

**Wellness Recovery Action Plan (WRAP) Training  
for BME women:  
an evaluation of process, cultural appropriateness  
and effectiveness**

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**April 2009**

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## **Notes and acknowledgements**

### **A note on terminology**

The authors are very conscious that various terms are used to refer to the many diverse communities in the UK. We have elected to use the term black and minority ethnic (BME) to describe the women involved in this research and their wider communities. In doing so we acknowledge the diversity that exists within these communities including many distinct ethnic groups and the varying levels of identification that individuals may have with 'black' and 'minority ethnic'.

The women participating in this research also frequently used the term BME in relation to themselves. The women also used the term 'Asian' to describe themselves and their communities, using this interchangeably with the term 'BME'. Within this report however, instead of the term 'Asian' we use the term 'South Asian' to more accurately reflect the fact that the overwhelming majority were of a Pakistani or Indian background.

As a consequence of the issues highlighted above, we use both the terms 'South Asian' and 'BME' throughout this report thus reflecting the interchangeable terminology used by the women themselves.

### **Disclaimer**

The opinions expressed in this publication are those of the researchers and are not necessarily those of the Scottish Recovery Network

### **Acknowledgements**

We would like to acknowledge the input and expertise of the women who so generously contributed to this evaluation, and to Pratima Pershad, Arma Sayed, Rona McBrierty, Simon Bradstreet, Dale Meller and Jenny Graydon.

## **Chapter One: Introduction**

This is a report on an independent evaluation of Wellness Recovery Action Planning (WRAP) training delivered to a group of BME women in Glasgow. This evaluation was commissioned by the Scottish Recovery Network (SRN) as part of its wider strategic activity in promoting and supporting recovery.

This chapter sets the context for the evaluation by briefly describing WRAP and how it has been implemented in Scotland. It then outlines the broader policy context for inequalities as these relate to Black and minority ethnic women in Scotland, and concludes with a short background to the evaluation.

### **About WRAP**

The origins of WRAP are clearly established: Mary Ellen Copeland, a white American woman with lived experience of mental health problems developed WRAP as a self management tool that is intended to help individuals take more control of their personal wellbeing and recovery.

The Copeland Centre which promotes the use of WRAP internationally describes WRAP as follows:

*‘WRAP is a structured system to monitor uncomfortable and distressing symptoms that can help you reduce, modify or eliminate those symptoms by using planned responses. This includes plans for how you want others to respond when symptoms have made it impossible for you to continue to make decisions, take care of yourself or keep yourself safe.’<sup>1</sup>*

More specifically WRAP training is intended to help individuals:

- stay as well as possible;
- keep track of difficult feelings and behaviors;
- develop action plans that should/will make them feel better; and
- tell others what to do for them when they are so ill that they are unable to make decisions, take care of themselves and keep safe.

WRAP training is underpinned by a number of key notions: that recovery is possible (‘hope’); that individuals should take personal responsibility for their own lives and well being (‘personal responsibility’); that is important to know yourself, to be self aware (‘education’); that it is important to believe in and advocate for oneself (‘self advocacy’); and that the support of others is vital (‘support’).

WRAP training involves facilitated exercises and discussions, and encouragement and support in developing personal action plans to help individuals in various aspects and stages of recovery. The content of the training and associated elements of the action plan are summarised in box one.

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<sup>1</sup> <http://www.copelandcenter.com/whatiswrap.html>

### **Box One: Key elements of WRAP training**

- Daily maintenance plan
- Wellness toolbox
- Identification of triggers & development of associated action plan
- Identification of early warning signs & development of associated action plan
- Identification of signs that things are breaking down & development of associated action plan
- Crisis planning
- Post crisis planning

In June 2008, SRN funded the training of 18 people as WRAP facilitators in order that they in turn could deliver the training to groups of people. For its part, SRN is promoting WRAP with a view to providing opportunities for people with serious mental health problems to develop their own WRAPs.

However, while WRAP was specifically developed by people with mental health problems for people with mental health problems, both the Copeland Centre and SRN<sup>2</sup> suggest that WRAP may be useful for anyone interested in planning and managing their mental health and wellbeing.

### **The Scottish context for mental health and race equality**

In Scotland, the framework for race equality across mental health services is driven by the Race Relations Amendment Act of 2000, the Equalities Strategy (Scottish Executive, 2000<sup>3</sup>), the subsequent Fair for All policy driver (Scottish Executive, 2001<sup>4</sup>) and subsequent guidance (Scottish Executive, 2002<sup>5</sup>) directing the public sector in Scotland. This legislation and policy provides a baseline on race equality practice and clear guidance to NHS boards and other public bodies on mainstreaming race equality. These policies directly led to the establishment of the National Resource Centre for Ethnic Minority Health (NRCEMH) hosted within NHS Health Scotland in 2002. The National Programme for the Improvement of Mental Health and Wellbeing initially funded a specific mental health programme within NRCEMH from 2004 which sought to strategically influence and improve the mental health and wellbeing of BME communities. This programme has subsequently been extended through funding from the Scottish Government until 2011 and is now hosted within NHS Health Scotland's Equalities and Planning Directorate.

Since 2006, this national programme of work on mental health and race equality amongst BME communities in Scotland has had a strong focus on service delivery and recovery. The programme has a well established partnership with the Scottish Recovery Network and other agencies across Scotland seeking to promote mental health and recovery in BME communities.

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<sup>2</sup> [http://www.scottishrecovery.net/content/default.asp?page=s16\\_5](http://www.scottishrecovery.net/content/default.asp?page=s16_5)

<sup>3</sup> Scottish Executive 2000 *Equalities Strategy*, Scottish Executive, Edinburgh

<sup>4</sup> Scottish Executive 2001 *Fair for All*, Scottish Executive, Edinburgh

<sup>5</sup> Scottish Executive 2002 *HDL51 Fair for All: Towards Culturally Competent Services*, Scottish Executive, Edinburgh

Set against this practice context, there is a general lack of recent research about ethnicity, mental health and wellbeing in Scotland, and relatively little is known about mental health interventions and their effectiveness for BME groups<sup>6</sup>. It is notable that this dearth of evidence occurs against a background of research indicating additional stressors experienced by South Asian women<sup>7</sup> and elevated suicide risk<sup>8</sup> (e.g. Raleigh & Balarajan 1999; McKenzie *et al* 2008).

### **About this evaluation**

SRN's activities include building the evidence base for recovery i.e. deepening understanding of what helps people recover and stay well<sup>10</sup>.

It is within this context that in September 2008 SRN commissioned this evaluation.

SRN and NHS Health Scotland have a long history of good partnership working with a mental health project that ran a 'recovery group' for BME women. This group was attended by a mix of women: those with current, including serious, mental health problems and others whose primary interest was a more general interest in mental health and/or to help others including family members with mental health problems.

The women attending this group had expressed an interest in attending WRAP training and the host agency, SRN and NHS Health Scotland recognised the opportunity to capitalise on this, and to conduct an evaluation that focused on the effectiveness and cultural appropriateness of the training.

It was believed that this would be the first evaluation not only of WRAP in Scotland, but also the first on BME women, and therefore having the potential to inform thinking on whether and how WRAP (and possibly other mental health training) might be rolled out, in particular, to BME communities.

The agencies agreed therefore that the evaluation should attend to the cultural sensitivity of WRAP training and the effectiveness of the training for this group of women.

The three agencies were keen that the evaluation preserved a partnership working approach. Due to staff changes however it was necessary for SRN to commission independent consultants to conduct the evaluation on its behalf, progressing this in collaboration with the other two agencies.

