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Issues in Mental Health Nursing

Qualitative investigation of the Wellness Recovery Action Plan in a UK NHS crisis care setting

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Abstract

Crisis theory suggests that in addition to presenting a threat to mental wellbeing, crises are also opportunities where successful interventions can lead to successful outcomes. UK mental health crisis teams aim to reduce hospital admission by treating people at home and by building resilience and supporting learning from crisis, yet data on repeat crisis episodes suggests this could be improved. This qualitative study sought to explore the Wellness Recovery Action Plan (WRAP) as a means of supporting resilience-building and maximising the opportunity potential of crisis. Themes which emerged were: The meaning of crisis; Engaging with the WRAP process; WRAP and self-management; Changes and transformations. This research suggests WRAP has potential in supporting recovery from crisis, revealing insights into the nature of crisis which can inform the further development of crisis services.

Keywords: mental health crisis, Wellness Recovery Action Plan, recovery, WRAP, user-led research

Introduction

Mental health crisis resolution and home treatment teams (CRHTs) have been operating in the UK National Health Service (NHS) since the early 2000s (Hopkins & McKenzie, 2009). Tasked with preventing hospital admissions using home-based interventions, they also aim to reduce people's vulnerability and build their resilience through "learning from crisis" (Department of Health, 2001). These aims should result in reduced burden on health services, and reduced burden of mental ill health in the population. It would be reasonable to assume that the incidence of repeat crises would be low if this resilience building and learning from crisis are successful. However, data for English CRHTs from the UK National Audit Office (2007) indicate a mean repeat crisis rate of one in five people within a year of baseline crisis episode. Glover, Arts & Babu (2006) concluded that CRHTs' introduction in England did reduce hospital admission, though the data on repeat crisis presentations

perhaps suggests that the "revolving door patient" phenomenon may simply have shifted arena.

Repeat crisis presentation is a complex phenomenon. Although Reid et al. (1999) see repeat presentations as distressing for patients and stressful for staff, Flowers & Bindman (2008) view them as opportunities to fine-tune effective responses to individual requirements and circumstances, which could lead to improved long term outcomes. This view of crisis presentation as *opportunity* echoes Caplan's 1989 reflections on his 1964 crisis model (Caplan 1989), whereby crisis resolution may be a period when self-management and self-efficacy can be enhanced. Although research into the experience of crisis is scarce, it has been suggested that it is both possible and desirable to learn from crises and to develop resilience thereafter (Borg et al., 2011).

Resilience- building and promoting self-management are key components of the recovery approach to mental health service provision (Shepherd, Boardman & Burns, 2010). This approach both underpins England's mental health strategy (Department of Health, 2012) and is argued as essential to every aspect of mental healthcare and nursing practice (Anthony, 1993; Department of Health 2006, p. 4). US Consumer activists Mead & Copeland (2000) connect recovery principles with crisis, and see a recovery-oriented crisis approach as providing opportunities for "growth and change" (p. 319). A UK consumer survey has called for crisis services geared to promoting recovery from the outset of care (MIND, 2011). Crisis periods have been mapped onto theoretical change processes by Leamy et al. (2011, p. 419). Recovery principles and crisis therefore connect within the care continuum, particularly in view of the hope and optimism intrinsic to recovery-oriented care, in addition to aligning with UK policy and consumer aspirations.

In an attempt to maximise the opportunity potential of crisis, in 2011 the Wellness Recovery Action Plan (WRAP) was introduced into a Yorkshire-based CRHT in the UK NHS to improve resilience-building, foster learning from crisis and promote recovery-oriented working. WRAP is a recovery-focussed educational programme aimed at monitoring, reducing and managing mental distress. It was developed in the USA through user-led research which explored how people with mental health problems manage their lives day-to-day (Copeland, 2010, p.9). WRAP is values-based, and underpinned by five key concepts: hope; learning; self-advocacy; personal responsibility; support networks (Copeland 2013). The programme contains a crisis planning section, but also includes a post crisis component which was perceived within the CRHT as having the potential to support "learning from crisis". WRAP is increasingly being integrated into NHS services as part of the recovery approach to mental healthcare (Slade et al., 2014).

