facilitate and encourage others to learn about recovery and complete a WRAP. Consequently, participants recommended that the selection process for the
facilitator’s course, in particular the application form, be reviewed and that the energy of those who did not secure a place “needed to be captured so that it could be used again in the future” (FG 2).

5.7 Mainstreaming Recovery and WRAP: Obstacles and concerns

This theme presents the perceived obstacles and concerns that both the two-day and five-day participants believed might impact negatively on the future of Recovery and WRAP. These revolved around personal confidence, current philosophy of services, leadership, maintaining the philosophy of recovery and WRAP, and burdening people with self experience.

Although many of the two-day participants were very positive about passing on the message of recovery and WRAP, and believed that they could pass on the concepts to people in an informal way, they questioned whether they had the requisite skills to communicate the essential components of Recovery and WRAP in a formal education context. Similarly, the five-day participants were very enthusiastic about becoming involved in developing and facilitating recovery and WRAP education, and many felt empowered “to go out and help other people”. However, some expressed a lack of confidence about facilitating a recovery and WRAP programme. This lack of confidence was especially evident among those who had never facilitated groups or educational sessions before. The following two quotations sum up this perspective, the first quote is from a participant who had facilitated other group sessions and the second quote is from a participant who had little previous experience:

“I have to say the consortium for me personally got it fairly well right, I’m very happy because I felt it complemented what I had, and I thought it was good for me. But I think ...if it was designed to teach people how to facilitate a WRAP program it didn’t do that. I suppose the consortium needs to be clear about what it wants to do, does it want to teach people how to use the WRAP program which is a tool, a framework or does it want to develop the appropriate ethos. That’s it, I think the big piece of work is the development of the appropriate ethos” (FG 5).

“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. ....I’m not familiar with that side of it. So if I had to put together a programme I’d have to spend quite a lot of time doing that” (FG5).

Despite this, many acknowledged it would take time to gain experience in delivering the programme and that their confidence was likely to increase with time and experience.

“We have got the tools really; we have got the tools... [but]...I will not be comfortable with it until I have delivered it a few times” (FG 5).
Others planned to increase their confidence and overcome fears by working with a co-facilitator, and spoke of how they intended to arrange this.

Although participants did acknowledge that “there’s a lot of people [practitioners within the mental health services] who are person-centred in their approach to care” they were of the view that they were working within a system that “dehumanized” people. Consequently, they perceived that a major challenge to developing a recovery oriented service was overcoming the traditional biomedical approach, and shifting the philosophy of care from the present preoccupation with illness to one of wellness. This is exemplified in the following quotations:

“We have support groups who meet monthly but it’s very difficult to shift from trauma...into wellness and recovery and how that can be supported” (FG 5).

“We’re very much working within a medical model...this is a whole new mindset and to bring it back into the system...we need an awful change of mindset” (FG 5).

Tied to this barrier was a perceived lack of input and support from medical personnel, which participants believed was reflected in the absence of medical practitioners within the programme. The absence of ‘buy in’ by those with perceived control over the mental health services, in the participants’ view, would make incorporating Recovery and WRAP within conventional mental health services very difficult, not only at an organisational level but at a philosophical level as well. Participants were of the view that disseminating the core values of Recovery and WRAP to people who may have not yet heard of recovery or were resistant to changing current beliefs and practices, for whatever reason, would be impossible if effective leadership was not demonstrated by all. This was not limited to mental health practitioners but also service users who perhaps adopted a passive and non-contributory role in the management of their own mental health.

“I was working with WRAP with one particular person and everything I asked he kept looking at me for the answer and I kept going, ‘No this is your WRAP, these are your wellness tools what works for you may not work for anyone else”’ (FG 5).

Practitioners also expressed concern that current practices might be re-labelled and repackaged as Recovery without any fundamental change in philosophy and approach to care, or without proper understanding of the principles underpinning Recovery and WRAP. This concern was exemplified in the following quote by a practitioner, who talked about what may happen, once they returned to the mental health service, having completed the programme:

“For me the tension is that people would be saying to me after this, ‘You’ve done WRAP, get it going here’. The perception is that it is actually some kind
of a tool, that it is actually something you bring in and you use it to treat people who have diagnosis. I feel that my duty and my responsibility is to actually communicate that [it] is much broader, and to keep it that way, so that the actual leveling of the playing field is there, that’s my responsibility. And I think that’s what I would see as the biggest thing I have to do, ... actually communicate to my colleagues, that it’s not another tool of the mental health services” (FG 5).

