

Article: WRAP Around New Zealand

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Abstract

Evaluates a Consumer-run workshop series on Wellness Recovery Action Planning (WRAP) and Trauma Informed Peer Support (TIPS) in New Zealand. Responses to questionnaires administered before and after the training were compared. Results showed significant changes in understanding of workshop contents, and similar non-significant trends were evident where ceiling or floor effects occurred. Some items, which measured opinions regarding workshop content, showed differential effects for people who did, and who did not identify as having personally experienced mental illness. Reliability analysis of a subscale revealed its potential for use as a standardised measure for evaluation of future training of this type.

The objective of recovery as an outcome for people with mental illness has become increasingly more widely accepted since the essence of recovery was defined by Deegan (1988) in terms that allowed for the recurrence of symptoms to occur, without the process of re-establishing a meaningful and worthwhile life in the community being abandoned or destroyed. Recovery is now recognised as a realistic and achievable outcome for the majority

of people who experience mental illness. Government policy direction in Great Britain, Canada, the United States of America, and New Zealand has included the concept of recovery (Curtis 1997), and professional practice and research in psychiatry is now recognising the importance of this shift and is moving in this direction(1). For example, in an article which addresses some of the underlying issues that influence the reluctance of the psychiatric profession to accept the possibility of recovery, **the current president of the American Psychiatric Association, Sharfstein** (2005), recently made the following statement:

“... as a profession, we [psychiatrists] have allowed the biopsychosocial model to become the bio-bio-bio model ... a "pill and an appointment" has dominated treatment. We must work hard to end this situation and get involved in advocacy to reform our health care system from the bottom up.” (p.3)

In New Zealand the recovery approach is recognised in a variety of policy documents, notably, the New Zealand Mental Health Sector Standards (Ministry of Health, 1997), in the Blueprint for Mental Health Services in New Zealand – How Things Need To Be (Mental Health Commission, 1998), Our Lives in 2014 – A Recovery Vision From People With Experience of Mental Illness (Mental Health Commission, 2004) and Te Tāhuhu: Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan (Ministry of Health, 2005). An important part of the recovery process is participation in the establishment of hope, and in choosing the way forward.

“...people who have shown significant or complete recovery from severe mental illness...[i.e.]...schizophrenia, bipolar disorder, or schizoaffective disorder; have cited hope as an extraordinarily important component in their recovery. Part of the recovery was being around people who saw their condition as not permanent, a condition from which they could take increasing control of their life and re-establish a place in society.” (Medscape Psychiatry & Mental Health, 2005)

This applies at both the individual and the systemic level. Davidson, Stayner, Nickou, Styron, Rowe, and Chinman (2001) used the example of a supported socialisation programme to elucidate the importance of social inclusion for recovery from mental illness. The key issue these authors identified is the value that social inclusion gives to the most mundane events in life. Participation in peer support during recovery from mental illness provides a unique set of opportunities for users of mental health services to become active participants in their own recovery, in that of their peers, in the reduction of stigma related to mental illness, and in the improvement of mental health services. Peer support occurs naturally within communities in a variety of forms, however stigma related to mental illness affects the level and extent of peer and community support available to people who experience mental illness in New Zealand (Peterson, Pere, Sheehan and Surgenor, 2004). Peer support is defined by Mead, Hilton & Curtis (2001) as a system of giving and receiving help

founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful.

“Peer support, therefore, becomes a natural extension of community rather than modelling professionalised caretaking of people defined as defective.” Mead, Hilton & Curtis (2001)

Learning about recovery with people who are living in recovery, provides a reflexive example of how one’s experience of mental illness can become a valuable source of knowledge and skill, a way to regain a sense of value in society, rather than both the illness and the person being seen as a burden. The inclusion of peers, other people who experience mental illness, in the process of delivering services that enable recovery, inspires hope and motivation to succeed. In general, recovery education is an approach that is complementary to, but not a replacement for other mental health treatment protocols. The underlying principle is that participants learn through their own experience and the experience of others and there is an assumption that no one is any better or has any higher value than anyone else. In this context people work together to increase understanding and promote wellness. Furthermore, peer support is not based on any philosophy or model but can incorporate or be adapted to anyone’s personal philosophy or cultural values (Copeland and Mead, 2004).

