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Perceptions of Wellness Recovery Action Plan (WRAP) training: A systematic review and metasynthesis.

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Title: Perceptions of Wellness Recovery Action Plan (WRAP) training: A systematic review and metasynthesis.

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Abstract

Purpose

This systematic review addressed two questions: 1) What is the qualitative evidence for~~are~~ the effects of Wellness Recovery Action Plan training, as perceived by adults with mental health difficulties using it? 2) What is the quality of qualitative literature evaluating WRAP?

Methodology

~~Six~~ Five electronic reference databases and the EThOS database for unpublished research were systematically searched, as well as two pertinent journals. Study quality was assessed using Critical Appraisal Skills Programme criteria~~. Thematic synthesis involved coding text line-by-line to create descriptive themes, then further analysed into analytical themes~~ and results analysed using thematic synthesis.

Findings

Of ~~253~~ 73 studies, ~~six~~ 12 qualitative papers met inclusion criteria and were generally good quality. Analyses demonstrated expected findings, such as increased understanding and active management of mental health in the context of group processes. Results also highlighted that~~the role of~~ WRAP training ~~in promoting~~promoted acceptance and ~~improving~~ improved communication with professionals. Peer delivery of WRAP was highly valued, with contrasting perceptions of peers and professionals evident. Some cultural considerations were raised by participants from ethnic minorities.~~.~~

Research implications

WRAP training participation has positive ~~outcomes~~ self-perceived effects beyond those captured by measures of recovery. Broader implications are suggested regarding earlier access to WRAP, professional support and communication between professionals and service

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users. Recommendations for further research include the relationship between social support and illness self-management and peer-delivered acceptance based approaches. Multiple time-point qualitative studies could offer insights into WRAP training processes and whether changes are sustained.

Originality / value

As the first review of qualitative evidence regarding WRAP training, value is offered both through increased understanding of outcomes and also guidance for future research.

Keywords: *Recovery, Wellness Recovery Action Plan, metasynthesis.*

Article classification: Literature review.

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Introduction

~~Systemic transformation of mental health services towards recovery-orientation may require at least a generation to materialise in any substantive way (Davidson *et al.*, 2006). Debates also remain regarding the varied accounts of 'recovery' and its meaning in mental health policy and practice (Gordon, 2013). That said, practice~~ Practice within Western mental health systems has been shifting towards recovery-orientation, despite systematic transformation requiring significant time to materialise (Davidson, O'Connell *et al.*, 2006). While some efforts to operationalize and implement recovery have involved a 'cosmetic' renaming of existing services, others have focused on clear strategies including education, consumer and family involvement, consumer-operated services, emphasis on relapse prevention and management, and incorporation of crisis planning (see Jacobson and Curis~~,~~ [2000]~~:~~ ~~see~~ for a more detailed outline of each strategy). Such developments ~~would be seen as part of~~arguably represent a movement away from traditional medical provision towards recovery-oriented health services. Peer-support and self-management are concepts related to this shift and contextualise the Wellness Recovery Action Plan (WRAP) (Copeland, 1997).

Peer-support

Mutual support is thought to: enhance individuals' understanding of issues, through sharing of similar life stories~~,~~; increase social networks and sense of community~~,~~; lead to increased hope and autonomy~~,~~; and offer socially valued roles, within specific behavioural settings in which new perspectives and skills can be learned (Davidson *et al.*, 1999). Closely related, mental health peer-support has proliferated ~~in line with the development of recovery-oriented services~~ (Davidson, Chinman *et al.*, 2006), where "peers" are individuals considered

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as living successfully with mental illnesses who support others with mental health issues. Peer-led services may enhance care through allowing individuals with similar difficulties to meet and discuss their issues, and receive empathy and suggestions from others who have faced similar challenges (Davidson, Chinman *et al.*, 2006). Research into peer support shows inconsistent findings ~~and use varied outcome measures~~, but includes some evidence that receiving peer support can lead to a reduction in admission rates and can improve individuals' sense of empowerment, self-esteem, confidence, social support, ~~and~~ social functioning, and hope – likely achieved through relationships founded on acceptance, empathy, and reduced stigma (Repper and Carter, 2011).

Many services now have peer-employees: peers who are hired into mental health positions (Solomon, 2004). The role is complex, as peer support workers hold multiple identities, which must be negotiated both by them (Dyble *et al.*, 2014) and those they support (Bailie *et al*, 2016). ~~Evidence suggests employment as a peer support worker can be both facilitative and detrimental to personal recovery, although the quality and extent of research is limited (Bailie and Tickle, 2015).~~ However, a systematic review of peer-support for individuals with 'severe mental illnesss' reported a moderate degree of effectiveness, including improvements in service-user empowerment, self-advocacy, hopefulness, engagement, and relationships with providers, as well as reduced inpatient admissions (Chinman *et al.,* 2014).

Self-management

Illness self-management is one of a core set of evidence-based interventions that improve outcomes for individuals ~~with severe menal illness~~ in relation to symptoms, functional status and quality of life (Drake *et al.*, 2001). It aims to enable the individual to gain control of their symptoms, recognise triggers, set goals, problem solve, share decision-

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making and develop relapse prevention strategies (Bodenheimer *et al.*, 2002). ~~Within mental health services, empirically supported core components of illness management programmes include psychoeducation, behavioural tailoring for medication, training in relapse prevention, and coping skills training employing cognitive-behavioural techniques (Mueser *et al.*, 2002).~~ It is assumed by some that 'illness self-management skills are crucial for individuals to function more effectively and to develop more personally meaningful lives (i.e., "recover")' (Salyers *et al.*, 2007, p.467).

Various forms of self-management exist, including group or individual sessions with professional input and online or self-help resources (Doughty *et al*., 2008), although a review found little evidence for the use of such strategies in mental health services and a lack of clarity in terms of how this could be promoted (Singh and Ham, 2006). The distinction between professional-delivered services and peer-delivered illness management programmes is said to be crucial, because of the hierarchical nature of the former and the unique position peers have to teach 'self' management skills based on personal experience (Mueser *et al.*, 2002).

The potential clinical and economic benefits of self-management of chronic health conditions are recognised in both preventing illness and promoting wellness through partnership working between the 'patient', family, community and clinician (Grady and Gough, 2014). Within chronic physical health conditions, there is evidence for the role of social support in the success of self-management (Gallant, 2003) and it would be reasonable to assume such a relationship within mental health self-management, but with the caveat that mental health or illness and recovery may be concepts more open to interpretation than physical ill-health conditions with clear recovery markers. Perhaps related to recognition of partnership and collaboration, a psychometric study of scales designed to measure illness self-management outcomes (Salyers *et al.*, 2007) highlighted the different perspectives

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between consumers and clinicians in relation to constructs of illness self-management and recovery, but suggested these perspectives may converge through working together in ~~illness self-management~~ programmes such as the Wellness Recovery Action Plan (Copeland, 1997). While the WRAP is described as a wellness based model that can be used by anybody, rather than an illness self-management programme used only by those with mental health problems, it is used widely in mental health settings and has many overlaps with the aforementioned principles (Bodenheimer et al., 2002).

