

Article: WRAP Evidence Base

http://mentalhealthrecovery.com/art_selfmanagement.html

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Although the concept of recovery from a mental illness is relatively new (Deegan, 1988), people with mental health difficulties have been self-managing and functioning in the community long before the idea of recovery became popularized (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987). People with psychiatric diagnoses have countless ways of “getting on with their lives” (Allott, Loganathan, & Fulford, 2002), which have begun to be documented and formalized over the past two decades.

Studies show that self-management --or a person’s determination to get better, manage the illness, take action, face problems, and make choices -- facilitates recovery from mental illnesses (Allott et al., 2002). Self-managed care strategies are as varied as people themselves, but some common techniques include: writing down or talking about problems, contacting or visiting with friends, exercising, praying/meditating, creative endeavors, practicing good nutrition, and engaging in self-advocacy (Rogers & Rogers, 2004). For many, voluntarily taking psychotropic medications and using formal services are aspects of self-managed care as well. In fact, it can be argued that self-management of psychiatric illnesses is at the heart of consumer-directed mental health treatment.

Several manualized self-management programs have been developed in recent years, but perhaps the most widely disseminated is Mary Ellen Copeland’s Wellness Recovery Action

Planning known as WRAP (Copeland 1997). WRAP is a program in which participants identify internal and external resources for facilitating recovery, and then use these tools to create their own, individualized plan for successful living (Copeland 1997). The creation of a WRAP plan generally begins with the development of a personal Wellness Toolbox, consisting of simple, safe, and free or low-cost self-management strategies such as a healthy diet, exercise, sleep patterns, and pursuit of adult life roles (Copeland 2004). The person then uses this Toolbox to create an individualized plan for using each strategy to obtain and maintain their recovery. The plan also includes identification of “early warning signs” of symptom exacerbation or crisis, and how the Toolbox can help people to manage and feel better. WRAP also encourages development of a crisis plan, which states how the person would like to be treated in times of crisis (similar to an advance directive for inpatient psychiatric care), as well as a post-crisis plan for getting back on the road to recovery.

Since mental illness self-management programs lie at the heart of consumer-directed care, it is not surprising that they are highly similar in their philosophy and intended outcomes to patient-centered medical care as identified by the Institute of Medicine (IOM) in its “Crossing the Quality Chasm” report (IOM, 2001). The goal of both types of programs is health-related behavioral and attitudinal change, with attention to acquiring new information and skills to better manage troublesome symptoms and maintain higher levels of health and functioning. The use of structured techniques and strategies for managing illness and ongoing self-

assessment and self-monitoring are also considered active ingredients in both approaches.

WRAP Evidence Base

There is an evidence base for WRAP due, in part, to the availability and widespread use of a pre-test post-test instrument developed by the model's creator and widely used by its facilitators. A number of pre-test/post-test design studies have examined the impact of WRAP on consumers' well-being, use of WRAP techniques, and recommendation of WRAP to other peers. The Vermont Recovery Education Project (no date) completed 23 cycles of WRAP training involving 435 participants in 1997 through 1999, 193 of whom completed pre-test and post-test evaluations for a 44% response rate. Paired, 2-tailed t-tests of mean differences for the 147 consumer WRAP participants found significant increases in consumers' self-reported knowledge of early warning signs of psychosis, tools and skills for coping with prodromal symptoms, preference for using natural supports, support groups, and other people with mental illness for support, use of wellness tools in their daily routines, and hope for recovery. Also found were significant increases in consumers' self-rated ability to create crisis plans, and to create plans that: expressed their needs and wishes, listed their supporters and people to contact in an emergency, and explained their early warning signs. Finally, results of paired t-test results showed that, following WRAP training, consumers reported being significantly more comfortable asking questions and obtaining information about community services, and engaging in self-advocacy.

The state of Minnesota's evaluation of its WRAP program examined the results of 42 WRAP cycles held throughout the state in 2002 and 2003. A total of 305 mental health consumers participated, and 234 of these completed pre-tests and post-tests for a 77% response rate (Buffington, 2003). Two-tailed tests of differences in proportions revealed that, following the training, significantly greater percentages of participants self-reported having hope for recovery, taking responsibility for their own wellness, having a support system in place, managing their medications well, having a list of things to do every day in order to remain well, being aware of their symptom triggers, awareness of their early warning signs of psychosis, having a plan to deal with prodromal symptoms, having developed a crisis plan, having a lifestyle that promotes recovery, and finding it easy to engage in recovery promoting activities. Of the 234 respondents, 140 or 44% responded to a follow-up survey conducted 90 days after the end of WRAP training. All of these respondents (100%) reported feeling more hopeful about their recovery and 93% (n=130) said they had encouraged other consumers to participate in WRAP training. Since WRAP initiatives are currently ongoing in all 50 state of the United States (Copeland, Personal Communication), there are numerous opportunities to engage in further, more rigorous evaluations that can inform the field about the efficacy and effectiveness of this consumer-directed service.

Conclusion

Using the U.S. Agency for Healthcare Research and Quality Evidence Rating Guidelines (1992), the research evidence base for WRAP is at Level IIb. That is, there is evidence from one or

more non-controlled, well-designed quasi-experimental studies that the intervention leads to behavioral or attitudinal change. Hopefully future research will explore the efficacy and effectiveness of this model in promoting recovery.

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