The training evaluated in the present study offers opportunities for people who experience mental illness to form peer support networks that enable them to help themselves and others toward recovery. Skovholt (1974, as cited in Salzer & Liptzin Shear, 2002)

has suggested four benefits gained by helpers working with people who have similar problems to their own. These are; (a) an increased sense of personal competence from positively affecting another person's life; (b) developing a sense of equality in giving and taking between self and others; (c) gaining personally relevant knowledge through helping; and (d) receiving social approval from the person they help and others. Such benefits can occur alongside conventional treatment.

Trainor, Shepherd, Boydell, Leff and Crawford (1997, as cited in Nelson, Ochocka, Lauzon and Trainor (2004)) provided empirical evidence of the value of participating in Consumer run projects. They showed that before joining a Consumer - Survivor Initiative

(CSI), study participants had a mean number of 48.36 hospital inpatient days in the preceding year. In the year after joining, the mean dropped to 4.29. The same participants began the study with a mean number of 3.54 contacts with crisis services. After joining, the mean dropped to 0.81 contacts. This evidence is supported by the findings of a longitudinal study by Nelson, Ochocka, Lauzon and Trainor (2004). Of the 118 participants in the longitudinal study, 64 percent have a diagnosis of a mood disorder, 33 percent have a schizophrenia diagnosis, 90 percent were taking a psychotropic medication, 75 percent had a primary therapist or caseworker, and 49 percent were also involved with some other community mental health agency. When the longitudinal study began, participants had an average of eight days of psychiatric hospitalization in the previous nine months. After participating as active members of CSI's for 18 months, the average number of days in hospital dropped significantly, to below two days. In

contrast to the control group in the longitudinal study, members who actively participated in their local CSI experienced significantly greater reductions in hospitalizations and symptom distress, and significantly greater improvements in social support and quality of life (Nelson et al, 2004).

The present study evaluated a series of workshops based on a combination of two training programmes – the Wellness Recovery Action Plan (WRAP) (Copeland, 2003), and Trauma Informed Peer Support (TIPS) (Copeland and Mead, 2004). The workshops were organised by a Consumer - Tangata Whaiora(2) run service, and held in November 2004 in Christchurch, Wellington and Palmerston North. A Consumer-run or Consumer-led service (also known as a Consumer - Survivor Initiative (CSI)) is here defined as a programme, project, or service planned, administered, delivered, and evaluated by a Consumer group based on needs defined by the Consumer group. Operation of the service requires governance by Consumers, Consumer staffing and supervision of staff, Consumer control of program policy, and Consumer responsibility for program implementation.

A range of materials developed by Copeland (2003) and Copeland and Mead (2004), are available to help guide individuals who wish to teach mental health recovery skills to people who experience psychiatric symptoms, to their family members and to health care professionals. This information can be used to lead small or large groups and to facilitate workshops and seminars. While not specifically intended for use in working with individuals it can also be used in this way with some adaptations.

WRAP is a system designed by people with mental illness for use in monitoring psychiatric symptoms and reducing, modifying or eliminating uncomfortable and distressing symptoms and through planned responses (Copeland and Mead, 2004). Each individual looks at what things contribute to maintaining wellness and to becoming unwell, identifying and developing strategies and skills that are needed to stay well, and where possible eliminating strategies and circumstances that contribute to relapse. For example, a wellness strategy may be as simple talking to a friend before discontinuing medication, or to avoid such strategies as alcohol or drug use in response to symptoms.