The Wellness Recovery Action Plan (WRAP)

A system clearly grounded in the principles of recovery-oriented care, including peer support and self-management, is the WRAP (Copeland, 1997), a structured peer-based, group programme approach to illness self-management which may be applied to the management of physical and mental well-being (Copeland, ~~2001~~2008), based on Copeland's personal experiences and learning from people with lived experience. WRAP training is facilitated by peers in recovery trained in WRAP by the Copeland Centre for Wellness and Recovery, and receiving mentoring from advanced WRAP facilitators (Copeland, 1997). Key objectives are for participants to identify internal and external resources for facilitating recovery through development of a personalised wellness plan (Copeland, 1997). A typical WRAP training series comprises 8-10 weekly sessions of group education to enable participants to improve their ability to take responsibility for their own wellness, manage mental health symptoms using self-help strategies and identify and utilise sources of support (Copeland, 1997; 2004). WRAP has five central concepts, of hope, personal responsibility, education, self-advocacy and support and is built on a range of values and ethics outlined a video available at: https://www.brattleborotv.org/wrap-wellness-recovery-action-plan/wrap-ep-1-beginning-your-wrap.

Group processes

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Given that WRAP is a group programme, it is important to consider groups processes, as well as content, as possibly affecting outcomes. Although focused on group psychotherapy, rather than illness self-management or peer support, Yalom (1985) identified 12 factors of group therapy. Some of these have clear overlap with recovery principles, peer support and illness self management, particularly: interpersonal learning – input (participants share each others' perceptions), imparting information (giving advice to one another), self-understanding, the instillation of hope, and existential factors (taking personal responsibility for actions) ~~and have also been shown to be important to individuals with psychosis (Restek-Petrović, *et al.*, 2014)~~. It is possible that these therapeutic factors are key contributory mechnisms of change in relation to peer support or illness self-management, although they have not been directly measured.

Qualitative research and WRAP

Quantitave research into WRAP outcomes has been conducted, with a focus on both clinical outcomes of 'symptom reduction' and also measures of self-perceived recovery outcomes. A recent review of these studies (Canacott *et al.*, 2019) indicated that WRAP was superior to active controls for promoting self-perceived recovery outcomes but not for reducing clinical symptomatology. However, a paradigm shift within mental health services from understandings of clinical to personal recovery (Slade, 2009) necessitates shifts within research also. It is no longer considered sufficient to measure only clinical outcomes, such as symptom reduction. There has been an increase in the use and acceptance of qualitative research methods within mental health research (Joseph *et al.*, 2009), which can generate hypotheses, explore subjective experiences of people with mental health problems, and investigate processes of recovery and the individual's active role in it (Davidson *et al.*, 2008). Research relating to WRAP training has reflected this trend, with studies attending to first-person accounts of using WRAP training and demonstrating similar findings as well as high

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levels of satisfaction with the WRAP both for consumers and facilitators (Doughty *et al.*, 2008).

Qualitative research can add value through its often inductive approach, which allows participants to give more open accounts than pre-determined quantitative questionnaires permit. This can allow for novel findings grounded in the experience of participants, and fits well with the emphasis of recovery-oriented approaches on individuals' meaning rather than that determined by 'experts'. This allows investigation not only of the potentially broad 'outcomes' of WRAP training, but also the processes that may contribute to the achievement of any outcomes. A systematic review of quantitative evidence (Canacott *et al.,* 2019) cannot sufficiently capture the breadth of evidence regarding 'effectiveness' of WRAP training as perceived by participants. Qualitative studies pertaining to WRAP training should therefore also be systematically reviewed to attain a broad understanding of potential outcomes of WRAP training – synthesising experiential accounts of WRAP and its subjective impact.

A common critique of qualitative studies is their ability to contribute to the evidence base due to generally small participant numbers and a lack of generalisability. This critique is increasingly addressed through the use of the synthesis of related qualitative studies through a systematic approach to collecting, analysing and interpreting their results (Lachal *et al.*, 2017). Metaynthesis is an interpretative process, which can provide new insights not found in primary studies (Ma *et al.*, 2015). To the authors' knowledge, no metasynthesis of qualitative research into WRAP training has been published.

Purpose

This review aimed to answer the questions: 'What is the qualitative evidence for the effects of Wellness Recovery Action Plan training, as perceived by adults with mental health difficulties using it?~~What do published qualitative studies evidence about are the effects of~~

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~~Wellness Recovery Action Plan training, as perceived by those using it?~~' and 'What is the quality of the existing literature evaluating WRAP?'. The objectives were to:

1) Systematically identify and assess the quality of qualitative studies into the experiences of individuals with mental health difficulties receiving WRAP training.

2) Use thematic synthesis to synthesise existing qualitative evidence for the effects of the WRAP training, as perceived by those using it.

Methodology

Epistemological position

This review was approached from a critical realist epistemological position, which holds that the knowledge of reality is mediate by our perceptions and beliefs (Spencer *et al.*, 2003). While WRAP training is an experience people have, the views that they form about it and express within qualitative studies will be mediated by their beliefs, just as any interpretations of these views will be mediated by the beliefs of qualitative researchers. Equally, the authors recognised the synthesis would be influenced by their position and beliefs as clinical psychologists with interests in adult mental health, WRAP training and qualitative research.

Searching

Five electronic reference databases (Medline, CINAHL, EMBASE, PsycINFO, PsycArticles) were searched on 07/06/2020 for the key phrase "Wellness Recovery Action Plan*" (in title, abstract, or [where available] full text). No date restrictions were set. To locate other eligible research articles, such as unpublished research, the same search phrase was entered into the EThOS database. Additional peer-reviewed literature was identified

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through hand-searching the reference lists of review articles. The Psychiatric Rehabilitation Journal and International Journal of Psychosocial Rehabilitation (journals that publish many articles relevant to the area of recovery in mental health) were also hand-searched to identify further articles

~~Six electronic reference databases (Medline, CINAHL, EMBASE, PsycINFO, PsycArticles, The Cochrane Library) were searched on 07/09/2017 using full-text, keywords, and Medical Subject Headings (MeSh)/Thesaurus headings terms as follows: 1) ((well* OR health*) (recover* OR recuperate*) (action* OR plan*)); 2) "Wellness Recovery Action Plan"; 3) "WRAP"; 4) exp. Mental Health; 5) 3 AND 4; 6) 1 OR 2 OR 5. No date restrictions were set. To locate other eligible research articles, such as unpublished research, the same search strategy was entered into the EThOS database. Additional peer-reviewed literature was identified through hand-searching the reference lists of review articles. The Psychiatric Rehabilitation Journal, which publishes many articles relevant to the area of recovery in mental health, was also hand-searched to identify further articles.~~

Study selection

The focus of this review was perceptions of the effects of WRAP training as perceived by those who had undertaken it, as reported in qualitative studies. This was deliberately broad to allow for any self-perceived effects of the WRAP to be captured, i.e. beyond those that might be intended or expected, but that might contribute to personal recovery.