WRAP has a small but growing evidence base. Two randomised controlled trials (RCTs) have reported statistically significant improvements in symptom and recovery measures (Cook et al., 2012; Cook et al., 2013). One of these RCTs examined whether WRAP components aimed at preventing breakdown would lead to less uptake of formal healthcare, concluding that WRAP reduced self-reported service use and perceived need for services. Further

qualitative work has explored WRAP's impact on service use (Jones et al., 2013). Although these studies suggest resilience-building capabilities for WRAP, to our knowledge no research has been conducted on WRAP in crisis settings. Therefore, the aim of this qualitative study was to explore how WRAP supports learning from crisis, vulnerability reduction and resilience-building, and its potential to impact on mental wellness and re-presentation.

A key aspect of this study is its "user-led" nature. The principal researcher (MCA) has experienced mental health crises and has used mental health services. User-led research is a growing field which has much to offer in developing and broadening the mental health knowledge-base (Rose, 2003; Beresford, 2013). It has potential to contribute to transformation of mental health practice (Davidson et al., 2010). Commonality of experiences as service users can enable discussions which, without the filters of professional categorisations and standpoints, may better reflect the realities of people's lives (Beresford, 2013). We have, however, recognised the bias potential of the lived experience standpoint, and have selected a highly reflective method which we combined with both personal reflection and reflective supervision throughout the project's lifespan.

METHOD

Study design

To gain an understanding of how people use WRAP in a crisis context we used a qualitative design with semi-structured interviews and an Interpretive Phenomenological Analysis (IPA) approach to interpreting and understanding the data. This approach is rooted in phenomenological philosophy and underpinned by Husserl's focus on describing lived and situated experience. Husserl's descriptive ideas were further developed by Heidegger, Merleau-Ponty and Sartre to encompass interpretive approaches which account for our place within the cultural world of relationships in which experience occurs (Smith, Flowers & Larkin, 2009). IPA is highly applicable to understanding people's reflections on life-changing experiences. Its hermeneutic approach seeks to uncover meaning and make sense of human experiences (Larkin, Watts, & Clifton, 2006). Interpretive epistemology is appropriate to research in which meaning is contingent on the social environment in which it emerges (Sweeney, 2009, pp. 25-28; Bryman, 2012, pp. 30 & 710). IPA has been used in user-led studies of recovery in mental health settings (Kilbride et al., 2013; Wood et al., 2010).

Study setting

The study setting was a large borough in the Yorkshire and Humber region of England, UK. Local population health is described as worse overall compared to the mean in England, and the level of deprivation is above the country's average (Public Health England, 2014).

Participants and recruitment procedures

The study recruited people aged 18+ years who had experienced at least one episode of crisis care from the local CRHT, had undertaken the CRHT course of WRAP education, had capacity to consent and were sufficiently competent in written and spoken English to be

able to undertake the research process. Participants were identified by a gatekeeper, the CRHT's WRAP facilitator. Recruitment of participants with specific experiences is challenging in NHS settings. Our method provided a practical way of accessing participants with a specific life experience yet also allowed for heterogeneity in other characteristics across the sample pool (Robinson, 2014). Potential interviewees were provided with study information, and elected to take part by contacting the principal researcher (MCA).

Ethical approval was gained from Leeds East NHS Research Ethics Committee (REC) and by the local NHS R&D research governance office (REC reference: 14/YH/0060; NHS R&D reference: local NHS R&D reference 0079/2014/NCT). Informed consent was sought and gained for interview participation and for anonymised reporting of interview extracts.