Early warning signs and triggers which produce symptoms are identified, and people identify daily things they need to do to stay well. The plan also includes what to do when things are going wrong, and in crisis situations, which treatments are preferred (and which treatments are unacceptable), and who is or is not to be involved in their care and in decision making about their care. This predetermined care plan is known as an Advance Directive. Recognition that the above must involve people taking responsibility for their own wellness and working on a daily basis to maintain it is a central theme in the programme. People are thereby empowered to control what happens to them by planning when they are well, for situations where they may be unable to make good decisions about their treatment.

Mead, Hilton & Curtis (2001) emphasise the role of power sharing and co-operation in recovery from mental illness. This underscores

the role of the participatory action research approach adopted in the present study, especially with regard to the inclusion of representatives of all stakeholders in the research process. This was enabled by the research project being Consumer led, and by the invitation to participate in the workshops being extended to Consumers - Tangata Whaiora, their families, Whanau, and friends, and to staff of mental health service providers and other interested parties nationwide.

The Vermont Recovery Education Project (Vermont Psychiatric Survivors Inc. & Vermont Department of Developmental and Mental Health Services, 2001) reported on a forty-hour recovery education programme, developed by Copeland, and administered in a series of cycles over periods of varying length between 1995 and 2001. A survey was administered at the first session in each cycle and then again at the last session using the same questions to measure changes in attitudes, feelings, knowledge, and skill development. 193 participants completed both the pre-test and the post-test questionnaires. Statistical analysis of results showed the training was effective, and in combination with qualitative analysis of open ended questions, showed people had gained knowledge, skills and hope for recovery from the training. The project did not evaluate long term outcomes for people using the service.

A review by Doughty and Tse (C.Doughty, personal communication, 2005) of the international literature looking for evidence for the effectiveness of Consumer-run or Consumer-led mental health services for people with mental disorders found no

published New Zealand based controlled or comparative studies. The present pilot study was designed to help determine the feasibility and acceptability (to Consumers - Tangata Whaiora) of such studies, and of this particular training in the New Zealand context. To date, the Copeland and Mead (2004) framework for recovery-based education for mental health Consumers and Non-Consumers has not been evaluated by any previous studies in New Zealand. The present study provides preliminary evidence on the effectiveness of this framework, and identifies a potentially useful scale that measures changes in understanding of key concepts in the WRAP programme.

Benefits of the research

Consumers - Tangata Whaiora are empowered by direct involvement in establishing research priorities for mental health recovery research. This project will generate New

Zealand specific information about individual views regarding peer support and recovery education. This research will complement a variety of other research initiatives that are underway within New Zealand which aim to specifically examine the concepts underpinning mental health recovery and lead to further outcomes based research. A recent example is the project of Gordon, Ellis, Haggerty, Pere, Platz, and McLaren (2004), entitled *Preliminary Work Towards the Development of a Self-Assessed Measure of Consumer Outcome*, which recommended the formal development of the type of tool presented here, and which has recently been awarded funding for further development (Gordon 2005, personal communication). The Mental Health Commission is currently

leading the development of a Consumer workforce strategy in mental health and the present study provides preliminary quantitative data that will help determine the feasibility of conducting future Consumer - Tangata Whaiora driven research projects. A subscale of the questionnaire developed for this study may be valuable in the assessment of future trainings involving this material.

Specific aims of the research:

1. To provide an initial study in the area of recovery education in New Zealand.
2. To examine any differences in responses between Consumers - Tangata Whaiora and mental health professionals and/or Non-Consumers before and after the delivery of education workshops on the content and value of peer support and wellness-recovery education.
3. To develop and test a rating scale that will assist in measurement of the effectiveness of subsequent recovery training programmes.

Ethical Issues

The time contributed by Mental Health Service staff was accommodated by the organisations they worked for as part of their normal training, and therefore did not interfere with the normal running of the services. Involvement of clinical staff and or patients required approval from the Canterbury, Wellington and Manawatu - Wanganui Medical Ethics Committees, which was granted from 22nd November 2004, until 31st October 2005. Relevant aspects

of this process are discussed below, and additional concerns noted by the present author are also addressed.