To be included, studies must:

- be written in English and included in peer-reviewed journals or "grey literature".
- Have participants who had undergone WRAP training as an intervention for mental health difficulties. The reason for requiring formal WRAP training (as opposed to

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individual use of WRAP), was because of concerns about fidelity to the approach when used outside the approved programme (Copeland Centre for Wellness and Recovery, 2014). Participants were not required to have any specific or formal mental health diagnosis.

- assess the experiences of WRAP training, from the perspective of those using it.

Studies were excluded if they:

- did not separate the views of those with mental health issues and other participants, such as mental health professional or peer facilitator.
- investigated perceptions of multiple self-management programmes and did not separate out data regarding the WRAP (if researchers were contacted and did not provide the necessary data).
- ~~I~~investigated perceptions of training to facilitate or educate others about WRAP, rather than being a direct recipient of WRAP training.

Following selection, data relevant to the review was extracted from each paper following detailed reading.

Quality Appraisal

It is important to appraise the quality of papers included in metasynthesis, to enable consideration of the value of the evidence presented and the relative weight of evidence provided by papers of different quality. ~~A number of tools are available for appraising qualitative studies.~~ The Critical Appraisal Skills Program (CASP, 2017) was chosen, as it is widely recognised and met the purposes of the present review. However, this was adapted from the use of 'No' / 'Can't tell' / 'Yes' responses to '0' / '1' / '2' responses respectively, to allow a total score per paper. A score of '1' was also used when a criterion was partially met. It was decided prior to the review that no studies would be excluded on the basis of their

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quality appraisal score, but that the appraisal would be used to highlight limitations of the included papers and make recommendations for future research. All papers were rated independently by LC and AT and the few differences found were resolved through discussion.

Analysis

Qualitative data ~~was~~ were copied into Microsoft Excel and thematic synthesis (Thomas and Harden, 2008) was used to analyse the data. Thematic synthesis involves coding all data from 'results' sections of included articles (whether participant quotes or the study authors' analysis of the data) line-by-line. These codes are then organised by grouping them together to create descriptive themes, without the use of any a priori theoretical framework and which stay close to the findings of included studies. Themes are then further analysed into analytical themes, which aim to go beyond the themes of the included studies to answer the question/s posed by the review. LC and AT did this independently and then arrived at the fin~~d~~al themes through discussion. The final themes were developed through an iterative process of moving between them and the data, to ensure that final themes were appropriately supported by the included studies.

Results

Search Results

~~Six~~ Twelve articles were identified for inclusion from an initial ~~253~~ 73 unique records identified through searching.

(Figure 1 about here)

Data abstraction and analysis

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Characteristics of selected studies are presented in Table 1. Numbers (1 – ~~6~~12) assigned to each study within Table 1 are used to refer to each study in the results section.

(Table 1 about here)

Study Characteristics and Key Findings

~~Six s~~Studies used qualitative methodology, employing a range of data collection methods including focus groups, individual interviews, telephone interviews and written responses to questionnaires. While ~~it is acknowledged~~ this variation ~~would~~ gives rise to different data, each method of data collection has advantages and disadvantages but the heterogeneity of approaches may have led to a broader inclusion of participants than any one method alone (Carter *et al.*, 2014). Data were not analysed separately according to data collection methods as this could give rise to misleading distrinctions arising from other factors, such as differing participant samples, overarching questions or specific questions posed to participants. Analysis methods included Constant Comparative Analysis, Social Constructionist Grounded Theory, Thematic Analysis, ~~and~~ Content Analysis and Interpretative Phenomenological Anaysis. Two studies (3, 4~~, 12~~) were mixed-methods but presented qualitative data separately. One (12) was a qualitative sub-study of a larger quantitative trial. Studies were predominantly cross-sectional, ~~and~~ recruited individuals at least one month into participation with WRAP training. ~~and all but one~~Only one (8) ~~did not include~~ included follow-up interviews to determine whether perceived changes were sustained. This is common in qualitative research but could be seen as a limitation: it would be reasonable to expect that individuals' perceptions might change during the course of participation in WRAP training and that something may be missed by not gathering individuals' views prior to participation in WRAP training.

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Quality appraisal of qualitative studies

Table 2 outlines the quality appraisal. Generally the aims, method, design and recruitment of studies appeared appropriate. A key issue that was not well addressed was the relationship between the researcher and participants. It is also interesting that one study did not appear to have considered ethical issues, but this is likely to be an omission in reporting. It is also noteworthy that in ~~four for~~five of the ~~six~~ 12 studies, it was not possible to determine whether analysis was sufficiently rigorous.

(Table 2 about here)

Synthesis of qualitative findings

Table 3 identifies the four themes, and subthemes, relating to outcomes of attending WRAP training, and the occurrence of these themes per study, indicated by *.

(**Table 3 about here**)

WRAP training processes supporting change:

Development and use of action plans and tool boxes

The development of action plans and tool boxes was cited as a key beneficial process within WRAP training as this enabled the application of strategies and skills to manage mental health, e.g. “Doing my Daily Maintenance and items in my Toolbox has been the most helpful” (3, p.118). One participant powerfully described their plan: “I used my WRAP plan

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like a bible… that was my foundations… everything else what I were feeling I had to cope with…, but I felt, like, [WRAP] were my foundations that kept me safe to go through it…' (~~6~~10, p.574). ~~However, not everybody used their WRAP so actively, with on individual stating he had "lost the information now" (9) and others stating they had not looked at their WRAP following training, some because they had not wanted a reminder of difficult times while feeling positive (2).~~ Active use of WRAP was associated with a reduction in symptoms and even preventing hospitalisation (9), as well as ~~Ashman *et al.* (2017) emphasised the potential for the crisis planning element within the WRAP plan to prevent a crisis but also described one participant's view that using WRAP led~~leading to crises being shorter and less intense (10). In the one study focusing on employment following WRAP, participants credited strategies learned in WRAP in their success with finding and retaining a job (11).