One participant expressed the view that participating in the programme required the person to have achieved some level of wellness.

“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” (FG 2).

Another perceived obstacle that was discussed in one hub related to the potential to exploit people with self experience who would be continually expected to share their experiences. Participants believed this created an ethical dilemma in terms of balancing the need for people with self experiences to be involved and creating extra emotional burden that may be detrimental to the mental health of those concerned. On the other hand a small cohort of participants who described themselves as practitioners believed that their experiences were in danger of being invalidated because they did not have a mental health problem that they could share with other members, and that this somehow negated their input.

5.8 Forward Movement and Sustaining Progress: Strategies for consideration

Notwithstanding the obstacles described in the previous section, there was an overwhelming sense that the participants were committed to sustaining and developing Recovery and WRAP and were concerned about how this could be done. Participants were of the view that if progress was to be achieved, a coherent national strategy that sets out action plans for implementing Recovery and WRAP was required; in their view this could have major financial implications for an already cash-starved mental health service. Without this, participants were of the view that local initiatives, although positive, would perpetuate the lack of co-ordination and consistency that is part of the current mental health services throughout the country. Central to this was the lack of certainty about the future of IMHREC, which was perceived as the driver behind the implementation of Recovery and WRAP. Consequently, participants believed that the continued existence and recognition of IMHREC at a national level was a key to the sustainability of the Recovery and WRAP agenda. Furthermore, it was suggested that the Mental Health Commission also had a pivotal role in implementing a recovery-oriented service.

Most of the participants were keen either to implement WRAP into their own practice or educate others about it. There was commentary which indicated a potential politicisation of participants, with many believing that they now had a role in
spreading the word and shifting the mental health service to a more collaborative and egalitarian system of mental health care, with people with self experiences at the centre.

For many participants, the core principles associated with Recovery and WRAP were more important than the actual action plan itself. Many offered suggestions on how Recovery could be implemented successfully at a practical level. Examples of these included having an apprenticeship model of facilitation and developing a support network for facilitators:

“One of the things I’d like is an apprenticeship and then you had to work with a mentor and that would be maybe somebody who would have been doing it for a couple of years, so you do your colleagues watch and then you do your apprenticeship for a couple of months and then you get your driving licence” (FG 5).

Others suggested that the sustainability of WRAP lies in its flexibility and diversity of application, citing examples of the various groups of individuals who might benefit from Recovery and WRAP education. The importance of educating family members as well as having medical endorsement is highlighted by the following participant:

“...they say, ‘What is this?’; they’d no idea, the little green book sort... They wanted to know where are the professionals, what is this all about, they just can’t relate to it. Like where’s the back up and who are these people? Where are they getting their ideas from? [Names a parent] would still be sceptical about it.... when there’s not a doctor involved, there’s a major problem when there’s not doctors involved” (FG2).

Some participants believed that other stakeholders such as friends and other healthcare providers such as general practitioners, and consultant psychiatrists could benefit from education on recovery and WRAP.

“The GPs because they are the gatekeepers. If I’m not coping very well the first point of contact is the GP. And there’s a whole lack of opportunities for GPs to be included because they work outside the system” (FG 2).

Others spoke about the importance of involving and educating people outside the health care system. Some participants thought that introducing Recovery and WRAP into schools would be a good way of educating younger people about mental health and recovery:

“Which would mean they would design their own WRAP for you know your typical secondary school student and design their own booklet and materials, everything that would go with it. So I thought that would be a great thing if that happened” (FG 5).
Some suggested introducing the concepts of Recovery and WRAP into other fora:

"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” (FG 5).

"WRAP recovery— it’s something that could be used in any context, it doesn’t have to be used solely within a health or mental health context. It could be used within HR [Human Resources]... So there’s a bigger audience” (FG 2).