Te Tiriti O Waitangi - The Treaty of Waitangi

The present study sought to honour the principles of the Treaty of Waitangi, as described in *He Tirohanga o Kawa ki te Tiriti o Waitangi: A Guide to the Principles of the Treaty of Waitangi*, (Te Puni Kōkiri, Wellington, 2001), especially the principle of partnership; the duty to act reasonably, honourably, and in good faith; the principle of mutual benefit; the duty to make informed decisions, and the principle of active protection. This was achieved through consultation with Mr. Matiu Balir who read and considered the questionnaire and supplied comments and advice, as detailed in the document attached as Appendix C to this document. Pauline Southorn Te Kaihapai Manaakitanga, Maori Mental Health Consumer Advisor Mental Health Services, Grey Base Hospital, Maori Representative on Steering Group for National Consumer Collective and member of Southern Consumer Network was also consulted regarding the content of the questionnaire. The present author acknowledges that further development and replication of this preliminary research will require wider and more comprehensive consultation with Maori. The principle of partnership was honoured by entering into a partnership with Consumers - Tangata Whaiora both as participants in, and as organisers of the workshop series, and by seeking advice on cultural appropriateness from Maori as detailed above. The duty to act reasonably, responsibly, and in good faith is a feature of the rigorous ethical approval process applied to the present study, and all practicable steps were taken to ensure the wellbeing of all

workshop attendees and organisational team members. The principle of mutual benefit was inherent in the nature of the material being presented, which has as its basis the idea of empowering people to improve their lives by improving relations with their community and the institutional organisations they come into contact with, in ways that benefit all, and foster mental wellness. The principle of redress is accommodated under New Zealand law, and having given due care and attention to the above principles, it is anticipated that there will be no requirement or cause for this principle to be applied.

Advice was sought and provided (Fuimaono Karl Pulotu-Endemann, Alo-o-Tuatagaloa, personal communication, 7th September 2004) regarding cultural factors to be considered in relation to interacting with people of Pacific Island cultures.

The research involved a maximum of two contacts with the researchers. The initial contact included the informed consent process, gathering of demographic and service use data, and the questionnaire. The second contact was a repetition of the initial questionnaire, with some additional quality assessment items added.

Participants were recruited by email, by advertisements in newsletters and a website, and in newspapers and community noticeboards. Potential participants were approached at the workshops, with clear and accurate information given about the project, and an information sheet provided. The information sheet⁽³⁾ emphasised that participation was purely voluntary and a

decision of participating or not did not influence the service/training received or any service/training they will receive in the future.

No specific physical or psychological risks to participants or third parties were anticipated, aside from those they would expect to be exposed to in the course of any group learning experience. The training was offered as a complement to standard treatment, therefore no variation to standard treatment was required.

Exclusion criteria for participation were:

1. Individuals who were not able to give informed consent
2. Individuals who had difficulties in the data collection due to impairment in concentration, or experiencing active psychiatric symptoms
3. Immediate risk of harm to self or other

Inclusion criteria for participation were:

1. Full day attendance at the workshop 9-4 pm.
2. Aged 18 years and over.
3. Able to read and write in English language.

The naturalistic paradigm of the study made control groups and randomisation impossible. The data collection was conducted by workshop facilitators, the present author, and/or the principal researcher. All have substantial practical experience working with people who experience psychiatric symptoms. A psychiatric nurse and fieldworker was present at the Christchurch and Dunedin workshops; a psychologist was present at the Wellington and Palmerston North workshops.

No audio or video recordings were made. The consent forms and questionnaire data collected was accessed only by the researchers, and is currently stored in locked cabinets and will be destroyed after 12 months. The original data and electronic information will be retained by the principle researcher for 10 years.