~~However, n~~There was some evidence not everybody used their WRAP so actively, with one individual stating he had "lost the information now" (9) and others stating they had not looked at their WRAP following training, some because they had not wanted a reminder of difficult times while feeling positive (2). Some stated that they wanted follow-up support to further develop the WRAP (2) or revise them as there was a lot of information to take in (9). Some participants had undertaken the WRAP multiple times and reported this was necessary as there was different learning each time (5, 9).

The group process

In addition to the content of WRAP plans, the group process was viewed as key by participants in ~~three~~ eight studies (~~1~~,2, 4, 5, 7, 8, 9, 10, 12~~6~~). Some thought that "undertaking the WRAP in a group, compared with undertaking WRAP one to one, would be more supportive, less intense, and had the potential to offer mutuality and the ability to learn together", which was seen to increase the likelihood of engagement (~~5~~7, p. 3). The group

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process was seen to provide unconditional relational support (5, 7), positive feedback (4, 5), shared information about how to manage mental health difficulties (2, 7, 8, 9, 12) and ~~and~~ reduced isolation (2, 3, 7, 9, 10, 12), e.g.

"It was nice to reveal my problems to other people that weren't gonna judge me and to know that you're not the only person in the world that has this kind of problem" (~~6~~10, p. 573).

Engagement with the group process was gradual and group members were not immediately comfortable, but that identification with other participants was a critical feature of WRAP learning for many (~~6~~10). Some studies evidenced that relationships developed within the groups continued after the groups (8, 9, 12).

There were, however, some notable exceptions in study 12, in which group members were randomly assigned to WRAP rather than an alternative intervention. Some expressed dislikes about being in a group generally, difficulties in interactions with other group members, and questioning other members' commitment to the group. Gordon and Cassidy (2) highlight the need to consider cultural context, as their South Asian female participants were a pre-existing group who consequently found it easier to open up in a very private culture in which there were concerns about mental health stigma, gender roles, protection of confidentiality in closely connected communities and the need for "a better understanding of each other, cultural, religious and like gender differences. They have more in common and their understanding is better, language is similar" (2, p.40). These findings highlight the importance of group members opting into groups and also potentially of harnessing pre-existing group membership.

Changes in how individuals related to mental health problems:

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Participants in all studies highlighted changes in how they related to their mental health problems. Ashman *et al.* (2017) describe the impact of the WRAP training on participants as profound, echoing the view of a participant in Pratt *et al.*'s (2013) study that WRAP training led to a fundamental, 'almost a seismic shift in thinking' (p.4) and descriptions of it as a turning point of realising there is hope for recovery (11, 12) and one's power to manage symptoms and reclaim life (11). Four subthemes were constructed:

Better understanding of mental health and recovery

All studies highlighted the important educational role of WRAP training. A better understanding for some was about the process of recovery, e.g. that "recovery and health happens by degrees, with steady effort…' (3, p. 118). For many, it was about an increased understanding and recognition of triggers or early warning signs (e.g. 1, 3, 4, 5, 9, 11, 12) and coping skills to respond (~~5~~7). Such knowledge could lead to alternative responses, e.g. "I now use my response to triggers and early warning signs when before, I thought they were [signs I was already in] crisis" (3, p.118). Participants in ~~one study~~three studies (~~1~~4, 5, 9) indicated the broad relevance and importance of the knowledge provided by WRAP training and a wish they had had the information sooner, e.g. "I wish I could have learned earlier in life about WRAP and my wellness tools. Everyone should take up WRAP" (5, p.851), ~~and~~ "I feel like this should be in public school" (p.851) and "It should be unwrapped long before you hit the mental health services… it should be an ethos of life" (4, p.2425).

Acceptance

Three studies (2, 4, 5) identified the theme of acceptance; of living with mental illness, of support and of managing uncertainty in the future. A number of participants reported that WRAP training changed their relationship with their illness, such that living a life alongside their illness became an option, in contrast to previous challenges in accepting

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mental illness, e.g. “I wonder if an acceptance of the fact that sometimes your life will be in crisis, and that knowing that there’s another side storm. You come out the storm.” (~~5~~7, p. 4).

Increased control, responsibility, self-efficacy and assertiveness

These and related concepts, such as autonomy, ownership, confidence and self-advocacy arose in ~~four studies~~all but one study (~~2, 4, 5, 6~~1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12~~5~~), sometimes related to the content of WRAP training and at other times the process. There seemed to be a shift towards greater personal responsibility for mental health, e.g.:

“I always vow never to go back up there (acute inpatient ward), but I end up being back there, and I think I actually have to try and take the control more into my own hands, and I think obviously WRAP is one way that I can take back that control…” (~~5~~7, p.5).

For some, this included a shift away from professional views, e.g.“To focus on my own recovery rather than what’s dictated by professionals, and to take ownership for myself” (~~2~~6, p.212)

It seemed that increased understanding of mental health and recovery (i.e. the content of WRAP) enabled greater self-efficacy and control over those things that can be managed, e.g. triggers and warning signs. Beyond mental health, ageing participants in one study (8) identified that WRAP helped them to affirm their lives and feel a better sense of control over everyday life experiences of growing old, despite those difficulties not changing per se. In addition, the process of WRAP training perhaps helped to develop the confidence to take more control, e.g. “I got a little bit of esteem from WRAP and that was able to help me speak up” (~~2~~6, p.213).

Two (2, 8) of the three studies (1) specifically recruiting participants from minority ethnic groups demonstrated contrasting findings in relation to assertiveness. Matsuoka (2015) found that female participants gained a sense of self-worth and consequent assertiveness and self-

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advocacy that contrasted with Japanese gendered cultural values of humbleness. In contrast, female South Asian participants (2) emphasised their sense of conflict between self-adocacy as encouraged by the WRAP and cultural gender roles.

Recognition of the importance of social support

Four studies recognised the importance of social support (1, 5, 6, 8, 9, 11, 12) not only in terms of receiving it but also providing it to others. Within WRAP training, 'unconditional relational support' was identified by Wilson *et al.* (2013) with one participant stating, "They are my second family" (p. 851). ~~and another declaring "I'm not alone. We're all together and all support each other" (p. 851).~~

As a result of WRAP training, some participants reported more actively seeking help from family members, professionals and other members of the group (~~4~~1, 2, 9, 11) but also valued social support more generally, e.g. "…that supporting and being supported by friends, etc. is really just one of the most integral parts of anyone's life" (3, p. 118~~). ~~) and "…realising that that personal touch and personal connection between people can be a vital tool for my mental health" (12, p.5)

In addition, participants in one study (~~1~~5), spoke of wanting to 'Pay it Forward' and offer support to others using their own stories to introduce others to the hope of recovery. Contributing to the lives of others provided a sense of self and a sense of purpose, thus supporting recovery (~~6~~10).