5.9 Summary
Overall, participants spoke very positively and were enthusiastic about the benefits they had achieved personally, professionally and within their broader social circle as a result of their participation in the programme. Participants described their experience as inspiring, invigorating and life changing. 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.

Prior to attending the programme, some participants viewed Recovery in a traditional medical manner, seeing it as the absence of symptoms, or as illness remission. Attending the programme exposed the participants to new ways of thinking about Recovery. Participants left the programme with a great sense of optimism about the concepts underpinning Recovery and WRAP and with clear messages of hope and personal validation. The programme clearly impacted on all participants’ belief in the capacity for wellness and recovery.

The emphasis within the programme on wellness, positive mental health and recovery were viewed as a positive move away from the dominant medical and illness paradigms. The focus on self help, self management, and taking responsibility and control was perceived by the participants to be empowering, refreshing and positive. Learning about Recovery and WRAP challenged the assumption that those with self experience of mental distress are passive recipients of mental health care. It also helped the participants to think differently about themselves and view mental distress as a normal reaction to life’s challenges. Participants described how the programme shifted their mind set and enabled them to open up a different dialogue with themselves and others, around recovery and wellness. For participants who came from a practitioner background, the programme also began a process of deep questioning around the values and knowledge base which underpin their practice.

Participants commented very favourably on the WRAP approach and were of the view that it helped place a certain structure or order on what people had been doing already, but without structure. The structure provided by WRAP was one which made eminent common sense, was logical and achievable. Several practitioners spoke of
learning new techniques to support their own or others’ mental health. Some participants reported that they fully immersed themselves in the concepts and adhered closely to the WRAP programme. In contrast, others used WRAP in an eclectic fashion, dipping into aspects of the programme without fully completing the different steps of the action plan. Many participants commented on how the programme helped them to become more aware of factors/triggers that influence their stress levels and how they learned new techniques and strategies to promote their recovery. As a consequence, they reported greater awareness and ability to manage and cope with negative experiences. Participants who were health practitioners spoke of using the ideas in their own lives, using them to open up a dialogue on recovery with those with self experience and other practitioners, and incorporating the principles and values into education programmes.

One of the most valuable aspects of the programmes appeared to be the mix of people with self experience, family members/carers and practitioners. Participants attributed many of the positive outcomes to the level of interaction, engagement and personal disclosure that was fostered throughout the days. Through the facilitative process of sharing and listening to each others’ experiences, participants were enabled to learn from each other, and support each other. Many commented that the process of shared education helped to equalise relationships, normalise mental distress, and communicate a strong message of partnership. This model of education was seen as essential to all future education endeavours on recovery.

In terms of the course structure and delivery, several participants stated that there was a good balance between the theory of Recovery and WRAP and putting it into practice. Some were of the view that they needed more time to complete their Wellness Recovery Action Plans and get other peoples’ perspectives and feedback. Others believed that a smaller group size would have made more time available for discussion.

Although many of the two-day participants were very positive about passing on the message of Recovery and WRAP, and believed that they could pass on the concepts to people in an informal way, they questioned whether they had the requisite skills to communicate the essential components of recovery and WRAP in a formal education context. Similarly, the five-day participants were very enthusiastic about becoming involved in developing and facilitating Recovery and WRAP education, and many felt able to do so. However, some participants who had never facilitated groups or educational sessions expressed a lack of confidence about facilitating a recovery and WRAP programme. However, they were of the view that with time and experience their confidence would grow.

Although the participants hoped that the core values and language associated with Recovery and WRAP would be influential in promoting and achieving lasting change
throughout the mental health services in Ireland, they did identify a number of barriers. Participants perceived that a major challenge to developing a recovery oriented service was overcoming the traditional biomedical approach, and shifting the philosophy of care from the present preoccupation with illness to one of wellness. They expressed concern that current practices might be re-labelled and repackaged as recovery without any fundamental change in philosophy and approach to care. Tied to these concerns were the lack of a national strategy for implementing a recovery oriented service, the uncertainty of IMHREC’s future (the consortium was perceived as the driver behind the implementation of recovery and WRAP), and the perceived lack of support from medical practitioners. Some participants expressed concern that people with self experience could be exposed to an extra burden if they were continually expected to share their experiences as a means of educating others.