Method

The study was a pre-test/post-test evaluation which examined participants' attitudes to and knowledge of recovery concepts before and after their participation in the workshop. The initial questionnaire⁽⁴⁾ consisted of two sections. Section one presented questions to gather demographic information. Section two was a series of statements, each with a Likert-type rating scale. Participants were asked to circle the answer that best reflected how much they agreed or disagreed with each statement. The second questionnaire⁴ was identical to the first except that it had an additional section at the end. Questions in section three were used to assess the delivery of the workshop. These last questions were included for the purpose of training development and are not analysed here.

Data Analysis

Overall 179 participants completed consent forms and questionnaires. Some participants attended two days or four days of training, with the second questionnaire administered after the last day. To ensure a clean data set, these participants were excluded from the present analysis, along with any who did not

complete all items in section two of both questionnaires. This resulted in the sample being reduced to 76 participants.

Because the data collected were from an interval scale, non-parametric methods of data analysis were used for the group difference analysis, and where parametric testing was conducted to reveal the influence of demographic features on certain results, the alpha level was set at $\alpha = .01$.

The Wilcoxon signed rank test for related samples was used to determine group differences between before and after scores for each questionnaire item. Chronbach's Alpha coefficient scores were calculated for a subscale of items that relate directly to content of the workshops, (items 1,3,4,5,7,8,9,13,14,15,16,and 17) in order to evaluate the subscale as a potential measure for evaluating future WRAP training within and beyond New Zealand. Finally mixed between and within subjects Analysis of Variance (ANOVA) tests were conducted to reveal information about the relevance of occupation and personal experience of mental illness to the changes observed between the before and after scores.

Results

The demographic data showed that of the 76 participants included in the final analysis, 39 (51%) identified as having personal experience of mental illness. Fifty participants (66%) were employed in mental health related jobs, and of those 22 (44%) also identified as having personal experience of mental illness. Significant group differences between before and after scores were found for nine of the 18 questionnaire items using the

Wilcoxon signed rank test for related samples. The results of these tests are presented in table 1 below.

Table

Differences in Questionnaire Responses at T1 and T2

Overall Means and Standard Deviations					Wilcoxon Signed Rank Tests	
T1			T2		Standard Score	Exact Sig (2-tailed)
Item	M	SD	M	SD	z	
1	2.92	.920	4.49	.739	-7.179(b)	
2	3.68	.867	4.21	.660	-5.151(b)	
4	2.38	1.006	1.92	.860	-3.855(c)	
9	3.45	1.237	4.22	.776	-4.934(b)	
11	3.59	.941	4.01	.841	-4.545(b)	
12	3.88	.909	4.17	.773	-3.869(b)	
14	4.03	.771	4.53	.528	-4.803(b)	
15	4.41(a)	.521	4.61	.492	-2.887(b)	

- (a) Possible ceiling effect.
- (b) Based on negative ranks
- (c) Based on positive ranks

The overall Chronbach's Alpha reliability coefficient score for the 12-item WRAP Training (WRAPT) subscale, incorporating both before and after scores, was $\alpha = .7329$. Only minor changes in the reliability coefficient score were observed when various items were removed. When the full sample of 179 participants was analysed, the Chronbach's Alpha reliability coefficient score reduced to $\alpha = .7064$. With items four and eight removed, the score obtained with the full sample was $\alpha = .8235$.

A mixed between and within subjects ANOVA conducted with experience of mental illness as the between subjects factor showed that for people who did not identify as having personal experience of mental illness (the Non-Consumer group), the group level of agreement with the statement in item five - "People who experience mental illness should have the opportunity to choose what treatment they will receive" – showed a significant interaction with that of people who did identify as having personal experience of mental illness (the Consumer group), at the $\alpha = .05$ level ($\alpha = 0.047$).

While this result is non-significant in respect of the limitations placed on the analysis because of the interval scale nature of the data, the result indicates a differential trend for Non-Consumers to have been influenced by the training with regard to this opinion. The mean for this group increased by 0.27 (mean at T1 = 4.11, SD = 0.699; mean at T2 = 4.38, SD= 0.639). In contrast the Consumer group showed a minimal decrease (0.03 points). Frequency data for the Consumer group showed the "agree" responses increased by one respondent at T2 with a corresponding decrease in "strongly agree" responses. In contrast the number of "neutral"

responses in the Non-Consumer group dropped from four to zero, and “agree” responses decreased from 22 to 20, with a corresponding increase of six in the number of “strongly agree” responses for this group.