Data collection and analysis

The semi-structured interview schedule was developed with the support of a service user group in an adjacent locality. This group were familiar with WRAP but had no members in the CRHT's catchment. Interviews were conducted by a member of the research team (MCA) at the participants' home and began with questions about their experiences of contact with the CRHT. Participants were asked to reflect on their experiences of crisis and WRAP, and to describe what was or was not helpful about it. Interviews were digitally audio-recorded, transcribed into MS Word and anonymised on transcription. Transcripts were uploaded to QSR NVivo 10 software. The process of analysis involved multiple iterations, commencing with listening to the recordings several times followed by repeated readings of the transcripts to gain familiarity with the source material. NVivo was used to aid more detailed analysis by identifying and labelling words and phrases indicative of key experiences within individual interview texts. Reflective discussion of these key experiences was undertaken, followed by cross-referencing within and across interviews which led to the emergence of common meaning clusters. Further reflective discussion of meaning clusters among researchers MCA and VH drew out super-ordinate themes, which were finally referenced back to the original transcripts to verify consistency across all participants.

Rigour

To ensure credibility and validity we were guided by the four principles outlined by Yardley (2000): sensitivity to context; commitment; transparency and coherence; impact/importance. Our translation of these principles into research practice reflects the methods described by Noble and Smith (2015). We reflected throughout on how our analysis was supported by the epistemological and ontological underpinnings of IPA. We also discussed and reflected on potential bias issues which may have emerged from the service user standpoint of this research.

RESULTS

The study population comprised six adults who met the inclusion criteria. Four interviewees were female, two were male. Ages ranged from 25 years to 59 years. Ethnicity of the interviewees was five White British people and one Black British person. Time elapsed between interviewees' WRAP courses and the interviews varied from fifteen months to two

and a half years. To maintain anonymity interviewees are identified using letters from A to F.

Four themes emerged from the interview analysis: The meaning of crisis; Engaging with the WRAP process; WRAP and self-management; Changes and transformations.

The themes, subthemes and their inter-relation to each other and to WRAP itself are shown in Figure 1. Emergent themes reflect a narrative structure common to all interviewees, who each underpinned their explanations of what WRAP came to mean for them with detailed descriptions of their experience of crisis.

The Meaning of Crisis

"Crisis" emerged as a complex phenomenon. Common to all experiences was the necessity of other people stepping in to enable access to support. While the need for other people to step in may, in CRHT terms, be simply indicative of crisis, its meaning to participants was deeper. All reported a loss of control, and a failure of usual coping and functioning, typified in this comment.

> 'I couldn't, I couldn't handle it, It was just, my mind went, everything, I just... couldn't handle it, I couldn't deal with it...' (Interviewee A)

This loss of control and failure to cope involved self-isolation in the cases of two interviewees, who withdrew into their homes. As each described busy working lives prior to crisis this can be regarded as uncharacteristic. The remaining four interviewees described loss of control in terms of risky behaviour. Three described attempts to end their lives, and one described abandoning home with no apparent purpose.

> '... in the end I just crashed and burned, walked out my flat, left it wide open, money all over the floor, door wide open, I just went off, don't know where I went. (Interviewee F)

The voice tone and body language in which these uncharacteristic and/or unsafe acts were described by participants was suggestive of a deep and enduring emotional impact of crisis. The self-isolation and risky behaviour described above can be seen as acts of despair, and suggests a loss of sense of purpose. This is captured in the comment below.

> 'I've always felt that going into a depression's like falling in to a deep dark hole... and it's like your future collapses...' (Interviewee E)

In addition to the two participants who described self-isolation as a personal *response* to crisis, the *crisis experience itself* was also described in terms of isolation and alienation by participants:

> '[you feel] on your own and that there is something seriously wrong with you.' (Interviewee C)