This was the first time that WRAP training had been delivered to BME participants. In order to make the training as useful for the women as possible, the evaluation was

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<sup>6</sup> Newbigging K, Bola M and Shah A 2008 Scoping Exercise with Black and Minority Ethnic Groups on Perceptions of Wellbeing in Scotland, University of Central Lancashire

<sup>7</sup> Bhugra D & Desai M 2002 *Attempted Suicide in South Asian Women*, *Advances in Psychiatric Treatment* (2002) 8: 418-423, Royal College of Psychiatrists

<sup>8</sup> Raleigh V & Balarajan R 1992 *Suicide and Self-Burning among Indians and West Indians in England and Wales*, *British Journal of Psychiatry* (1992) 129: 365-368

<sup>9</sup> McKenzie K, Kamaldeep B, Nanchahal K & Blizard B 2008 *Suicide rates in people of South Asian origin in England and Wales: 1993-2003*, *British Journal of Psychiatry* (2008) 193: 406-409

<sup>10</sup> <http://www.scottishrecovery.net/content/default.asp?page=s4>

deliberately formative in nature i.e. the findings were used (as they emerged) to shape the delivery of the training, specifically to make it accessible and appropriate to women from BME communities.

The training was delivered by a highly experienced WRAP trainer who was able to reflect on how the training sessions mirrored and/or differed from ones she had previously delivered. In this way she too became actively involved in the research process.

As highlighted above, a significant focus of this evaluation lies on *processes*, specifically to identify and describe lessons learned regarding the training and its cultural relevance and appropriateness.

The evaluation also focuses on the question of effectiveness i.e. what evidence was there that the WRAP training resulted in improved outcomes for the women e.g. the extent to which women developed improved insight into their own mental health, and developed or strengthened their plans and behaviours in terms of staying well and managing their own recovery.

## **Chapter 2: Methods and Design**

### **Summary**

Several approaches were used in the design of this evaluation. These were:

- individual interviews with participants before and several weeks after the WRAP training;
- one focus group with participants before and another immediately following completion of the WRAP training;
- a pre- and post- training individual interview with the WRAP trainer;
- researcher observations of all training sessions and a follow up session; and
- reflective sessions conducted after each training session.

This chapter summarises the methods used to meet the evaluation objectives.

### **A note on data collection**

All participants received an information sheet describing the evaluation and how their views would be used and reported, and provided signed consent prior to taking part in the evaluation.<sup>11</sup>

All individual interviews and focus groups were conducted using semi-structured guides that had been previously approved by the research team and commissioner. Individual interviews and focus groups were recorded and fully transcribed.

The observational sessions were conducted using an 'observational framework'. Observations were captured by note taking.

### **Participant interviews and focus groups**

A focus group was conducted with the woman prior to the training. This focused on understanding of recovery, awareness and expectations of the WRAP training, and views on important cultural and religious issues that are important in understanding South Asian women's mental health and wellbeing. This group was attended by four women and facilitated by one of the researchers and the group's co-ordinator.

In addition, individual interviews were conducted with six women prior to the start of training. The seventh woman did not attend. As a warm-up, these interviews explored women's current awareness and understanding of the concept of recovery and of WRAP training. Their motivation for attending the training and their expectations were also explored. The interviews also provided baseline information on what the women were currently doing to keep well, and their insights and actions when things start to go wrong / when they do not feel so good mentally.

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<sup>11</sup> It should be noted that the women also received information and discussed their participation in the training with the group's usual co-ordinator.



A second focus group was conducted immediately after the last training session with six women attending this. Facilitated by one of the researchers and another member of the research steering group, this focused on participants' general views of the training including its cultural relevance, and their understanding of the key concepts underpinning WRAP.

Finally, seven follow up individual interviews were conducted post training. These were conducted two to three weeks after the final follow up session, that is eight or nine weeks after the completion of the training. This set of interviews explored individuals' experience of the training, how they were using and developing their 'WRAPs' and again exploring what were doing to keep well. As such they aimed to provide a point of comparison with the pre- training interviews, providing a set of 'before' and 'after' data for six of the seven participants.

The focus groups lasted an hour, and the interviews ranged in length from about 30 –50 minutes.

### **Trainer Interviews**

An individual interview was conducted with the WRAP trainer before and after the training. The pre-training interview was used largely to expand the researchers' understanding of WRAP and its delivery and to inform the development of the interview guides and observational framework. The post training interview was used to explore the trainer's overall reflections on the training process and perceptions on the participants' engagement.

### **Observational Work**

All four training sessions and the one follow up session were observed by the researchers. This evaluation method afforded the researchers the opportunity to witness first hand each of the training sessions, including not only delivery of the programme but the interaction and engagement of the group participants.

The researcher(s) sat at the back of the room in a position where the whole group could be observed but where they were as unobtrusive as possible. They did not engage with the group in any active way throughout the sessions.

Several steps were also taken to reduce potential for researcher bias in this observational component of the evaluation.

Firstly, an observational framework was developed and used at each session to guide the researchers' observations and reporting. This guide covered the following areas:

- group process and dynamics of participant engagement;
- understanding of WRAP concepts and ideas, and individuals' development of their own WRAPs;
- methods of working used within the training and level of engagement with each; and
- issues of language and interpretation and other aspects of cultural sensitivity.

In addition, researchers paid attention to changes in process over the course of the whole training.

Secondly, both researchers attended *two* of the trainings and one or the other sat in on the remaining sessions. Having both researchers present at the first session allowed them to reflect on their independent observations afterwards and check the use of the observational framework guide. Observations were captured through note taking and fuller writing up immediately following the training sessions.

The researchers also compared and discussed notes after sessions, taking care to explore any reactions evoked or interpretations being made.

The information from the observational sessions was also used to inform the development of the post training interviews and focus group.

### **Reflective Sessions**

One element built into the evaluation process was the use of reflective sessions. These sessions took place immediately after each of the four training sessions. They included the researcher(s) involved in observing that session, the WRAP trainer, the group's co-ordinator, a Health Scotland representative and (for the first two sessions only) the interpreter. The sessions were structured in such a way that the first part included the trainer and interpreter and the second part was reserved for the core research team.

These sessions provided an ongoing opportunity to share researcher observations and the perceptions of the WRAP trainer and those involved in supporting its delivery. Notably because the group's co-ordinator and the Health Scotland representative are South Asian it was felt they would be particularly well placed to comment on issues of cultural relevance.

As highlighted by some of the examples in Chapter 5 these reflective sessions resulted in amendments being made to the training as it progressed, making it more responsive to this particular group context. As such, this element of the evaluation design facilitated a process of active research where the emerging evaluation findings were used in an ongoing way to inform the delivery of the training.

### **Analysis and reporting of data**

All transcribed data were analysed for emergent themes. In addition, pre- and post-training interviews were compared and contrasted to help illuminate findings in relation to the impact of the training on women's thoughts, feelings and behaviours.

The findings from the observational work are mostly presented in a descriptive way. To ensure clarity around the boundary of 'what was observed' and our interpretations of this, we have presented our inferences in the form of hypotheses.

We intentionally do not attach identifiers to any quotes in this report in order to protect the anonymity of the women involved. This is particularly important in view of the small number of participants and to ensure that a reader cannot link several

quotes from the same individual as they read through the report and thereby identify who said what.

### **Triangulation of data**

The data from each of the methods used (including the trainer's reflections captured in the post training interview) were compared and contrasted. In this way we identified areas where themes were aligned across methods and also areas where differences emerged, for example differences between what was observed in the group and what women said in individual interviews.

## **Chapter 3: Pre-WRAP Focus Group**

### **Summary**

There were varying levels of understanding of the term recovery expressed within the group.

Two women personally identified with the notion of recovery applying to them.

Women described a number of factors supporting their recovery, including spirituality, a range of physical activities and social contact outside the home. Group support such as their current recovery/carers group was highlighted throughout as being particularly important.

A number of cultural themes emerged as being significant in women experiencing isolation and lack of support. These included the stigma of talking about mental health issues within the South Asian community, gender and family roles as well as the differences between South Asian and a more western culture.

A focus group was held with women 5 weeks prior to the start of training. Only four women attended and the group lasted for 55 minutes.

As with the post WRAP focus group, the intention was to explore general themes with the women, leaving the one-to-one interviews to look at more individual processes. The discussion therefore centred on understanding of recovery and the purpose of the WRAP training, what factors supported the process of recovery, with a large part of the discussion focusing on broader cultural issues, particularly in relation to mental health.