A mixed between and within subjects ANOVA conducted for each of the matched reversed items 10 and 11, with experience of mental illness as the between subjects factor, revealed a presentation effect. The statement in item 10 – “The opinions of psychiatrists and other health professionals should be given more weight than those of the person receiving treatment” - showed no significant change in overall group scores (Wilk’s Lambda $\lambda = .999$, $F = .38$, $df (1,74)$, $\alpha = .846$) but did show an interaction between groups, however this did not reach the specified level of significance. Scores for the Consumer group increased by 0.18 points (mean at T1 = 1.85, SD = 0.904; mean at T2 = 2.03, SD = 1.038) and scores for the Non-Consumer group decreased by 0.22 points (mean at T1 = 2.22, SD = 0.848; mean at T2 = 2.00, SD = 0.872). This interaction was significant at the $\alpha = .05$ level (actual $\alpha = .039$). As mentioned above this falls outside the significance limits set for these data, however results for the following item warrant some discussion of this feature.

The statement in Item 11 – “The opinions of the person receiving treatment should be given more weight than those of psychiatrists and other health professionals” - was a simple reversal of that in Item 10. The results for Item 11 however were markedly different to those predicted by the results of Item 10. In this instance, the overall responses showed a significant difference between T1 and T2, (Wilk’s Lambda $\lambda = 0.795$, $F = 19.096$, $df (1, 74)$, $\alpha < 0.0005$)

and no indication of any interaction between group scores. Group means were very similar to one another at both T1 and T2.

A mixed between and within subjects ANOVA conducted with experience of mental illness as the between subjects factor showed a significant difference (Wilk's Lambda $\lambda = 0.801$, $F = 18.402$, $df (1, 74)$, $\alpha < 0.0005$) at T2 in the overall group level of agreement with the statement in item 12 - "People who experience mental illness should decide whether or not family members and significant others are to be consulted regarding their treatment and recovery process". There was also a significant effect for the between subjects factor ($F = 12.823$, $df (1, 74)$, $\alpha = 0.01$). These results indicate that the Consumer group agreed more strongly with this statement than did the Non-Consumer group, and that both groups were influenced to a similar degree by the training.

ANOVAs conducted with employment as the between subjects factor found no significant differences between groups, irrespective of their experience of mental illness.

Discussion

Overall the data presented above show that the workshops were effective in presenting the information they contained, and had a significant influence on the opinions of the participants regarding recovery concepts. This influence approached the level of statistical significance even where the opinions were strongly aligned with the workshop content at T1, although in some instances this was true for the Non-Consumer group only. The potential for social desirability bias in the information provided by

participants was addressed by asking participants to answer honestly, and informing them that there are no right or wrong answers to the questions asked. However, the ceiling effects evident for a number of the items indicate that the participants were either a self selected group of people with genuine existing attitudes aligned with the course content, or responded to the initial questionnaire with a form of social desirability bias. Nevertheless, although they did not reach significance, the trends evident in the data for those items subject to ceiling effects showed an increase in the number of maximum agreement responses, and decreases in the lower scores. The inverse was also true for reversed items, included to prevent response set bias, which showed floor effects. The above trends suggest that the workshops were effective in influencing even these strongly held attitudes.

The WRAPT subscale analyses indicate that with some further refinement the subscale could become a highly reliable measure for evaluation of future recovery workshops. However the skewed distribution of this sample in terms of agreement with the ideas expressed through the workshops, as indicated by the ceiling and floor effects found in 44 percent of items, suggests that replication with a more normally distributed sample is advisable to confirm the reliability of the scale.