More open and honest communication, especially with professionals

Four studies (1, 6, 7, 10) found that participation in WRAP training increased openness and honesty in communication about mental health, particularly with professionals, e.g.

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"WRAP gave me the idea of taking my list of wellness tools to the psychiatrist's office and using it to discuss [things]…. [It] made me bring up and talk about a lot of things that I wouldn't have otherwise" (~~2~~6, p.212). One explicitly stated "WRAP has made me more honest. I often still feel they (psychiatrists) don't really understand, but I lie to them less than I did. Now I am more assertive because of WRAP" (~~2~~6, p.213). Professionals interviewed by Zhang *et al.*, (2007) also identified that individuals who had completed WRAP training became more confident to ask for help, assert their needs and 'strive for rights and medication' (p. 6).

Some participants (~~4, 5~~1,7) also spoke of communicating more honestly with friends and family, sometimes sharing difficulties for the first time and describing no longer having to live a "secret life" of managing mental illness (~~5~~7, p. 4). Such communication was more challenging for UK South Asian participants, who shared concerns about stigma and consequences for both themselves and family members (2).

The importance of peer facilitators and contrast with professionals

~~Three~~ Four studies (2, 3, 6, 10) raised the issue of peer facilitators and the impact of this on the resonance of WRAP training for participants, as "No one can tell it like someone who's been through it" (3, p. 118). Not only were peer facilitators seen as valuable in their own right, but also when contrasted with 'professionals', e.g.

"When you find out the people running the group have the same issues you have, it allows you to relate to them in a way you can't with people who don't. It's very different. Not hierarchical, not like normal mental health treatment" (~~2~~6, p. 212).

Jones *et al.* (2013) found participants who believe "it's only other consumer providers who really know how to help" (p.212) and one participant vowed never to work with non-peer professionals again. Perhaps worryingly for existing services, one participant explicitly

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expressed the view that psychiatrists and professionals "don't respect me as an authority like WRAP does. They're the authority, and I don't know anything – that's how they think" (~~2~~6, p. 212). Others (7) described feeling valued within WRAP training and how this contrasted with low expectations they felt professionals held. This was set against the broader recognition of WRAP's recovery-oriented approach and "focus on getting well rather than sickness" (4, p. 2425), which contrasted with experiences in services of being told mental health difficulties were chronic and had to be lived with (11). ~~focus on wellness~~ ~~Others in the same study(7) described feeling valued within WRAP training and how this contrasted with low expectations they felt professionals held.~~ Overall, this theme not only highlights the benefit of peer support, but also the shortcomings of professional services.

Conclusions and Implications for practice

Findings relating to WRAP training processes supporting change are not unexpected. The development of action plans and tool boxes relate directly to principles of illness self-management (Mueser *et al.*, 2002), while the findings regarding the group process could be seen to be related to principles of peer support and also Yalom's (1985) therapeutic factors. The educational elements of WRAP training, together with relapse prevention / management, crisis planning and consumer involvement all indicate that WRAP training can be seen as a clear framework for the implementation of recovery-oriented practice as outlined by Jacobson and Curtis (2000). The results raise a question about the potential preventative benefits of access to the principles of WRAP earlier in people's contact with mental health services and perhaps before they reach mental health services at all.

In addition to expected findings, the synthesis indicates perhaps unintended effects of WRAP training, as well as nuances of its effects. This evidence provides context within which quantitative studies of the 'outcomes' of WRAP training must be considered. A

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related review and meta-analysis of quantitatively measured recovery outcomes of WRAP training (Cancott *et al.*, 2019) identified no significant pooled effect of WRAP on clinical symptomatology but a significant pooled effect on self-perceived recovery (relative to inactive control conditions). Qualitative analyses may provide some insight into mediating variables of positive outcomes, such as greater sense of control, confidence, and hope – i.e., many of the principal goals of WRAP training (Copeland, 1997). Individuals with enduring mental ~~illness~~ health problems commonly report anxiety surrounding their prognosis and the unpredictability of ~~mental illness~~mental health problems (McCann and Clark, 2009) and it seems plausible that WRAP-attributed gains in perceived control, illness understanding, and hope could assuage this anxiety.

It is also possible that more open and honest communication with mental health services may have led to improved care, then reflected in recovery markers and sometimes reduced symptoms. Arguably, the qualitative synthesis highlights that there is work to be done to promote open and honest communication with professionals that could promote recovery, even in the absence of WRAP training. This perhaps fits with an increasing focus on shared decision-making within psychiatry (e.g. Davidson *et al.*, 2017). This review cannot address issues of power between psychiatrists and those they treat, but future studies should consider previous findings that psychiatrists perceive patients training in shared decision-making to be more 'difficult' (Hamann, 2011). Further, the review adds weight to the value of peer-delivered services both because of their direct benefits and the perceived contrast with professional-delivered services, supporting the assertion of Mueser *et al.*, (2002) about the crucial distinction between the two.

Qualitative analysis identified changes in self-perception as a result of attending WRAP training. For many individuals with ~~severe mental illness~~mental health problems, it is likely that at some point they have experienced stigma or unfair treatment (Corrigan and

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Watson, 2002) and may have a desire to become free of their illness. The premise of the WRAP opposes this and in many ways moves towards acceptance. Findings from this analysis support the view that acceptance of 'mental illness' is a key step towards recovery (Mizock *et al*., 2014). It is possible that acceptance may reduce the secondary psychological battle of living with chronic illness and enable individuals to live meaningful lives. It is of interest that quantitative studies of WRAP outcomes identified in a review (Canacott *et al.,* 2019) did not use measures of 'acceptance'.

~~The findings of this review in relation to acceptance perhaps support for the increasing interest in acceptance based approaches, such as Acceptance and Commitment Therapy (ACT), for individuals experiencing psychosis (e.g. Bach *et al*., 2012), including group interventions (O'Donoghue *et al*., 2018). ACT is argued by O'Donoghue *et al.* (2018) to map onto recovery processes outlined in the 'CHIME' framework for personal recovery (Leamy *et al*., 2011) which emphasises key principles of connectedness, hope, identity, meaning, and empowerment. However, the evidence for ACT is largely focused on interventions delivered by professionals, rather than peers. The compatability of Acceptance and Commitment Therapy and peer support has previously been outlined, with a call for further investigation of the benefits of peer involvement in the delivery of ACT (*Betts et al.*, 2013). This review both indicates that peer-delivered services can increase acceptance even when not focused on this as an outcome and highlights the perceived benefits of services delivered by peers rather than professionals. This arguably strengthens the rationale for developing and investigating the outcomes of peer-delivered acceptance-based interventions.~~

Results from qualitative analysis identify a number of positive ~~outcomes~~ self-percceived effects which map on to many of the domains of recovery identified within the evidence-base (e.g., Slade, 2009; Tew *et al.*, 2009). Such personal developments are likely to contribute to higher levels of self-efficacy (Bandura, 1977) and reinforce perceived control.