The remainder of this chapter presents the themes emerging from this facilitated discussion.

### **Understanding Recovery**

Women's communicated understanding of recovery was variable. Whilst a small number referred to the process nature of recovery, another talked more about achieving recovery from the perspective of getting better and the belief that there would be an end point:

*I think, personally speaking, I don't think I've ever attained full recovery. I can't speak for anybody else. For my own self, I've never received that full recovery. I think every morning I wake up, saying to myself, I've got this illness – when will I get better? And I do have better days, but it's not in full recovery, as much as I'd like it to be.*

From the general discussion we were unable to conclude whether *all* the women had a very well developed understanding of the term recovery as an ongoing process. Furthermore the researchers wondered if some women may have experienced

linguistic difficulties in fully communicating the concept. Two women however said explicitly that they felt the term applied directly to them as individuals.

### **Factors supporting recovery**

Women identified several factors which they believed to be helpful in the recovery process. Three women emphasised strongly the importance of support through talking to others and more specifically, the value of attending a support group such as the one to which they currently belonged. The elements of support they particularly valued within this format were a sense of social connectedness, being heard and being able to share their experiences with one another:

*Talking about the illness helps me. Coming out of the house and coming to groups like this and talking about it because how many people want to listen to you day and night about your problem and your health? You know you've got this illness – how many people really understand what you're going through? I would say not many people do and it's nice to have you, air your thoughts and you know just have a voice and a listening ear. And listen to other people who also share your problems and your health.*

*And you think you're not the only one – there are people who have the same thoughts.*

The importance of this type of structured support mechanism was a strong theme for the women that they returned to at several points throughout the focus group, and it features again later in this chapter under the context of cultural issues.

Another woman identified the importance for her of 'positive thinking' in relation to recovery and linked this to selectively listening to others who gave her positive messages about herself:

*Like for example, negative things, the reason I thought of negative things because other people has give me negative thoughts...and I mean then I stopped listening to the negative and I said, 'no, I'm gonna listen to the positive people who will give me encouragement...and I've done that so far.*

Other examples of what women believed was personally helpful in their recovery included physical activities such as yoga, walking and swimming, and being able to meet socially with other South Asian women outside of the home. One woman talked of the importance of daily prayer, and on further enquiry a further two identified prayer and spirituality as an important aspect of personal support.

### **Understanding of WRAP Training**

Some women described their understanding of WRAP training as building upon their own process of recovery. For some, this extended to a desire to help family and friends recover. Two women expressed a dual hope from the training: that they might personally benefit from the training and then in turn be able to help others:

*I'd like to be able to help myself first in trying to improve the quality of my life,*

*and then try and pass the message on to others.*

*You can only help others if you are feeling well yourself. If you're not well, you can't do any good to others.*

The women did not communicate any detailed understanding of the training, for example, around its approach, delivery or any of its key concepts. All believed it would be useful however.

### **Cultural Issues**

Cultural influence was a very strong theme which ran through much of the focus group discussion and the women themselves would often use it as a reference point which they returned to in relation to other questions. In other words, their particular cultural context was the framework within which they made sense and described much of their personal experiences and understanding.

The main themes emerging in relation to their cultural perspective were around:

- The notion of stigma within the South Asian community around mental health difficulties
- The roles of gender and family within the South Asian community
- The experience of living as a South Asian woman within a 'western' society and the sense of difference within that

### **Stigma around mental health issues**

Early on within the focus group discussion one woman spontaneously described the cultural norm of not talking about or sharing experiences within the South Asian community in relation to emotions or relationship difficulties, and expressed this in contrast to her views of a more 'western' culture:

*Because, in Asian families, you see, I don't know if it's wrong or right – we are very private, because it's a shame to talk about other family affairs or things like, it's not like Western – if you have a problem, like I used to work in a shop. A stranger come to my shop and she would tell all the story about her husband, her mother-in-law and things like that. I was amazed how she can talk about it. I don't even know her – I can't do that. That is the way we're brought up. That's the mind, or the way our mind works. So I think it's nice if we can sit together and listen to others and that's what the recovery group is – sitting together and talking and listening and learning from others.*

When invited to expand on this theme, two women described the stigma of talking specifically about mental health issues within the South Asian community, which included a strong fatalistic belief that one cannot recover from mental illness:

*I think a stigma is very strong in our society, and even having a small mental problem, people think you're not complete and, oh her, she can't understand*

anyway. Then the stigma is really hard to get by.

*Secondly, sometimes people think, they don't have knowledge there is a cure. They don't think that there is a cure – they just think that they keep to themselves. They don't go to see the doctor, they don't go to the groups and they don't discuss with their friends – they just keep it to themselves because they think that, oh, no cure, and if I tell something that's a shame. That's a bad thing for explain to myself how I feel – so that's why they keep it to themselves. So that's why this training is very important to open them up.*

Linked to this sense of stigma was the associated lack of support available within the community. One woman described how this resulted in her holding back from confiding in friends, whilst another described how she had lost a friend through the process of trying to open up more:

*I mean, I really have to watch out who I'm saying it to you know as xxx was saying, you know there are friends and I don't talk to them, say anything to them, much, actually, and I just make it, you know, something small talk – just leave it to general and that's it.*

*I lost a very close friend through my illness, recently – just didn't want to know me. Contacted her in the month of Ramadan, I sent her a message, and she sent a message back to me, but I could tell that she didn't want to have any relationship with me anymore, no friendship.*

One woman also described the stark contrast in her experience of support between having a physical condition and her mental health difficulty:

*Yeah, I XXXXX [had a physical condition] two years ago and there were visitors every two hours coming in to enquire about me, bringing me food, looking after me and my kids – and I just couldn't stop crying, because I said, "Why? What's such a difference between my XXXX [physical condition] and what's happened to my mind"*

Within the context of the stigmatised view of mental health difficulties, the women again emphasised the importance of their current group:

*..the other person can't understand how you feel. In group, if I talk to her, she understand me. She say that, because she wants to maybe learn out of it she will get something out of my conversation because she's going on the same path.*

*Groups are very, very important, yeah.*

### **Roles of gender and family**

Gender roles within the women's cultural context also emerged as a strong theme, and in particular in relation to the impact on women's mental health. Some women described how South Asian men hold the power within relationships and another expanded on this to highlight how isolating this dynamic could be for women when

they lived within a western society where they could see 'western' women having a different experience and perceiving them as having more freedom:

*It doesn't matter if woman earn more or less – that's nothing to do with that. He is the boss. He is the last, he will have the last say. Sometimes that kind of things bring you down because working in this society, if I'm working in India, because I haven't seen anything better, so that won't affect me. Working in the western culture, if I see my colleagues are more open, have more going out life and social life and I am not allowed, that could really affect my health – mentally, anyway.*

Women also described cultural expectations around their role as carers within the family, with them having responsibility for child care and caring for their husband. This was described by two of the members in such a way that suggested this position was then internalised by women so that they themselves began to feel strongly that they 'should' behave in these ways. In turn this was described as impacting on their mental health. The following two extracts of exchanges between the women illustrate this:

*Because we don't give importance to ourself how anybody else can do it, put it that way – because even husband say, "If you're no feeling well, just leave it" but feel guilty that if my husband comes home and there's no dinner on the table – even though he, I don't see that he will demand that, but being- even that way, that we have to do it.*

*Mental make up is like that, yeah.*

*Yeah.*

*And that adds to the depression.*

*Yeah.*

And:

*I think being a woman is a very hard thing, and if you say Asian woman, it's much harder*

In what way? [Interviewer]

*Oh, every way because we have more responsibilities and more demand from society from the family, because all the responsibilities are on women – so it's very hard.*

And is that the family responsibilities or financial responsibilities? [Interviewer]

*Family and...*

*Cultural.*

*Cultural – because women deal with, men are busy making money – all the responsibilities are on the woman to make up the dinners, make up the difference, move about the society, what to give to whom – I mean, she has to keep account of everything. It's her responsibility.*

And what do you think that does to her mental health? [Interviewer]



*Doesn't do it good.*

As well as gender roles, the wider field of the significance of extended family within the South Asian community, in particular the status of elders (parents, parents-in-law) was also seen as at times as contributing to isolation. This was highlighted by one of the younger members of the group who gave an example of another young woman she knew:

*Well there is one lady I know, I mean, and obviously she still, I mean, she's only a year or two younger than I am, but obviously she's having difficulties, basically, going out and, for example, if she goes out, the mother gets with her, so annoyed and says, "Where are you? When are you coming? Why are you not here?... she's old enough to have her own freedom now and her mum and dad, especially her mum, puts her down. She's not allowed to have anybody in her house, and she's not allowed to go out. If, for example, she goes out, her mother asks her too many questions one after another – and that, I mean, that gets into an argument, you know.*

In addition to this, two women gave examples of how they had felt service providers had been insensitive to the particular difficulties they faced or regarding the support they needed. This included a perceived lack of support from a G.P. during a time of crisis, and for another, prayer needs not being fully met or respected during a stay in hospital.