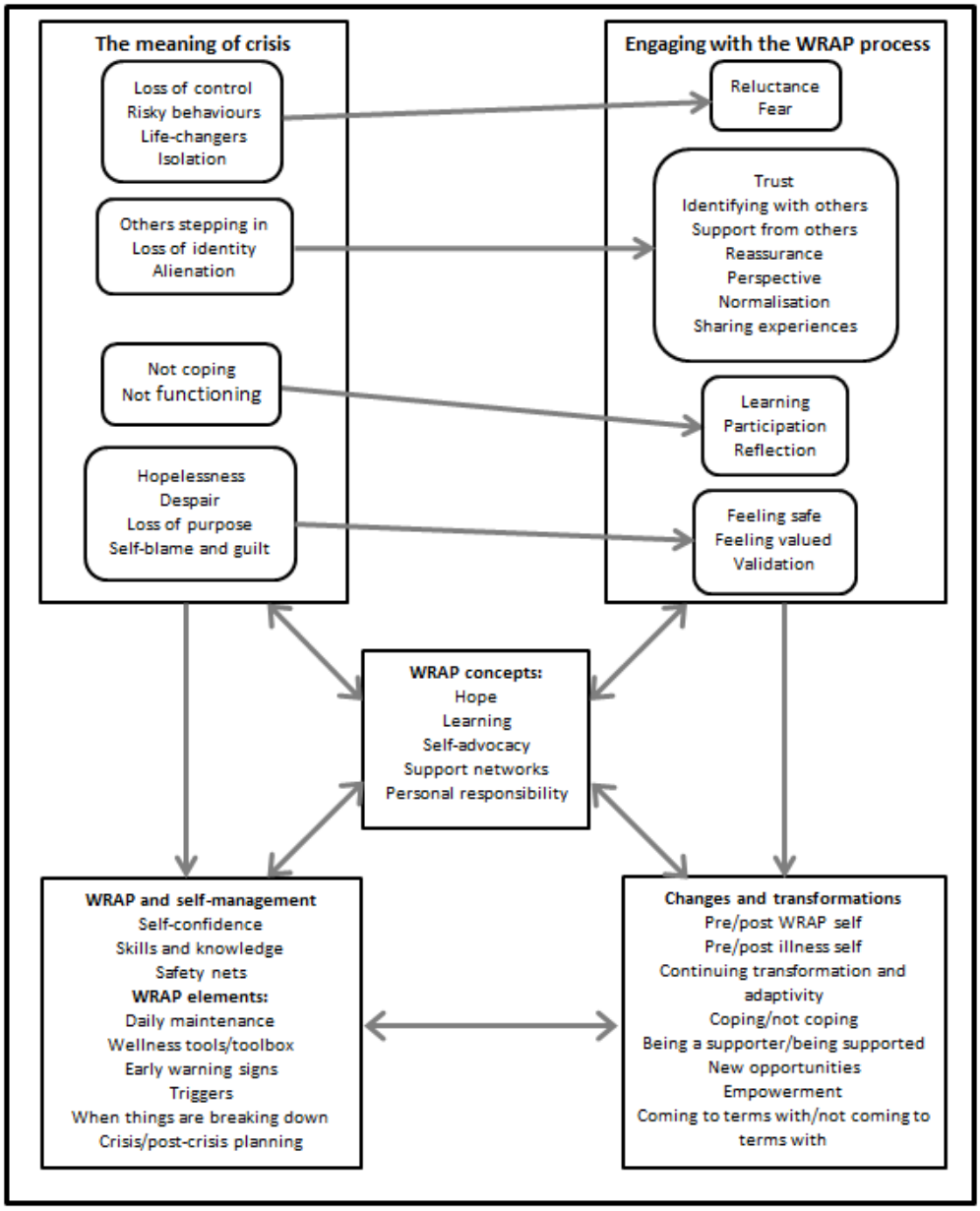

Figure 1. Themes, sub-themes and inter-relations

Although there are remarkable commonalities in people's crisis experiences there were differences in perceptions of how crisis came about. One participant described periodically falling into severe depression without apparent cause. Another described the build-up of a combination of unresolved childhood abuse and bereavement issues. One felt that crisis had emerged from unresolved teenage experiences. One ascribed a suicide attempt to "relationship breakdown", another to diagnosis of a physically limiting health condition and consequent loss of professional role. Loss of work capacity was also seen as causative by another participant. In the cases where relationship breakdown, bereavement or childhood issues were involved, each participant related a degree of self-blame and a sense of guilt.