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The recognition of social support was highlighted, but perhaps warrants further exploration in future research in terms of the role of social support in illness self-management, given findings from physical health research (Gallant, 2003). It is of interest that the one study in which participants reported disliking the group process was one in which they were randomly assigned to WRAP or another intervention. This indicates the importance of control over opting into a WRAP group intervention. Similarly, control over group membership and the use of pre-existing groups may increase acceptability of WRAP within come cultural contexts, as found by Gordon and Cassidy (2009).

Overall, despite the limitations discussed, the general conclusion of this review is that participation in WRAP training has many positive ~~outcomes~~ perceived effects for participants, beyond those that can be captured by quantitative measures of either clinical outcomes or self-perceived recovery. Future qualitative studies regarding WRAP training would benefit from consideration of quality criteria in design and reporting to overcome issues identified in this review, ~~such as lack of reflexivity of researchers, unclear analytic methods, unreliable recording of findings, and absence of inter-rater reliability considerations~~particularly the relationship between researchers and participants. Qualitative studies that gather data at multiple time points including prior to commencement of WRAP training may offer valuable information about participants' changing perceptions across the course of WRAP training, as well as whether perceived changes are sustained at follow-up. As WRAP training continues to expand internationally, further research regarding its short and long-term practice are essential to develop its position as an evidence-based intervention.

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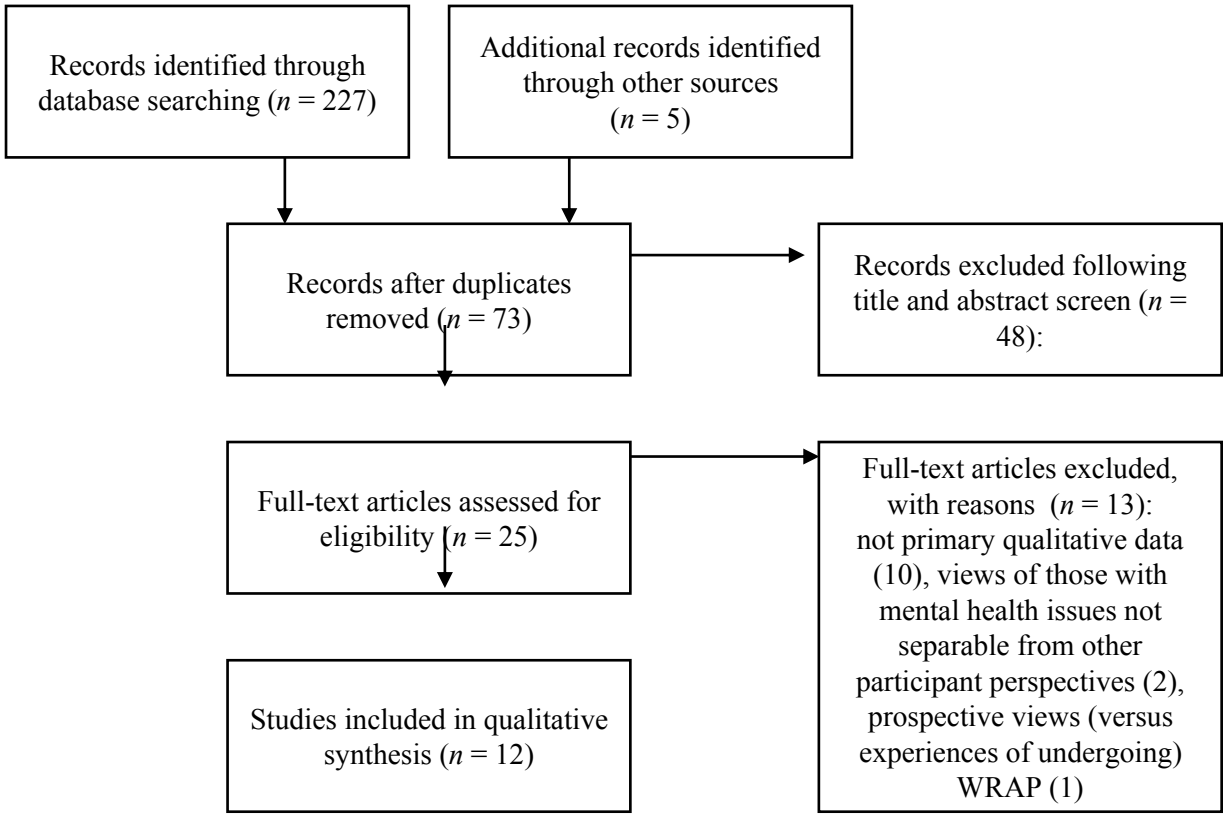
Records identified through database searching (n = 227)
Additional records identified through other sources (n = 5)
Records after duplicates removed (n = 73)
Records excluded following title and abstract screen (n = 48):
Full-text articles assessed for eligibility (n = 25)
Full-text articles excluded, with reasons (n = 13): not primary qualitative data (10), views of those with mental health issues not separable from other participant perspectives (2), prospective views (versus experiences of undergoing) WRAP (1)
Studies included in qualitative synthesis (n = 12)

Table 1: *Characteristics of selected studies*

Assigned study number (1-12) Author(s), Year and Location	**Design**	**Study Sample N=Total (Female : male) (inclusion criteria)**	**Research Aims / Questions**	**Methodology** Data collection Analysis	**Qualitative themes reported**
1. Zhang et al., 2007, New Zealand	Cross-sectional	N=13 (11:2), Chinese consumers with mental health diagnoses of a self-help organisation. Mixed psychiatric diagnoses. Ethnicity = all Chinese. Aged 25 - >65 years; Education levels not reported. (specific inclusion criteria not reported)	To examine the acceptability, applicability and effectiveness of the WRAP	Individual interviews (n=8), focus groups (n=5) Analysis not reported	1) Knowledge of WRAP: remembered details from training. 2) Utilisation of WRAP: used plan in daily life and crisis plan when not stable. 3) Influences of WRAP: life more stable; symptoms reduced; more positive thinking; improved relationships; greater self-advocacy and support seeking; improved quality of life. 4) Sharing the WRAP plan: most shared recovery plan with other members of the service or family members. None shared with professionals. 5) Suggested changes: to make the plan more appropriate to Chinese culture, e.g. simplify language and more Chinese-style wellness tools.
2. Gordon & Cassidy, 2009, UK	Pre-post	N=6 (6:0; focus group) N=7 (7:0; interviews) Black and Minority Ethnic (BME) women, who were South Asian.	To evaluate the use of WRAP with BME women in Scotland, in relation to process, cultural appropriateness and effectiveness.	Semi-structured interviews and focus groups before and after WRAP training†††.	1) The value of talking: group discussions. 2) Staying well: women made changes to their lives following training. 3) The women did not revisit or actively use their WRAPs following training. 4) Not all participants grasped all key concepts or elements of WRAP. 5) Participants would like follow-up sessions to further develop their WRAPs.