The commonality of experience arising from each of the above cultural themes was the resulting sense of isolation and lack of support available. Women often returned to these themes to emphasise or re-state the importance of structured support mechanisms such as their current recovery/carers group.

## **Chapter 4: Pre-WRAP interviews**

### **Summary**

One to one interviews were conducted with six women.

Two interviewees had recent experiences of serious mental health problems. Another three stated that their primary motivation for attending the training was to help others.

Most had a good grasp of the concept of recovery, and purposefully built a number of activities into their lives to look after their mental health. One woman did not seem to do so however.

Women identified significant stigma and taboo around mental health within their community, and their personal privacy was an important feature of their lives.

In this chapter we report on key issues that emerged from the one-to-one interviews that were conducted with the women prior to their participation in the training.

The findings are based on interviews with six women: one woman who went on to participate in the training did not attend for her pre-training interview.

Interviews lasted between 29 and 42 minutes.

### **Profile of interviewees**

WRAP is usually delivered to individuals who are in recovery and/or to support them in their own recovery. In the case of this evaluation, the training was delivered to women attending an existing recovery group comprising not only by individuals experiencing mental health problems but also those whose primary interest lay in supporting others.

As the focus of this evaluation is not only on the cultural appropriateness of WRAP but also on assessing how useful the participating women found it, we briefly characterise the individuals interviewed<sup>12</sup>. Our description of these individuals is deliberately of a very general nature in order to protect their anonymity.

Thus, of the six interviewed:

- two made specific reference to fairly recent episodes of hospitalisation and described themselves as currently being in recovery;
- a further one said that she had experienced poor mental health several years ago, and that although much improved, she still has bad times;

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<sup>12</sup> Note: We understand from the recovery group's key worker that the one woman who failed to attend her interview attends the group primarily in the role as a carer/support for a family member experiences mental health problems.

- three made reference to experiencing mental health problems in the past (in one case, over 20 years ago) but no longer suffered from these, and primarily attended the recovery group because of their interest in helping others.

## Understanding and defining recovery

In the interview conducted with the trainer prior to the delivery of WRAP she identified aspects of recovery that are central to the training. Thus she emphasised the importance of participants understanding that recovery is a process, that they feel positive about the potential for living a satisfying life, and that they recognise that recovery is a highly personal process:

*I think it's important to acknowledge that recovery is very individual and very unique... It's just to get people to buy in, in their individual way, the belief that things can be very different. But I think the thing I like about the programme, you know, being able to draw on your own personal experiences, that recovery isn't going onwards and upwards – it's about managing the difficulties you have in the way that actually encourages you to keep going [trainer].*

We therefore asked women what they understood by the concept of recovery. In response, five of the six women defined recovery in ways that indicated that they understood at least some of its defining elements<sup>13</sup>. Thus, these five indicating that they viewed recovery as a *process*, and not necessarily as an end point. For example:

*To me it means that you're not fully well, and it means that you're not really ill, that you're in between. Sometimes you can be, fit and well and lead a normal life, like people who don't have the illness. Other days you're low and you're down and you just want to stay in your bed, you want to be looked after generally. So recovery's in the middle, where you're up and about and doing things, but you're not 100% fit and you're not 100% way down low.*

Two acknowledged that recovery can be a very long term and highly individualised process that is relevant to people with long term or serious mental health problems. Extracts from their interviews follow:

*Well, to me, it is a long term thing to recover, and I think it's very personal, as well. Although you, you're helped by, you know, your medication and everything, but you do not recover from mental health straight after you come out of hospital, or you take medication, you know, while you take medication you're recovering – if you don't take medication anymore, you're still recovering because you don't want to go back to what you were, so you take steps not to go back, and you're still in recovery. I think it's a very long term thing. That's what I think.*

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<sup>13</sup> We take our definition of recovery as the one promoted by the Scottish Recovery Network. These are displayed at: <http://www.scottishrecovery.net/content/default.asp?page=s4>

*Well, it's anyone who's had a mental health kind of issue, and, or an illness or whatever, and is recovering – is in the process of recovering or has recovered. And it's both of them – it's not either/or. It's encompassing all of those people and recovery means different things to different people so, for you, you might be well and other people might think, oh well, no actually – she's recovering, she's not recovered. ... if you're, you know, on medication of any sort, or seeing some people, you know, like a CPN or a psychiatrist, or whatever, but it's not very often and you've come out of hospital and you're functioning fine – you're doing, getting on, having hobbies, doing voluntary work, working or whatever – seeing friends, getting on with life. So I think that is, to me, that is recovered.*

However, while five succeeded in defining recovery in ways that indicated that they understood important aspects of the concept, one woman struggled to do so. While it is important to acknowledge that her struggle with defining the concept may reflect difficulties in her ability to articulate rather than understand the concept, it seemed that she thought of recovery in terms of the benefits she accrued from attending her recovery support group rather than understanding the principle itself:

*Well recovery means to me, is a chance to talk to someone, like whoever's in the group or one to one the way we're doing now. And, to open up - I mean some certain things you can't even say in the household, you can do it in the recovery (group).*

As highlighted above, this last interviewee's inability to define recovery may simply reflect her difficulty in expressing complex concepts in the English language. Certainly, another interviewee struggled with finding the words to explain the meaning of recovery although with prompting from the interviewer she was able to demonstrate that she understood the concept.

Thus, while the majority of the interviewees had a good grasp of the concept of recovery before the training – something that the trainer felt would be important – it seemed that two may have experienced difficulties in expressing complex ideas in English.

### **Expectations of training**

We asked women to outline their expectations of the training. These were variable: when we asked women what they expected they would learn, two women said they did not know anything at all about the training, whereas the others held either a very general notion or more detailed and specific ideas about what would be involved.

Thus one woman shared her very basic understanding about WRAP, and in so doing, indicated that she understood that it would be focused on recovery issues:

*in terms of the WRAP training, it's, what was it WRAP? So it's Recovery, you know. What does it stand for again? Recovery Action Plan or something?*

Another expressed her expectations about the training in terms of the process involved by saying that it would provide opportunities to talk to other women.

By contrast, two described their expectations in far more detailed terms. One of these understood that WRAP would provide a framework for thinking about and structuring recovery, and believed that it would also equip her with new ideas or techniques:

*Well I'm sure there are things, you know, it will give me ideas on how to systematically, like, you know, to think about it, you know to, there are other things to cope in life, you know, with you know techniques and things people know. ...But if there is anything to help, any new thing, anything – also, you know, when people show you how to do it, and you listen to professionals, you know, then it's easier for you to kind of include all the techniques and things in your life, like self improvement, or whatever you're going to teach, so you know, we're going to find out.*

Both this interviewee and another stated that they expected that the training would involve the provision of information on key sources of support.