Engaging with the WRAP Process

Having described the impact and meaning of crisis above, this theme encompasses people's experiences of their initial engagement with WRAP when they undertook the course. This highlights aspects critical to WRAP's action as a recovery agent, as well as demonstrating how the course may mark the start of a process of continuing engagement with recovery.

Following their crises the interviewees embarked on a WRAP course of eight weekly sessions. Not all embraced the prospect enthusiastically - two felt that they would be unlikely to gain anything from it. It took time for all interviewees to become comfortable in the WRAP course:

> '...it was a gradual thing, because obviously we're all there for the same reason and we're all scared.' (Interviewee A)

This 'gradual' process of becoming comfortable appears to be not only about personal confidence – a critical feature of WRAP learning seems to be identification with other participants. This identification was related as providing reassurance and perspective:

> '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.' (Interviewee C)

This identification and normalisation has its own inherent value, but is also crucial in that it enables people to share experiences safely. Sharing experiences safely and developing trust among course participants appeared critical to the development of the peer support networks which hallmark recovery processes generally, and WRAP in particular. The development of relationships with peers also appeared to have an impact on some of negative self-image issues, described in the theme *The meaning of crisis* as inherent in the crisis experience.

> 'I really feel I can be open with everybody, be truthful, and not be ashamed of [having a mental health problem] any more.' (Interviewee B)

> '...to talk about my problems, and to help to, sort of, give people my version on their problems, to think that I am actually worthy of being around!' (Interviewee C)

The development of peer support and its associated identification directly challenges the isolation and alienation of mental health crisis and enabled participants to learn from each other. Some participants identified with the founder of WRAP, Copeland, introduced in a video at the start of the course. Identification with her mirrors the identification with other participants in that it appears to validate the skills and knowledge imparted and, perhaps crucially, their applicability to people's own situations.

> 'Seeing the film on Mary Copeland, er, I could identify with a lot of things.' (Interviewee F)

Likewise it was reported as important that the facilitators created trust. This appeared to be accomplished by a non-judgemental and respectful approach, more like equal participants

than leaders. This suggests that while WRAP groups were run by facilitators (some of whom were not paid mental health workers) it is not "expert-led" in the sense that traditional medical services are. This resonates with recovery philosophy, and further validates WRAP skills and knowledge as being applicable to participants' own lives.

Overall people were positive about the way WRAP courses were provided:

> 'I can't think of anything that didn't help me.' (Interviewee A)

WRAP and Self-management

This theme sets out what people reported as having learned from WRAP and, more importantly, how they apply WRAP in their daily lives. The first thing to note is participants' descriptions of WRAP's ubiquity in their lives:

> 'I use it every single day.' (Interviewee D)

Another participant commented that comparing coping strategies with others acted to validate some of the person's own wellness maintenance methods. This links to the normalisation inherent in the process of WRAP engagement.

Many of the interviewees spoke of specific elements of WRAP that they found particularly helpful, such as the wellness toolbox.

> '...they have a suggestion that there's a wellness toolbox where you put certain items, er, things to sort of prompt you to do various things like, that you need to do, or are good for you or whatever so, y'know, it might be a drugs packet to remind you to take your pills, or a shower gel to remind you to get a hot bath or whatever... ' (Interviewee E)

WRAP's wellness toolbox appears to have value in its contents and their application to maintaining wellness in addition to being perceived, of itself, as a safety net. Wellness tools are also used to self-monitor:

> '...if I notice that I've had a few days where I've maybe, I don't know, where I've maybe sat on the sofa in my scruffy clothes and not opened my curtains, I'll think "alarm bells". It might be nothing, but then again it could be a sign, so that side of it I use all the time, I'm constantly aware.' (Interviewee A)

This reflects a perception of WRAP as helping to deal with difficulties as they arise, and characterises WRAP as a set of skills, or a process of utilising skills. Not only were self-monitoring skills reported, participants also described developing analytical skills that enabled them to trace the origins of emerging problems, and to adjust their lives and wellness tools in response to this. Developing and employing skills for daily maintenance seemed important to participants and may, by regularly helping maintain wellness, assist in the prevention of crisis.