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					6) Cultural issues of significance included: how small and connected the South Asian Community is, how private South Asian women can be and that delivery should be to existing groups rather than a group of strangers; mental health stigma in the South Asian community; gendered roles and expectations challenging principles of self-advocacy and assertiveness; addressing the needs of those with limited English.
3. Cook et al., 2010, USA	Quasi-experimental (single-group pretest-posttest)	N=381 (247:134), mental health consumers/ survivors in a community setting. Diagnoses not reported. Mixed ethnicity. Aged 18 – 61+ years. Education levels not reported. (identified themselves as consumers or survivors or psychiatric services; completed WRAP training in Vermont or Minnesota).	To evaluate the outcomes of two statewide initiatives teaching self-management	Questionnaire Constant Comparative Analysis (Glaser & Strauss, 1967)	1) Wellness as an attainable and ongoing process 2) Wellness influenced by the support of others 3) Increased recognition and success in managing stressors and symptoms. 4) Less perceived social isolation 5) Application WRAP strategies in everyday life 6) The value of consumers as facilitators
4. Higgins et al.,	Cross-sectional	N=33 (qualitative). Gender, diagnoses, ethnicity, ages and	To evaluate the effect of Wellness Recovery Action Planning on	Mixed methods. Qualitative data gathered	1) Recovery and WRAP: An inspiring and invigorating experience.

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	2012, Ireland		levels of education not reported / not extractable for focus group participants.	participants' knowledge, attitudes and skills in using the WRAP approach.	through focus groups. Thematic analysis.	2) Recovery and WRAP: Shifting the paradigm of mental health care. 3) Putting Recovery and WRAP into practice: A simple and practical toolkit consideration. 4) Learning together: Diversity of perspective and levelling the playing field. 5) Structure and delivery of the programme: mixed reactions. 6) Mainstreaming recovery and WRAP: obstacles and concerns. 7) Forward movement and sustaining progress: strategies for consideration.
5.	Wilson et al., 2013, USA	Cross-sectional	N=26 (13:13) (quantitative), N=18 (qualitative). Outpatient community mental health sample. Diagnoses, ethnicity. ages and levels of education not reported. (18+ years of age; at least one month of WRAP; not in crisis at data collection; able to answer questions on WRAP)	To investigate participant satisfaction with WRAP	One-to-one interview Content analysis	1) Retrospective desire for early WRAP introduction: earlier knowledge of WRAP believed likely to have improved mental health recovery. 2) Pay it Forward: desire to share one's story to change others' lives by promoting hope, which provides one with a sense of worth. 3) Unconditional Relational support: the need for support from family, friends, WRAP facilitators or participants for comfort, support and guidance. 4) It Takes Time: recovery is an intentional process which requires time and effort.

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6. Jones et al., 2013, USA	Cross-sectional	N=54 (34:17 †), mental health consumers in a community setting. Mixed diagnoses, ethnicity, ages and levels of education. (Self-identify as a consumer of mental health services; have participated in at least one full WRAP programme)	To examine the relationship between participation in the WRAP and self-determination in service use, medication adherence and engagement with treatment providers.	Focus groups	1) Self-determination and adherence/compliance are mutually opposed: Compliance seen as incompatible with the recovery model 2) Self-determination and adherence/compliance can be complimentary: Some had a trajectory in which they were initially 'forced' and later came to agree with the decision. Some had a give-and-take between external pressure to take medication and own self-motivation. Others found reminders to take medication helpful. 3) Compliance/adherence are sometimes necessary: some service users seen by others to need compliance; others preferred to follow orders of an "expert provider"; some made positive comments about compliance. 4) Peers make a difference: non-hierarchical peer support and leadership key. 5) Increased self-determination: WRAP increased autonomous motivation, confidence and self-efficacy, or behavioural enaction. 6) Increased awareness: of triggers, warning signs; behavioural patterns; medication. This could lead to increased acceptance. 7) Increased self-advocacy with providers: WRAP led to increased assertive interactions with clinicians, particularly psychiatrists and other prescribers.
7. Pratt et al., 2013, UK	Cross-sectional	N=21 (focus groups), N=11 (individual interview††)	To assess the relevance and impact of the WRAP as a tool	Individual interviews, focus groups	1) Group participants' experience: process of learning and reflection; learning about recovery. 2) Perceived benefits of WRAP: lasting benefits including ability to challenge own behaviours,

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		Gender, diagnoses, ethnicity age and education levels not reported. (had participated in WRAP training within time of recruitment).	for self-management and wellness planning	Thematic analysis	identify alternative responses and prioritise. Improvements in mental health. 3) Group setting: mutual support, less intensity than 1:1 work; challenging stigma; feeling not alone. 4) Integration of WRAP in daily life: integrated learning in various ways. Offered security, insight, and tools to draw on to support recovery. 5) Challenges: crisis planning could be difficult to complete either because the individual had not experienced a genuine crisis or because of the sensitivities of thinking back to the crisis.
8. Matsuoka, 2015, Canada	Longitudinal	N=8 (6:2) Japanese-Canadian older adults who had completed WRAP workshops. Diagnosis not a requirement but 5 reported a diagnosis of mental illness (not reported in the paper).	'Does WRAP help ethnic / racial minority older adults on the path to recovery?' To explore applicability of WRAP to older Japanese-Canadians; to build a basis for non-pharmacological community resources for ethnic / racial minority adults; to gain understanding of 'recovery' from perspective of Japanese-Canadian older adults; to gain	Anonymous end-of-workshop questionnaire, post-workshop interviews, six-month and one-year follow-up phone calls and participant observation guidelines.	1) Self-worth: Participants learned about and gained a better sense of themselves. 2) Being positive – hope. WRAP led to thinking positively and was associated with recovery. Positivity led to hope and increased a sense of control over difficulties. 3) Being self-reflective and mindful. This was the case for some, but not all participants. 4) Support / connection: Both being supported by and learning to support others, within and beyond the end of the group. 5) Self-advocacy: with medical professionals and in relation to living environment.