*If you knew that these are the people you could contact, they can give you help, you know? ...Anything that's existing to help people, you know, organisation-wise].*

*First thing, the people who are suffering with the mental health, they should be aware of their rights. What they supposed to do if they are ill, or the relative is ill – where do they have to go? ...I should know where to approach to help the people. And people should know, who are suffering, they should know also, because I want be all in all I have to go somewhere to get more information.*

These specific expectations (and desires) to receive information on sources of support were seen by the women to be particularly important for people in BME communities. As one explained:

*Many other people are like that (don't know where to go). Then they don't feel that we are the strangers in this place.*

### **Motivation for attending**

Interviewees expressed different reasons for wanting to attend the WRAP training.

Thus, the two individuals who had experienced more serious mental health problems and considered themselves to be currently in recovery said that they hoped that the training would be of personal use, in particular by assisting them in their own recovery. In explaining their motivation, they identified specific outcomes that they hoped the training would deliver:

*Well I hope to achieve that word 'recovery'.... so that I can, not be dependent on other people. So that I'm up and about and doing my own thing and feeling happy within myself. ... to take the gloominess away.*

*I'm hoping to have a better insight into my own illness and get information that'll help me stay better and help explain it to other people better as well, in that way.*

Three specified that their primary motivation for engaging with WRAP training was to help others, with one going on to say that while she was 'not particularly interested in sticking with the BME community' she felt that she was well placed to help them because she spoke their language.

Despite these three women's motivation to help others being the key reason for attending the training, they acknowledged that the training may be personally relevant too:

*It's like updating what I'm always learning to do, and it could help – it helps me, I know, things you always say – I don't need it anymore or anything. It's not true. You always need a little bit new things to cope with, you know? And it's not only for while you're mentally ill, the WRAP training – I'm sure becoming well is, I think, you know. And it will help people around me who got the depression as well – while I am well, and I hope I'll not be unwell again.*

One said that her motivation for taking part was self improvement more generally, and that a stimulus for her taking part was the hope that she would be awarded a certificate for her participation.

### **Current knowledge and action in relation to mental health**

The purpose of WRAP training is to help individuals:

- stay as well as possible;
- keep track of difficult feelings and behaviors;
- develop action plans to that should/will make them feel better; and to
- tell others what to do for them when they are so ill that they are unable to make decisions, take care of themselves and keep safe.

We therefore tried to identify what women did in respect of the above prior to attending the training. So we asked women what they currently do to stay well, whether they have a daily or weekly plan or structure that they follow, what makes them feel worse and/or whether they are aware of early signs that their mental health is deteriorating.

In recognition of the diverse needs of the group, in particular, that they did not all have serious mental health problems, we also asked the women what helped when they were not feeling well.

Five of the six women (including both of those who had fairly recently been hospitalised for their mental health problems) identified a wide range of positive measures that they took to look after their mental health and to stay as well as possible. Commonly they talked of the importance of an established daily routine that included attending to domestic and family responsibilities, as well as engaging in activities that were more focused on looking after themselves. Thus they talked of

the importance of a well balanced diet, getting sufficient sleep, being physically active (e.g. going for a walk, swimming, or doing yoga), of talking and/or meeting up with family and friends, and in some cases, helping others in the community. Such activities were described as deliberate and conscious attempts to stay well. For example, talking to friends and community work were described as important so as not to feel isolated.

The account below is illustrative of the extensive range of activities that these women used to stay well:

*I get out and about, so I make sure I go out for a walk and get some fresh air and make sure that I see my friends regularly so at least once a week. And I do other things like I do a XXX class, and I do some voluntary work as well. So I do, I keep some activity in my day, some structure to my day so that I've got something to get up for. I can look forward to something during the week, like seeing my friends, going out for a walk or, you know, getting some fresh air, going shopping ... And I walk a few times a week... So that's the things I do for keeping well, keeping healthy.*

By contrast, one woman had quite a limited repertoire of activities that she deliberately used to help her stay well. Instead she said that she '*just like(s) to go day by day actually*', and that going window shopping was the one thing that she purposefully did for her mental health.

Besides doing physical things to keep well, virtually all (including the woman referred to in the latter example) talked about the importance of positive thinking. For example:

*If I do negative thinking, you know, I just sit and I said no, I really have to make it into the positive you know.*

*I used to like imagine the worse all the time but no, I've learned totally to think – not to think you know the worst of things – always think positively mostly you know. So that's how I cope.*

Finally, some women also identified their spirituality as personally important, and giving them an inner strength. For example:

*Makes a big, big difference if somebody gives you the lecture on spirituality because you don't look for the God outside, God is inside. If you love yourself, you love other people, that's it.*

The women for whom spirituality was important talked about associated activities that they built into their lives such as daily prayer, speaking to spiritual leaders and watching spiritual channels on television.

Because WRAP training is intended to help participants keep track of difficult feelings and behaviours, we asked women what makes them feel worse and/or whether they are aware of early signs that their mental health is deteriorating. In WRAP terms, these would be described as 'early signs'.

Several women identified negative thinking as such early signs. For example:

*You are going on and on for the same thing again, when you think that something is annoying you or something is depressing you, you're repeating the, your brain is thinking, thinking, thinking down the same line instead of moving from the other direction.... Your concentration and focus is on one thing, negativity – negative thoughts.*

In addition, women identified a range of external factors that can make them unwell. In WRAP, such external factors are termed as triggers.

Diverse triggers were identified. For some, these concerned the behaviour of specific individuals or particular circumstances which led to feeling unheard, insecure or treated badly. In response, some talked of the importance of maintaining an open or positive mind, and of responding in ways that were likely to be constructive. For example:

*I think if somebody's annoying me and I argue with that person and that does not help me, right? If I resolve them in a nice way, polite way, I think then I will feel happy.*

Two talked of physically withdrawing in response to a particular trigger. One talked of going out for a walk while another withdrew into a room by herself and of comfort eating:

*What I do, either I eat chocolate or something to ease it down or eat one thing just after another just to try and control it or stay in the room and that's it.*

As mentioned earlier, two of the women had spent some time in hospital fairly recently. One of these talked about how powerless she felt at the point of crisis:

*There's absolutely nothing (I can do) at that stage. No plan. No structure. It's too late for that now... when I'm in the stage of being sick and unwell, it's hospitalization for me.*

## **Cultural issues**

Some of the women identified aspects of the BME community that they felt had a bearing on the training. The most frequently mentioned issue was that of the highly stigmatised attitudes to mental health within the BME community, together with a belief that these negative attitudes were more commonly experienced and more extreme in nature than those generally held in the non-BME communities, particularly for those mental health problems that involve medication (or can culminate in hospitalisation). Several also described how people with mental health problems may be rejected or ostracised by the BME community. This extract from one of the interviews is illustrative of these points:

*I think just, there's such a stigma and a taboo about mental health issues and mental illness in the, in our community that I think to talk about it and to be*



*open about it and to not be ashamed of mental illness, and see it as just another illness, like a broken leg or a broken arm, the same as that, then that, you know, in the Asian community, it's, you just see it as a big stigma, you know, a big taboo – and you don't, it's you almost become like an untouchable if you are mentally ill from your family and friends. So you don't talk about it openly and things – like myself, I have friends that know about my illness, but my family doesn't know about it and my other friends who, of the Asian background or whatever, they don't know*

What would they think about it? [Interviewer]

*They would just shun me, they would just shun me, because they don't understand and they would just think, "oh, she's mentally ill – she's retarded, she's this, she's that." And they would just not, or anybody with depression, it was quite, they treat it like maybe say "oh well, I'm depressed sometimes, you know?" It's not the same thing because I take medication for it whereas they don't. So there is, there is a difference.*

Importantly, women identified these stigmatised attitudes as impacting on their willingness to share personal details of their lives, particularly around mental health, with others from the BME community. As one woman summed it up 'BME women are very private'.

Given the importance placed on personal privacy and concerns about stigmatised attitudes to mental health, it was noteworthy that in their interviews two women disclosed details about their personal lives that they said that they had not shared with others in the recovery group, or indeed with their family and friends for fear of rejection.