Most of the participants were keen to be involved in either implementing Recovery and WRAP principles into their own practice or educating others about it. For many participants, the core principals associated with recovery and WRAP were more important than the actual action plan itself. Many 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.
Chapter 6: Discussion

6.1 Findings Set in Context

The aim of the study was to evaluate the impact of the Mental Health Recovery and Wellness Recovery Action Planning (WRAP) programmes on participants’ knowledge, attitude and skills of mental health Recovery and the WRAP approach. The objectives of the study were:

- To evaluate participants’ attitudes, knowledge and skills regarding Mental Health Recovery and WRAP education programme pre and post programme delivery
- To describe the level and extent of participants’ application of the Mental Health Recovery and WRAP principles in their own life/practice
- To make recommendations for action and support structures to sustain the further development of the Mental Health Recovery and WRAP education programme nationally and its mainstreaming into mental health services as appropriate.

The study involved a large sample, drawn from multiple sites around the Republic of Ireland and used a pre and post test design with focus group interviews. Overall, both the 2-day and 5-day programmes were evaluated very positively by participants. Participants expressed very positive views about the benefits they had achieved personally, professionally and within their broader social circle and viewed the programme as an empowering experience.

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 (Doughty et al., 2008, Culloty, 2005, Hill et al., 2009, www.mentalhealthrecovery.com). Although findings from the quantitative measures indicated that participants already had considerable knowledge of WRAP and Recovery prior to participation, and held positive attitudes toward 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 five-day participants.

The ceiling effect on the RKS and the RAQ7 could be due to the fact that the participants had already completed the two-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 toward 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. Participants also reported learning new techniques and strategies to promote their own recovery. Similar positive outcomes have been reported in other evaluations. These included a significant 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, Doughty et al., 2008, Culloty, 2005, www.mentalhealthrecovery.com).

In addition to enhancing the participants’ ability to manage their own mental health, both the quantitative and qualitative findings indicated that the programme increased participants’ confidence to help another person to develop his/her own WRAP plan and provide peer support. Similarly, in Doughty et al.'s (2008) study, the majority of participants reported that the programme had impacted positively on their ability to facilitate another person to develop a WRAP.

Among the factors identified by people with self experiences as important for recovery are optimism about recovery, finding hope and taking personal responsibility (Andresen et al., 2003, Young and Ensing, 1999). Recovery is not something that practitioners can do to a person; it is something that people do for themselves (Anthony, 1993), and this was strongly endorsed by the participants in this study who spoke of the role and challenge of personal responsibility in Recovery. Practitioners, however, can have a positive impact on possibility and potential by creating a positive and enriching environment. Central to this is practitioners having a hope and a belief in the possibility of Recovery (Higgins, 2008). People with self experience and practitioners reported leaving 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 take control of the own lives and recovery, and a greater sense of empowerment and agency. Participants clearly welcomed the focus on personal responsibility, self help and self management, supporting Culloty’s (2005)
view that WRAP as a tool has the potential to build on principles like hope, empowerment, responsibility and self help.

As part of a wider commitment to involving people with self experience and carers in all aspects of healthcare, there has been an increased call for their involvement in education (Department of Health and Children, 2006). It is argued that if an ethos of partnership, which values the expertise of self experience and carers, is to underpin service delivery, then such partnerships must also be a cornerstone of all mental health education (Tew et al., 2004). One of the most valuable aspects of the programme was the bringing together of people with self experience, practitioners and to a lesser extent family members/carers. Findings from this study suggest that involvement of people with self experience, family and carers increased partnership skills and served to challenge professional orthodoxies and power. Findings also suggested that the tripartite approach was possibly the catalyst for practitioners to begin a process of reappraising their values and practice, and the implications of current approaches to care on people’s lives. There is some suggestion within the literature that taking on a valued role in education can have positive outcomes for people with self experience, such as raised self esteem, empowerment and gaining new insight into their lives (Walters et al., 2003, Barnes et al., 2006, Repper and Breeze, 2007), findings congruent with this study. Participating in the programme gave some participants a palpable sense of personal validation, equality and affirmation of the contribution that people with self experience can make to the education of others, both lay and practitioners. 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.