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				preliminary understanding of the importance of social workers in the WRAP process with older-adults.		
9.	Horan & Fox, 2016, Ireland	Cross-sectional	N=4 (1:3), Individuals who had participated in a WRAP programme in a community mental health centre. Two participants completed WRAP once, one twice, and one three times. 3 completed it in a group, one individually. Mixed diagnoses / mental health concerns. Ethnicity and education levels not reported. Aged 35 – 61 years.	To understand the value of the WRAP as an intervention in psychosocial rehabilitation from the perspective of participants. To explore individual's experience of the WRAP; To elicit the role of the WRAP in individuals' recovery, their perceptions of the therapeutic elements of the WRAP and their use of the WRAP after the programme ended.	Individual semi-structured interviews. A descriptive phenomenological approach. Thematic analysis.	1) The meaning of recovery is personal, with distinctive differences between individuals. 2) The role of WRAP in recovery: WRAP contributed to an improvement in mental health through reduction in symptoms and prevention of hospitalisation. 3) The therapeutic elements of WRAP: content as educational; positive impact of facilitation in a supportive group. 4) The experience of being a WRAP participant: Mixed experiences and some recommendations for improvements, including needing it to be introduced earlier.
6.	Ashman et al., 2017, UK	Cross-sectional	N=6 (4:2), Individuals who had used mental health crisis resolution and home treatment teams.	To explore the WRAP as a supporting resilience-building and maximising opportunity potential of a crisis	Individual interviews Interpretive Phenomenological Analysis	1) The meaning of crisis: a complex phenomenon with different causes, which required others to step in due to loss of control. 2) Engaging with the WRAP process: not all enthusiastically. Takes time to be comfortable with the process. Non-expert led as key.

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			Diagnoses and education not reported. Ethnicity = five White British and one Black British. Aged 25 – 49 years. (Aged 18+ and experienced at least one episode of crisis care from local Crisis Resolution Home Treatment team and undertaken WRAP training, capacity to consent, sufficiently competence in written and spoken English).			3) WRAP and self-management: what people learned from WRAP and how they use it in their daily lives. 4) Changes and transformations: Profound impact of WRAP in terms of hope, learning, self-advocacy, personal responsibility, and support networks.
7.	Olney & Emery-Flores, 2017, USA	Cross-sectional	N=10 (6:4) Eight White; ethnicity not reported for 2. Mixed educational levels. Mixed diagnoses. Aged 48 – 69. (Psychiatric diagnosis; received	1. How does WRAP impact employment? 2. How are employees using tools or strategies learned through	Individual interviews. Phenomenology.	1) Then and now: WRAP as a turning point in changing participants' thinking and lives and realising one's power to manage symptoms and reclaim one's life. 2) Strategies for wellness: Knowledge, tools and support learned through WRAP and how these impacted participants' work life. 3) Toward employment success: Using specific strategies learned through WRAP to maintain and enhance employment.

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			employment agency services; completion of an 8-week WRAP training; currently employed or employed for 90 days after WRAP training; spoke English; of working age)	WRAP on the job?		
8.	Carpenter-Song et al., 2019, USA.	Comparative effectiveness trial with qualitative substudy	N=15 (WRAP) (6:9) Mixed diagnoses, ethnicity and educational levels. Ages not reported. (Diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depressive disorder; aged 18+; rating on Recovery Assessment Scale indicative of need for services)	To examine whether people with serious mental illness notice and care about specific features of WRAP (and a comparison intervention) and how it shapes experiences of symptoms, recovery and quality of life. Qualitative methods facilitated insight into first person perspectives.	Semi-structured interviews. Meaning-centred medical anthropological approaches.	1) High satisfaction with WRAP: provided new information about symptoms and coping strategies not received elsewhere in treatment. Supportive community of individuals with shared experience of mental illness. 2) Some participants chose not to attend WRAP, either because of disliking group-based interactions or because of competing priorities. 3) Impact: New skills and fresh insights led to shifts in perspectives about mental illness and themselves. Increased hope and offered skills. 4) Some challenges of group dynamics.

† This paper acknowledges that full data were not available for all participants.

†† Eleven participants from focus groups subsequently completed individual interviews.

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††† In line with the aims of this review, only data from post-WRAP training interviews and focus groups were extracted and included in the synthesis.

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Table 2. *Quality appraisal*

Question from CASP	Zhang et al. (2007)	Gordon & Cassidy (2009)	Cook et al. (2010)	Higgins et al. (2012)	Wilson et al. (2013)	Jones et al. (2013)	Pratt et al. (2013)	Matsuoka (2015)	Horan & Fox (2016)	Ashman et al. (2017)	Olney & Emery-Flores (2017)	Carpenter-Song et al. (2019)
Is there a clear statement of the aims of research?	2	2	2	2	2	2	2	2	2	2	2	2
Is a qualitative methodology appropriate?	2	2	2	2	2	2	2	2	2	2	2	2
Was the research design appropriate to the aims?	1	2	2	2	2	2	2	2	2	2	2	2
Was the recruitment strategy appropriate to the aims?	2	2	2	2	2	2	2	2	2	2	2	2
Was the data collected in a way that addressed the research issue?	1	2	2	2	1	1	2	2	2	2	2	2
Has the relationship between researcher and participants been adequately considered?	2	0	2	0	0	1	0	2	1	1	1	0

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Have ethical issues been taken into consideration?	2	1	2	2	2	0	2	2	2	2	1	2
Was the data analysis sufficiently rigorous?	0	1	1	2	1	1	2	2	2	2	2	2
Is there a clear statement of findings?	1	2	2	2	2	2	2	2	2	2	2	2
How valuable is the research?	1	2	2	2	2	2	2	2	2	2	2	2
Total (maximum = 20)	14	16	19	18	16	15	18	20	19	19	18	18

Key: *Score 0 = little or no justification or explanation. Score 1= study addressed the issue but did not fully elaborate on it. Score 2 (strong) = article extensively justified and explained the criteria.*

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Theme Subtheme	Study											
	Zhang et al., (2007)	Gordon & Cassidy (2009)	Cook et al, (2010)	Higgins et al., (2012)	Wilson et al., (2013)	Jones et al., (2013)	Pratt et al., (2013)	Matsuoka (2015)	Horan & Fox (2016)	Ashman et al. (2017)	Olney & Emery-Flores (2017)	Carpenter-Song et al. (2019)
WRAP processes supporting change:												
Development and use of action plans and tool boxes	*	*	*	*			*	*	*	*	*	*
The group process	*	*		*	*		*	*	*	*		*
Changes in how individuals related to mental health problems:												
Better understanding of mental health and recovery	*	*	*	*	*	*	*		*	*		*
Acceptance	*	*				*	*					
Increased control, self-efficacy and assertiveness	*	*		*		*	*	*	*	*	*	*
Recognition of the role of social support	*	*	*		*	*		*	*		*	*
More open and honest communication, especially with professionals	*					*	*	*		*		
The importance of peer facilitators and contrast with professionals		*	*	*		*				*	*	

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