Because of these issues around personal privacy, it was felt that there needed to be recognition that the training represented a big step for some women:

*There are certain ladies that, in our group that may need a bit more kind of sensitivity around their cultural aspect, and to realise that, you know, because they've been so isolated before and to come here and to come to this training and thing is a big deal for them, and it's a big step for them.*

Finally one woman suggested that language may present a challenge for some of the (other) women, and as a consequence that it would be important that the training does not involve complex or highly technical language. She suggested that the opportunity to ask questions throughout the training would be important.

## **Chapter 5: Observations of WRAP Training Sessions**

### **Summary**

Participants showed their engagement with the WRAP training through their active participation in suggested exercises, taking notes and expressing positive feedback at each session.

Over the sessions, the necessary contributions of the trainer, co-facilitator and interpreter became clearer.

There was some clarification of WRAP terms needed throughout. It was not clear from observations to what extent this was a cultural/language issue.

The group energy was higher when the women were sharing examples from their lived experience in particular regarding the constraints they faced within their own cultural context.

The crisis planning element of the training was not directly relevant to all the women in the group.

The dynamic within the group reflected the range of participants which included those with lived experience of mental health problems and others who described themselves as carers and/ with 'less serious' mental health issues past and present.

The reflective sessions were useful for sharing emerging findings and perceptions and inform the training process on a session by session basis.

None of the women had developed their WRAPS at the time of the follow up session.

The observational findings reported in this chapter are set within the context of the WRAP training package as delivered to this particular group of women.

### **The training and group context**

This WRAP training was delivered to group of predominantly South Asian women who knew each other through attendance at a recovery group and/or a carers' support group.

The WRAP training was delivered over four sessions. The original training proposal for the group was three training sessions, but as the training unfolded, this was deemed insufficient to cover all the elements of the training so a fourth training session was delivered.

At the end of the fourth session the trainer suggested that the women might require some extra support in dealing with difficult feelings which may have emerged as a

result of the training, and in their focus group, the women indicated that they would appreciate a follow up session to assist them in developing their WRAPs. To meet these needs, a further follow up session was therefore provided six weeks after the fourth training session.

The training took place over a two week period in November 2008. The training was delivered by a WRAP trainer, and the training process was supported by the group's co-ordinator. An interpreter was present for the first two and the first part of the third training sessions.

Initially, eight women were intending to participate. However, one developed an illness prior to the start of training and could not attend at all. Participation at the sessions was rather variable across sessions and is detailed below.

#### **Box 2: Breakdown of Session Attendance**

##### Session 1

Four women attended; remaining three attended short additional 'catch-up session' provided by trainer.

##### Session 2

Six women attended (one arriving an hour late)

##### Session 3

Started the session late with three women in attendance. One other member arrived 1 hour late and a further one still arrived 2 hours late although both women had communicated that they would be late; one had a viral illness and missed remainder of training (this woman had ongoing acute mental health problems)

##### Session 4

Six women attended full session.

There are also a number of features of the participants which are noteworthy in describing the context of the training and evaluation.

- They comprised individuals from pre-existing groups where members were already known to one another and relationships within the group already existed. This means patterns of relating already exist.
- There were two sets of mothers and daughters.
- They embarked on the training with a range of expectations; some stating that they wanted the training for their own mental health, while others main concern was to help others.
- There was a mix of group members. Some who experience long standing mental health difficulties including experience of hospitalisation; others who have never experienced this.

#### **Observational findings**

Using the observational framework described in Chapter 2, the following main themes emerged from the observational data.

## **Creating safety and developing group parameters**

Within the pre-training interviews women highlighted some of the difficulties which exist within the 'South Asian community' in talking openly about mental health or emotional difficulties. Therefore we identified the creation of safety within this group as one of the key areas to observe. If done well it could provide an unusual opportunity for women to feel supported in sharing with others and to engage fully with the training.

Safety in the group was addressed in a number of ways. Firstly, a 'comfort agreement' was established within the first session. This process was initiated by the trainer and then created in a collaborative manner highlighting issues such as the importance of listening to and respecting each others' views and experiences. This comfort agreement was written on the flipchart and then referred back to at each of the subsequent training sessions and follow up session.

Secondly, clear ground rules were established around the parameters of confidentiality. There was emphasis paid to suggesting participants took personal responsibility for sharing only what they felt okay to share. This issue was built upon by the trainer affirming the women to trust their own experiences, reminding them that they were *'the experts on themselves'*.

The structure of each session was also described at the outset including break times. There was no particular enquiry or request made for breaks to fit with cultural or religious practices such as prayer times.

The women's hopes and expectations were explored at an early stage in the first session. One woman described her hope as *'to live up to the expectations of this pilot scheme'*. In response to this both the trainer and group's co-ordinator both assured this individual and the group about the purpose of the training and the parameters of the evaluation. It was not clear during the training if any of the other women held this hope or fear.

Throughout the training sessions members often arrived late for sessions. On some occasions a reason was given for this, including having other commitments, a doctor's appointment and child care arrangements. However, as observers, we wonder whether this late-coming reflected:

- some pre-existing dynamic due to them being an already formed group;
- their engagement with the training;
- their wider life circumstances which created difficulty in protecting this time; or indeed, some combination of these factors.

## **Content of WRAP: Language and interpretation**

One area of prime importance within the evaluation was the exploration of how this group of women were able to understand the language of WRAP including its specific terms and concepts such as 'self advocacy', 'education', 'triggers' etc.

Women were observed to ask questions and seek clarification on a number of occasions in relation to these terms. Within the first two training sessions in particular, the interpreter and group's usual co-ordinator became very actively involved in explaining *their* understanding of the terms to the women. They were both however hearing and developing an understanding of these concepts themselves for the first time<sup>14</sup>. Throughout this process the trainer had to re-explain concepts to the group. When the interpreter became involved, speaking in Urdu, Punjabi or Hindi, this was not translated back into English. This meant that often the trainer did not then know what was being said in the discussions with the women. These difficulties around clarity of roles and interpretation are picked up again later in this chapter.

Most of the women were observed writing a lot during the explanations being given.

The trainer would often refer to her own personal experiences to help explain WRAP concepts. One instance of this was using a personal scenario to help describe what was meant by the term 'trigger'. When this approach was taken the women looked engaged and interested in what the trainer was saying and it often seemed to expand their understanding of the term in question. This was observed through them listening actively, nodding, writing and on occasion replying with reflective statements which demonstrated some understanding.

On occasion there were direct quotes from Mary Ellen Copeland shared with the group, for example, definitions of terms such as 'education' and 'self advocacy'. When these were read out the women were quiet, and asked few questions. Both researchers independently found these quotes at times difficult to comprehend on first hearing, and felt surprise that the women did not seek elucidation.

The latter concepts introduced in WRAP are around 'when things are breaking down' and 'crisis planning'. The women worked with these when they were introduced, seeking clarification and exploring meaning with the trainer. However both researchers again independently wondered about their relevance to some members of the group who have not had or did not currently experience more severe or enduring mental health difficulties. This was discussed within the reflective sessions. As a result, the concept of crisis planning was revisited by the trainer in a subsequent session. In the task of finding personal relevance to group members there were suggestions from the trainer and group members that there are times in life where it is useful to plan for a crisis generally. This seemed to mean outwith the realms of a mental health crisis.

The level of English speaking and comprehension was variable although generally high within this group of women. This was experienced through the researchers' engagement with the women in the interviews and focus groups as well as feedback from the group co-ordinator who knows the women well.

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<sup>14</sup> This observation was confirmed in the reflective sessions.

It was decided in the planning stages however to have an interpreter present during the training. As described above the group's usual co-ordinator was also present during each of the training sessions.

In the early sessions the group's usual co-ordinator was also involved in explaining terms and concepts. This was done sometimes in Urdu, Punjabi or Hindi and sometimes in English.

In the first session the interpreter sat at the table as part of the main group of women. She became heavily engaged with one group participant sitting next to her and was not used by the rest of the group. Often the level of her engagement with this one participant meant she seemed much less available to the other members of the group.