The women in Gordon and Cassidy’s (2009) study found that the most useful and valuable aspect of their experience was having the opportunity to engage in discussion and hear each others’ views and experiences, thereby learning from each other. This was also true within this study. 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 story telling, disclosure and dialogue that was fostered throughout the days. It was also widely agreed that this process not only fostered a sense of togetherness, but also equalised the relationships between all involved.

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 medicalisation 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”.
Buchanan-Barker and Barker (2006) pointed out that recovering from stigma can often be more challenging than recovering from the consequences of a mental health problem. The emphasis within the programme on wellness, positive mental health and the message that people can live with and recover from mental illness were viewed as a positive move away from the dominant medical and illness paradigms and a powerful de-stigmatising message, which needed to be communicated widely. 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.

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, as well as concerns around the impact of heavy caseloads and heavy administrative tasks on practitioners’ time to facilitate the people to develop a WRAP (Culloty, 2005). There were mixed views around duration, with some people who only completed the 2-day programme wanting more time. In one cohort, some dissatisfaction was expressed with the room size and a number of people who did not achieve a place on the 5-day programme also expressed extreme disappointment.

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’ perceptions of their ability to teach and facilitate the principles underpinning Recovery and WRAP. Those areas that participants perceived that they had become most skilled at facilitating after the program were Wellness Recovery Action Planning, Peer Support, Self Advocacy/Self Agency and Crisis/Post Crisis Planning. The greatest increases in facilitation skills came in Hope, Wellness Tools, and Values Based Care. Those areas that participants perceived that they were least skilled at facilitating after the programme were the Role of Personal Responsibility in Recovery and Advance Agreements. 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 over aspirational 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-day and 5-day) to become involved in spreading the message of Recovery and WRAP. The efforts they had put into sharing their learning with others reflected the opportunities available to them and their confidence to date. 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.

Borkin (2000) reported some differences in attitudes to Recovery among the various groups included in their study. Health care practitioners had slightly more positive attitudes than people with self experiences and family members. However, in this study and similarly to Doughty et al.’s (2008) study, there were no significant differences in quantitative outcomes between people with self experience, carers and practitioners. Doughty et al. (2008) suggests 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.

The Recovery vision cannot be realized without significant changes to professional practice, social attitudes, public discourses, cultural norms and assumptions, and economic and social structures (MIND, 2008). Participants in this study were indeed mindful of this and expressed concern about the lack of a national strategy to implement Recovery education, lack of funding, the uncertain future of IMHREC, the perceived lack of “buy in” by medical practitioners and the challenge of personal responsibility for recovery. In their view, without strategic leadership, funding and structures to support development, changes would not occur in practice.

In summary, the findings of this study support the belief that Recovery and WRAP education has the potential to increase people’s knowledge, promote positive attitudes toward Recovery, and provide people with strategies to support mental health. It also has the potential to be a message of hope and empowerment. If delivered using the tripartite model used in this study, it has the ability to transform people’s world views, challenging traditional orthodoxies and power. This supports Slade’s (2009:235) view that the process of recovery is far more wide-reaching and long lasting than “getting rid of symptoms, restoring social functioning, avoiding relapse and the other preoccupations of the current medical paradigm”.

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-judgemental, supporting and facilitative learning environment that enabled participants to actively engage with learning and transform their world views. This ran in tandem with their ability to create an environment where common humanity and vulnerability were respected and nurtured. Their knowledge and skills, together with their ability to practice and live out the values and beliefs upon which the programme was conceived, ensured that the programme was educationally relevant, emotionally
supportive and ethically responsive. In rolling out 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 in Ireland.

6.2 Limitations

Overall the results are very positive, although they need to be interpreted in light of the following issues:

- The study did not include a control group for comparison and relied on self-reporting to assess outcomes.

- Participants volunteered to take part in the programme, which may have attracted individuals who were motivated to change; thus the sample is not likely to be representative of the general population of health practitioners, carers/family members or people with self experience.

- The questionnaires were administrated at the beginning and end of the 2-day 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, long-term outcomes were not considered in the evaluation.