Although one participant found it difficult to complete a crisis plan due to problems recalling events and feelings from the crisis stage, most reported finding the crisis plan element of WRAP to be both important and reassuring:

'...you know now you're not gonna fall back and go crashing into y'know needing crisis teams and all, y'know this expensive burden on everybody else.' (Interviewee E)

One interviewee reported repeat crises post-WRAP. This was partly triggered by unexplained physical health problems, and partly by the aftermath of childhood abuse. These repeat episodes or 'mini-crisises', were reported to have been ameliorated by use of WRAP, making them both shorter duration and less intense. Critically, WRAP was also seen as providing an underpinning resilience which enabled these difficult issues to be faced.

'I used my WRAP plan 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...'

Changes and Transformations

People reported that WRAP had a profound impact on them. These changes were frequently reported in terms of the five key concepts of WRAP: Hope; Learning; Self-advocacy; Personal responsibility; and Support networks.

There was a reported contrast to the hopelessness of the crisis experience, described variously as:

'I've got hope because of WRAP.' (Interviewee A)

'[WRAP] was a light at the end of the tunnel for me.' (Interviewee B)

People reported feeling transformed by WRAP learning.

'What they've taught us just makes life seem a lot easier. I can analyse things and maybe work out why I feel like that.' (Interviewee C)

Two interviewees have progressed to other education following WRAP, one of whom explicitly reported this as being a result of the course. Interviewees also reflected learning self-advocacy, seen not only as a skill but also as an indicator of increased confidence.

'...and I've found WRAP has made me, given me a better voice...' (Interviewee B)

Participants reported feeling felt that they had moved on from a crisis where others were in control, to a state where they themselves have greater control over their own lives. This sense of control encompasses confidence, responsibility, insight into the self, and the regaining of the sense of purpose which had been threatened by the crisis experience.

'I know it is my responsibility to look after my health.' (Interviewee A)

'I feel like I'm getting somewhere, so I feel better in myself, because I know what's going on now.' (Interviewee B)

The perceived value of gaining access to a support network was illustrated in the theme *Engaging with the WRAP process*. Some interviewees attached importance to the fact that WRAP has enabled them to become contributors to support networks as well as beneficiaries of them:

'...what I mean is, it's helped me to help others.' (Interviewee B)

> '...within the family, [WRAP] has helped me to help my [grown up child].' (Interviewee C)

One participant linked contributing to other people's lives directly to sense of self and sense of purpose.

> 'It nurtures my soul, if I can't do it then I've got no point of being here.' (Interviewee D)

A feature of the dialogues emerging from overview of the whole dataset was how little participants talked of their experiences in illness or medical terms. This stands in contrast with the authors' usual experiences of talking to mental health service users. Participants' interpretation of recovery was not expressed in medical model language:

> ' So yeah it's made... not made, it's making me a better person, a much better person, yeah!' (Interviewee A)

> 'I know what my strengths are, know what my weaknesses are. [WRAP has] helped me to understand myself.' (Interviewee E)

Finally, while the overwhelming reports of WRAP experiences were positive, one negative comment emerged during interviews:

> "I was kind of hoping it would be a little bit more, in the sense that, mentally speaking, it's an Elastoplast… Whereas I was definitely trying to get out, I was trying to solve the actual root cause of the problem, y'know what I mean?" (Interviewee E)

This was later qualified by the interviewee who suggested WRAP was, in this case, a stepping stone to other paths to wellness.

> "...the context of being around those people and being able to express myself in that environment helped me to start implementing my spirituality 'cos I mean, it is essentially much more about living your life for others. I did in that, in those group sessions, I was helping people, in little ways, to help and support other people." (Interviewee E)

This comment also echoes many of the above findings about WRAP supporting connections with others and as a route to rediscovery of a contributing self.