The reflective sessions were used to discuss this particular communication dynamic and it became clear that there was a lack of clarity around the relative roles of the trainer, group facilitator and interpreter.

The role of the interpreter was clarified to the group at the following session with an assurance that she was available for the whole group to use and that women should ask directly if they wished a word or phrase interpreted. Her seating position was also changed, with her purposively moved to be seated at the top of the table next to the trainer. This clarification of role resulted in the interpreter not being requested for any input by the women. Again the reflective sessions were used to discuss this. In the third session, following the realisation that the women were not using the interpreter coupled with the co-ordinator's role in explaining and clarifying the trainer's input, there was an agreement that the interpreter was not required for the remainder of the training.

### **Participation dynamics**

This section describes the observations made around women's participation within the group, changes across sessions and the ending of training.

Women were invited to share their reflections and experiences during a number of different exercises in the training. Examples included sharing ideas on what they do to keep well, identifying triggers and internal signs that make them start to feel unwell.

Group members looked as though they were listening intently to each others' contributions, sometimes making notes on what others said or suggested, or commenting on what each other said.

Throughout the sessions there was however, little deeper expressing of emotions or sharing of inner reality. There was also little facilitation or enabling this to happen. This was not acknowledged or named within the group, so the researchers were unclear about the meaning behind this observation. Hypotheses might include that we were observing:

- pre-existing group dynamics and group norms around acceptable levels of sharing

- strong cultural norms around being careful about what is shared of oneself creating an unfamiliarity with the process of reflecting and openly sharing emotional realities
- difficulties with language and in particular, being able to communicate their individual meaning and expressing emotions in a second language
- trainer's facilitation and managing of the boundary between this being a group with a training task as opposed to opening up therapeutic issues.

Only one of the above possible factors was spontaneously voiced within the group, which was the norm of not talking about mental illness or difficult emotion within South Asian communities, the stigma of mental illness and resulting isolation that can be experienced. Other group members nodded in acknowledgement and agreement with this issue when it was raised but it was not explored further in terms of how this cultural issue might be having an impact on *this group now*.

There was also a marked example observed where one member of the group with a longer history of mental ill health revealed her story of the impact on her family of her hospitalisation. This was clearly difficult for her to recall and share in the group. However, her story was followed by another member coming in very quickly and loudly with a 'related' example but which showed no empathy or connectedness with what had just been related. Both observers were left feeling the more vulnerable group member seemed rather isolated following her effort to share. Again this raised the question of having such a mix of participants in the same group.

There were several times across the sessions where the energy of the group changed markedly with members becoming more lively and animated. This occurred on two particular occasions when a group member followed by another gave very practical examples of the difficulties they faced in protecting space and time for themselves. These examples were directly related to cultural and gender expectations, for example, the expectation that family or friends can arrive unexpectedly and stay as long as they wish with the cultural belief that the women will cook and care for them. The other group members agreed in an animated fashion with this and linked it to the real difficulties they face around implementing 'self advocacy' and 'wellness' suggestions.

Other occasions where the energy of the group changed noticeably was within Session Three where there was some discussion around the idea that the women might use one another and this ongoing group as a support. Within this was the stated hope that they get to know more about one another and that they can be supported here to further develop what they are beginning to explore.

A further observation made by both researchers independently was the expressed positivism of the women throughout the training. Whenever asked how they were doing, or how they were getting on with the training, they always replied affirmatively, with feedback being generally positive. There were also ways it was reflected within some of the training approaches used; for example, focusing at the outset on one positive thing they did that week to feel good, and at the end of the training, stating one positive thing about the training.

### *Change across sessions*

In general the level of sharing, speaking out and actively seeking clarification increased across the whole body of the four training sessions although with the quieter members of the group remaining reserved and the more vocal members continuing to speak out.

The points of clarification sought tended to be around the terms and concepts belonging to WRAP but not the general language used by the trainer, although at times this seemed quite complex to the observers.

### **Methods of Working**

During delivery of the training there were several different methods of working observed:

- whole group teaching and discussion;
- small group/paired discussion; and
- working alone on writing tasks.

The researchers were interested in observing what happened when each of these approaches was used, in particular how the women were able to engage with them. This was explored further within the post-training interviews. The main things observed during the training sessions were:

- the trainer did the majority of talking within the main group;
- most of the women did a lot of writing when the trainer was talking or noting responses on flip chart paper. They even wrote down the personal examples given by the trainer, for example her own 'signs of when things are breaking down';
- when the group was asked to form pairs, the mothers and daughters within the group voluntarily paired up with others outside their family group;
- women engaged with the writing tasks when this was suggested; and
- the level of engagement of the women with one another when working in pairs was highly variable.

On occasions some pairs did not speak at all, but did their own solitary writing task within their 'pair'. At other times there was a mix of sharing and writing within the pairs. On one occasion there was highly animated discussion with little or no writing. One member of this pair reported afterwards that they were 'just chatting'. On one occasion there was a small grouping where one member was dominating the discussion while another member of the group with current mental health difficulties was very quiet with her eyes lowered through most of it.

When there was whole group discussion, or when the women provided responses and ideas, these were often captured by the trainer and written on a flip chart in English. Both of the researchers sitting at the back of the room could not read these. The women also did not seem to actively refer back to the written materials on flip



charts. The observers were left wondering how accessible a medium this was for the women.

Each woman was observed to engage with writing in their own WRAPs during the training sessions and brought their personal WRAPs along each time.

### **Reflective sessions and associated training refinements**

As described in Chapter 2, each training session was followed by a reflective session. These sessions provided an opportunity to reflect on the training on a session by session basis, with amendments being agreed and implemented as the training progressed. One example of this was being able to reflect on the role of the interpreter and implement changes as described earlier.

Another example was the opportunity to reflect upon the input on crisis planning for the group. As described earlier this particular group included only a small number of members experiencing more severe mental health difficulties. The reflections of the trainer, group co-ordinator and researchers were consistent in wondering about the direct relevance of this part of the training for all members. As a result of these reflections the trainer was able to return to this area at the following session and work more with the women on finding a point of relevance within it for each of them.

### **Follow up session**

As described earlier, an additional follow up session was scheduled for six weeks after the final training session. Five women attended this session. It was unclear whether women had an understanding of the purpose of this session. Two women referred to it as a 'focus group'. The trainer asked the women how they wanted to use this opportunity. As they did not volunteer any ideas the trainer used the time to recap on the main themes covered by the previous WRAP training sessions.

Only one woman brought her WRAP document to the session. On enquiry none of the women had looked at their WRAP or developed it since the training ended. Some said they had thought about it, others said it had been a busy time of year (over Christmas and New Year period). The women reported feeling positive over the time period since they last met and some attributed this to the WRAP training.

During discussions within this follow up session there seemed to be a shared view among the women that they would benefit from further developing their WRAPs as part of a group rather than on their own.

At this session the women also shared a number of culturally relevant examples of how their role as women within that context created real difficulties in them speaking out and getting support. There was energetic agreement among the women on this and around their shared frustration at the situation. One woman expressed it thus:

*We are still standing in the same place than when we came. India has moved on more.*

They also voiced a real need for WRAP to be available in their own language to reach into their communities to increase self awareness and '*show up what is happening*', Again, the women were animated at this idea and at the acknowledgement of some of the difficulties that they as women faced within their community to support themselves and access support for their mental well being.

## **Chapter 6: Post-WRAP Focus Group**

### **Summary**

A focus group was conducted immediately following the final training session. Six women attended.

The women valued the training particularly the opportunities to talk with other participants.

Women were able to demonstrate an understanding of some, but not all of the concepts central to WRAP.

There was a desire for a follow up session to further develop WRAPs.

The importance of personal privacy within BME communities was discussed together with some other issues deemed by the women to be culturally relevant.

Mixed preferences were evident regarding whether women would prefer BME-only groups for future training or culturally mixed ones.

A focus group was conducted immediately following the final training session as this was the time that was most convenient for the women.

Six women attended<sup>15</sup> and the focus group ran for 55 minutes.