- Only a small number of participants who completed the two-day programme participated in the focus groups, therefore it cannot be assumed that their views are representative of the group as a whole.
Chapter 7: Conclusions and Recommendations

7.1 Conclusion
This is the first study in Ireland which evaluated a Recovery and WRAP education programme with representation from people with self experience, family members, community development workers and mental health care practitioners, drawn from multiple sites around the Republic of Ireland. The evaluation employed a multi-method approach using a pre and post test design with focus group interviews.

Findings from the study indicated that providing mental health practitioners and people with self 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 principles, and their ability to teach and facilitate these changes in others. This education also inspires, invigorates and empowers people, and for many, it is a life changing experience.

While it can be concluded that the programme was a success and achieved its objective of introducing the concepts of Recovery and Wellness Recovery Action Planning (WRAP) into the practices and lives of people with self experience of mental health problems, mental health practitioners and to a lesser extent family/carer members and teaching them strategies to promote mental health Recovery, it also moved beyond that objective. In addition to the research outcomes, as discussed, it is important to acknowledge that the project has provided a blueprint for the development of Recovery and WRAP education in Ireland, and has demonstrated the importance of engaging and harnessing the energy and knowledge of local communities from the outset. It has demonstrated the importance and power of a tripartite model of education, if facilitated with skill and empathy. Finally, in addition to the recovery website and educational materials developed by the consortium, the recovery education programme has produced 67 WRAP facilitators, who are available to assist in moving the Recovery agenda forward. Mental Health Service Providers and Educators seeking to embed Recovery principles into service delivery and education are more likely to do so if they adopt the principles and methods used in the Recovery and WRAP education programme used in this study.

7.2 Recommendations
In light of the findings from this study, the researchers make 14 recommendations:

1. A national mental health recovery network for Ireland is developed. Consideration be given to developing the consortium that formed IMHREC as the network.
2. A national strategy for mental health recovery education be developed, with due consideration of the need to have a wider public focus and expand recovery education outside traditional mental health care environments into general health settings and the wider community, including schools and community networks.

3. Funding is made available to implement a mental health Recovery education programme for all mental health practitioners in Ireland that is inclusive of family members/carers and people with self experience.

4. An identified person/group with autonomy and authority to produce recovery education programmes is appointed.

5. The Mental Health Commission develops a national mental health recovery collaborative to put recovery at the heart of all mental health provision through Local Recovery Implementation Groups.

6. Educational accrediting bodies ensure the inclusion of recovery principles, values and practices is central to undergraduate and postgraduate education curricula that prepare mental health practitioners to work in mental health services in Ireland.

7. Funding be made available for evaluating initiatives developed to promote recovery in people living with mental health problems.

8. The network of recovery facilitators developed as a result of this programme be supported to facilitate the development of locally organised recovery education programmes.

9. Consideration be given to the development of a mentorship programme for facilitators.

10. Those who completed the 2-day programme but did not have access to the five-day facilitation be offered, as a priority, the opportunity to complete the five-day programme.

11. Similar programmes be developed and offered in areas of the country not catered for by the IMHREC project.

12. Future programmes need to address the concerns expressed by participants regarding content, facilitation and issues such as duration and room layout and recruitment of family members/carers and medical practitioners.

13. A follow-up study of participants be undertaken to examine whether the changes reported in this study were maintained over time, and to examine
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how participants who completed the programme used their knowledge and skills to support their own or others’ mental health. It would also be important to explore what proportion of participants actually formulated a WRAP plan either for themselves or for someone else and facilitated a formal education programme. In addition, a study is required to evaluate the outcomes of education programmes delivered by the facilitators prepared through the IMHREC process.

14. Further evaluation studies are conducted using experimental approaches. In addition, international researchers with an interest in Recovery and WRAP education agree on core outcome measurement tools so that direct comparisons between future Recovery and WRAP education evaluations can be made.
References


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SOCIAL CARE INSTITUTE FOR EXCELLENCE (SCIE), CARE SERVICES IMPROVEMENT PARTNERSHIP (CSIP) & ROYAL COLLEGE OF PSYCHIATRISTS (RCPsych) (2007) A Common Purpose: Recovery in Future Mental Health Services. A joint position paper, Social Care Institute for Excellence (SCIE), Care Services Improvement Partnership (CSIP) and Royal College of Psychiatrists (RCPsych).