Discussion

In this study we set out to explore how WRAP supports learning from crisis. What we also gained was a valuable insight into the meaning of crisis, which was described above as complex and profoundly affecting, reflecting reports from other qualitative crisis research (Borg et al. 2011, Gullslett, Kim & Borg 2014). Although not all participants described life-changing events as precipitating factors in crisis, crisis itself was viewed as having a profound impact on all their lives. The crisis experience was described as initially characterised by helplessness and hopelessness. This impacted on people's sense of self and sense of purpose, and was marked by unusual and/or risky behaviours, and often acts of despair. There was a reported failure to cope or function. The experience of the crisis itself

also emerged as alienating. These factors all impacted on the way people initially engaged with WRAP.

Participants' reflections on engagement with WRAP courses suggest people believe that the engagement process had positive benefits in and of itself in terms of helping them to overcome the impact of their crisis experiences. Although there was some initial scepticism about WRAP, people reported feeling that identification with others enabled a normalisation and validation of their experiences. Reflection of personal experiences with others appeared critical to this process. People reported beginning to feel safe and valued within the WRAP course environment. This appears to have developed from, as well as contributed to, mutual learning and support.

It appears, then, that the course itself acts as an agent of social re-engagement, and that a product of this engagement's reciprocity may be development of a more positive view of the self. Contrasting this with the reported negative impact of crisis suggests engagement with WRAP may produce marked shifts in peoples' beliefs about themselves. These factors together appear to create an attitude, and a set of beliefs, which then enable a process of learning and practising self-management skills. They may also lead to the recovery of a valued, contributory social role.

The various components of WRAP were reported as being regularly used in participants' lives. The knowledge and skills gained through the WRAP course were also reported as being utilised regularly, and as contributing to wellness. In some cases these skills and knowledge were reported as enabling difficulties to be resolved day-to-day, and in one case led to reportedly briefer, and perhaps less traumatic, crisis episodes. WRAP thus appears to be able to contribute to crisis prevention by regularly maintaining wellness using WRAP tools and processes, as well as contributing to a more positive self-belief which underpins self-efficacy.

Our study matches expectations raised by quantitative research into WRAP (Fukui et al., 2011; Cook et al., 2012; Cook et al., 2013). It is reasonable to assume that if WRAP can demonstrably improve measures of mental wellbeing then it will, as we found, be valued as a whole by participants. We have also been able to affirm findings of other qualitative and mixed methods WRAP research (Higgins et al., 2012; Wilson, Hutson, & Holston, 2012; Jones et al., 2013; Pratt et al., 2013) that the programme is valued by participants. But in conducting and analysing one-to-one qualitative interviews our study has enabled us to draw out specific aspects of the WRAP programme itself, as well as characteristics of the WRAP education programme which appeared to play key roles in recovery, learning from crisis and resilience-building.

In terms of aspects of the WRAP programme, firstly our findings reflect some broader crisis research. Hopkins & Niemec (2007) suggest there is perceived value among service users in developing personal plans for resilience following crisis, and Thornicroft et al. (2013) concluded that use of crisis plans can make people feel more positive about, and more in

control of, their mental health. Our participants valued crisis planning as a perceived safety net and offered examples of their use in practice. Secondly, other studies (Wilson et al., 2012; Jones et al. 2013) reported participants incorporating WRAP's self-monitoring, wellness tools and awareness of triggers into their lives, and that these practices support self-awareness and promote self-determination. These are reported in both studies to have had an impact on uptake of services and on personal resilience. Our findings support these conclusions.

A further aspect of WRAP which emerged strongly from our study was its group setting, which enabled identification with others and mutual support. This is reported elsewhere as a valued component of WRAP education research (Higgins et al., 2012; Wilson et al., 2012; Jones et al., 2013; Pratt et al., 2013). Our interviewees' accounts of their engagement with the WRAP process suggest that identification and mutual support are not only valued by participants, but are also key components of recovery and resilience-building. Identification with others appeared to build hope and counter stigma. The reciprocity of mutual support was also reported as enabling people to undertake a valued role. These are seen elsewhere as key aspects of recovery (Gullslett et al., 2014).