The results of the ANOVA for item five showed a differential trend for the Non-Consumer group to be influenced by the training, despite the fact that at T1 92.1 percent of the total sample either agreed or strongly agreed with the statement – “People who experience mental illness should have the opportunity to choose what treatment they will receive”. A possible explanation is that

some ideas and perspectives about treatment choices presented in the training, while familiar to Consumers, were sufficiently new for Non-Consumers to be influenced by them.

Overall, the results for items 10 and 11 indicate that order of presentation had a significant effect. The low mean score for item 10 indicates a possible floor effect, and this is supported by the frequency data which show 73.7 percent of responses at T1 were either “disagree” or “strongly disagree”, however the interaction described above indicates the influence of such a floor effect may not be robust. It appears that in the first instance the Non-Consumer group was influenced to reduce their agreement with the statement favouring the opinions of psychiatrists and other health professionals, while the Consumer group was relatively unmoved. In the second instance, agreement with the statement favouring the opinions of people receiving treatment increased significantly for both parties. From the present data it is impossible to discern whether the effect is due to the order of placement of the parties concerned (person receiving treatment versus psychiatrists and other health professionals) within the item, or whether the effect is due to the order of presentation of the items. This question could be resolved in future research by counterbalancing the order in which these two items are presented. The naturalistic paradigm of the present study could present some difficulties in this respect, because not all participants in the workshops chose to participate in the study. However if the number of participants overall was similar to that in the present study, randomisation of the various forms of the two

items, prior to the distribution of the questionnaires, would probably provide a sufficient sample size in each condition.

Conclusion

The present study confirms that the workshops were valuable in that they produced measurable changes in levels of understanding of the course material and in attitudes toward recovery related topics. It has been demonstrated that although there are some differences in the particular areas of influence, both Consumers and Non-Consumers were informed and influenced by this training in ways that support recovery, and empower Consumer choice in the recovery process. Furthermore, this was true for people from a variety of social circumstances, whether employed in mental health related work, in other types of work, or unemployed. This preliminary evidence provides a basis for further studies to evaluate recovery education in New Zealand.

The WRAP programme is rapidly gaining popularity in New Zealand, with several of the 50 trainers certified at a four day workshop in this series now conducting their own WRAP trainings around the country. The present study offers an empirical basis to support the ongoing expansion of this innovative programme for promoting mental health and increasing the range of choices for Tangata Whaiora in Aotearoa to seek self determination (Tino Rangatiratanga) of their wellness outcomes.

In addition, the WRAPT subscale was found to be sufficiently reliable to warrant further investigation and development as a standard tool for evaluating recovery education. With further

development, people providing WRAP training could use the subscale to make comparable assessments to ensure future trainings are of the highest quality. As objectives 5.3, 5.4 and 5.5 of the Service User Workforce Development Strategy (Mental Health Commission, 2005) are implemented during the next few years, the range of people attending recovery oriented training, including WRAP based training, will expand and this may provide opportunities for replication of aspects of the present study with samples that are more diverse in their initial views.

Further opportunities for research exist in assessment of outcomes for Consumers – Tangata Whaiora who use the WRAP system. Future WRAP training programmes will provide an expanding array of people who are familiar with the WRAP concepts and may provide opportunities to link outcome research projects with potential participants, either directly or through providing researcher contact information for participants to self-select.

The author of the WRAP programme has provided an example, and this project an opportunity, for the present author to engage with peers who have experience of mental illness, and thus make an important step in his own recovery. Future research in this area should continue to model Consumer leadership and participation in all aspects of the research, as role model visibility is a key element in the inspiration of hope for recovery.

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(1) See for e.g. Mulligan, 2003; Resnick, Fontana, Lehman, and Rosenheck, 2005

(2) A range of terms used in the literature to describe people with experience of mental illness include consumers, service users, psychiatric survivors, and tangata whaiora (people seeking wellness). The terms Consumer , Consumer(s) - Tangata whaiora, and service user are here used interchangeably to reflect the extensive use of these terms in Aotearoa New Zealand.

(3) See Appendix A

(4) See Appendix B

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