Other aspects of WRAP *as process* seem crucial. Mutual support among participants creates a supportive environment in which learning is enabled, but importantly is a setting in which people can safely explore and make sense of complex and profoundly affecting experiences. Borg et al., (2011) assert that learning crisis management skills is related directly to an understanding of the crisis itself. We link this also to findings from Higgins et al. (2012) who report that WRAP moves away from a medicalised view of recovery. Our research participants' descriptions of the social and personal contexts of their crises, and their predominant use of non-medical language in describing their recovery suggests they view themselves as recovering from life crises, rather than from episodes of "illness". One aim of the CRHT in introducing WRAP was to support recovery-oriented working. It is suggested by Winness, Borg, & Kim (2010) that promoting "life stories" rather than "illness stories" is one way of promoting recovery practice.

In terms of crisis theory Caplan (1964) described crisis as representing both threat and opportunity, with outcomes contingent on the effectiveness of "helping forces" that intervene within a window of opportunity. His later elaborations (Caplan, 1989) on his early theory expanded his definition of "helping forces" beyond those of intervening professionals to include the skills, resources and competences of those experiencing crisis. These may be partly innate, but may also be acquired. Our study suggests that WRAP may be a valid way in which people can acquire and develop these competences. Such personal competencies, allied to nursing competencies and placed within nursing processes, may be a key aspect of the resolution phase of mental health crisis (Brennaman, 2012).

Strengths and limitations

This study examined WRAP in a particular setting, a UK CRHT, thus addressing a reported need to research WRAP, and recovery, in a range of settings (Cook et al., 2012; Leamy et al., 2011). It appears to be the first WRAP study where qualitative research is based solely on one-to-one interviews rather than focus groups or focus groups combined with interviews. This arguably may have enabled the uncovering of more personal accounts of WRAP and recovery history than focus groups might allow. Our study participants had also been using WRAP for considerable periods. Other research is less specific about timescales, describing WRAP participation for "at least one month" (Wilson et al., 2013), conducting interviews almost immediately following short WRAP courses (Pratt et al., 2013) or not specifying timescales (Jones et al., 2013). The setting had the advantage that it enabled access to participants who met NHS crisis criteria, rather than who self-reported as experiencing crisis. In considering WRAP in a specific crisis context, our study allowed participants the opportunity to reveal what crisis meant to them in terms of changed life circumstances and impact on mental health.

This study also adds to a growing body of service user led research. This may have contributed to greater openness on behalf of participants and may also have enabled a broader standpoint than traditional research methods. This has, however, necessitated incorporating much reflexivity into the research process.

The qualitative nature of this study means that generalisation of findings is not appropriate. Importantly the study's findings reflect expectations raised by quantitative research, and echo the findings of other qualitative or mixed methods work, confirming WRAP as valued by mental health service users, and as having the potential to promote resilience which may reduce or modify further service uptake.

Implications for practice

Mental health crisis is not the sole province of CRHTs. This study suggests WRAP as having the potential to promote development of adaptive self-management skills which may be applicable in a broader range of mental healthcare settings. UK NHS services are obliged to create personalised crisis plans. Such plans are supported by WRAP, which may additionally provide people with the self-monitoring skills and self-efficacy required to make crisis plans effective.

Many of the benefits reported by this study's participants appear rooted in the mutual identification, validation and support that emerges from delivering WRAP in a group environment, and therefore there may be benefit in service providers promoting WRAP education as a group activity, rather than placing it within one-to-one treatment settings.

Conclusions

Overall, WRAP was reported as having a transformational effect on participants' lives and on mental health self-management capacity, which may have the potential to impact on repeat crisis presentation.

This study appears to further validate WRAP as a recovery programme with a great deal of potential. Further research is needed into the longer-term impact of WRAP, and into its use in a broader range of settings.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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