The focus group discussion was intended to be quite general and non-intrusive with the facilitators taking care to not probe on personal issues. More detailed exploration of personal views was intentionally reserved for the follow up one to one interviews that were to be conducted nearly two months later.

Accordingly in the focus group, facilitated discussions centred on women's views of the training, their understanding of the key concepts and dimensions underpinning WRAP and their views on the utility of these, their motivation to complete their personal WRAPs, and finally their views on the cultural appropriateness of the training.

In this chapter, we report the findings in relation to each of these issues.

### **General views of the training**

All the women spoke extremely positively about the training, describing it as useful and enjoyable. Several said that they liked the structured approach of the training, with a couple saying that they valued the breadth of the training with its focus on maintaining wellbeing through to coping with a crisis.

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<sup>15</sup> Due to illness, one woman missed the last training session and the focus group that ran after it

A couple felt that the training did not so much introduce new ideas but rather reinforced and *structured* what they already knew. For example:

*It's nothing new but, to give them a shape, that's new. ... I don't say that it's anything written there which (in) back of mind is not there.*

The trainer was praised for her clarity, and the fact that she was a mental health service user herself was a source of inspiration to the women. The trainer's use of personal examples to illustrate WRAP ideas was described by one as '*making it real, very real*'.

Some highlighted the value of the training providing opportunities to hear what the other women had to say, with one identifying this as the '*best thing*', another going as far to say '*without the personal part we all shared, it would have been a bit dull*'. While there was an acknowledgement that it took time for the women to open up, one reflected on the benefit of them all knowing each beforehand:

*We also knew each other beforehand, all this group was, we knew each other so it wasn't that much a problem, because we came here before for other things. So we met before, even taking this course so it was, more easy to you know, open up and tell a little bit more about ourselves, you know it wasn't difficult. We know we can trust each other. But I think if it was a new group, a new people, that would have been really hard to open up and tell your stories.*

One woman said that she found the training intense and emotionally challenging but that she understood that this was a necessary part of the process, and reflected on the encouragement that the trainer had provided in terms of participants continuing to look after themselves:

*It's not always comfortable to go back, you know to think when you were not well makes you think back at the bad moment, about the sad moment, but it was necessary, and also XXXX (the trainer) said that the end of every session, do something good for yourself, and you know, relax and things, so that helped. Otherwise you have to you know, introspect and look inside all the past things, that's quite heavy for some people who is, you know to look back.*

### **Understanding of concepts**

A number of central concepts are discussed in the training and are central to WRAP. These are hope, personal responsibility, education, self-advocacy and support.

In the focus group, the women were asked to explain what they understood by education and self-advocacy as our observations of the training suggested that some of the women might not have fully grasped their meaning.

A very obvious limitation of using the focus group for exploring understanding was that while we were able to uncover whether *anyone* understood the various concepts, we were not able to find out *how many* did so.

## Education

Two women defined education in ways that indicated they understood its meaning in the WRAP context:

*Education is, in this sense is recognise yourself, and how to go forward. That's education. Because that's what this training is, I think it does mean that to see the crisis, to see the triggers, that's education for me.*

*For me, education is a, to learn the training, and to know about myself. And to know about other people as well.*

A third woman was unable to demonstrate whether she had in fact grasped the concept:

*That's helped the way XXXX (trainer) teach us and she give them all the time- this is education for us. I mean we learn a lot. It's no mean only you go to university or college, you learn anything that these adult education.*

The focus group facilitator encouraged others in the group to provide their definitions but they were not forthcoming, with one saying that she would prefer to just listen to what the others said.

## Self-advocacy

Several struggled to explain the meaning of self-advocacy: one responded 'self-advocacy means, first seek inside, what you are, and talk to yourself' and a second offered 'define themselves'. These two responses suggest at best quite a tenuous and limited grasp of the term's meaning.

Three women demonstrated their understanding of the concept however:

*I see self-advocacy, after doing this, like you're more strong to voice your views and what your needs are. So when you need something, you tell people, or services or you know, get the courage. Because you know now what you want, then it's easier to self-advocate, and go and say, that's what I want, the way I want it is this way.*

*Needs, and how to ask for it.*

*It's actually before you actually are, going into the crisis area, that self-advocacy would come in useful, where you know what your needs'll be, you could go to the GP, CPN, the doctor, discuss what your problem are, go to your supportive friends and family. Once you've actually got the full-blown, episode of your illness, that's when self-advocacy is- doesn't apply to you.*

One of the women who understood the concept anticipated challenges and limits around self-advocating for herself in practice:

*I just wanted to say a little thing about this, how I feel it. It's not always easy and we're not all ready- I mean I am not prepared because we've done this course, to defend myself all the time. I should- I have to learn to, ask other people to be, you know, to express my views as well you know what I mean. It's- we've learned, but you still need lots of other people, you know around you and services and everything.*

## **Elements of WRAP**

We explored women's understanding and views on the utility of the WRAP content or sections e.g. daily maintenance plan, identification of triggers and action plan etc.

Many of the women said that they found the maintenance plan a useful notion. However, from the discussions, it seemed that some women did not fully understand its meaning: instead of grasping that the maintenance plan was a highly personal tool, and predicated on an individual understanding those things that she needed to stay well, several viewed it as an imperative to be structured in the way they conducted their daily lives. These two accounts illustrate this:

*Now I learned one thing, plan your day. From the morning what you're going for doing first, then what you're doing next, what you're doing there. So that will keep me on the track, and I will have a happy day.*

*If you are not hundred percent, planning does keep you on track. You know where you are and I think it catch you before you get confused because you know what the next task is, how to go about. So daily maintenance is when we teach our children from the beginning what time to get up.....*

Surprisingly given the confusion about the maintenance plan, the more complex notion of triggers and the development of an associated action plan was well understood by four of the women, as was the distinction between these (external) events and early warning signs which are internal. This exchange from the focus group is illustrative of this:

*....Knowing the triggers, when you write them down, you're armed a little bit better to avoid them, once you've written down, you say oh, that's right, that's how I, you know, there is my weak point, that's where I become worried or these people are annoying me or how do I avoid that and you know, people you don't like or something like that, whatever it is, major or minor I think is quite useful to know the triggers.*

Can I just ask, what do you understand as the difference between the triggers and the early warning signs? [Interviewer]

*Trigger is shocking, somebody gave you shock or something you're watching on the telly, bad news like nine-eleven or earthquake or anything, that makes you, triggering you. And you right away, dead down. And other kind of trigger as well, if your married, your husband is bad, they can pinpoint, really, really*

*trigger you as well. And that's my understanding it's that, because that's how I feel you know.*

*I think triggers are external*

*Ah this is what I was going to say, trigger is external.*

*Surrounding you.*

*Early signs are hidden.*

*If you have argument with someone –that's triggers. And early warning signs, that's internal.*

The group discussions also revealed an appreciation that associated action plans are intended to prevent things escalating to crisis point. In so doing, the women revealed that they understood how the whole WRAP provides a structured and staged approach as this extract from the focus group illustrates:

*Early signs are, before we really, it's that crisis point, we can take in our hands and plan our day, somehow to get away from the situation, to go further into that depression and things like that. Or if we don't see the signs, we can go down the hill without knowing it.*

*So early signs actually help you to see in the view, and take action to prevent that happening.*

*Anybody else want to comment on that? [Interviewer]*

*Crisis is more than early warning signs, that's more stronger. But early warning signs, that's up to you. And you can rectify yourself through your WRAP. But early- crisis means that's very serious. This is what I think.*

*I think this.*

The comments from one woman however revealed her failure to understand the concept of triggers and another woman did not share her thoughts on the matter so we can not draw on any conclusions regarding her level of comprehension.

Finally an appreciation of the purpose and value of the crisis plan and post-crisis plan was evident from the accounts of four women. One felt however that there would be limits to how useful a crisis plan would be, saying '*it's not always possible*'.

Interestingly, one woman who did not experience (serious) mental health problems talked about how '*whatever I would write in my crisis plan, before writing I will let XXXXX (others) know if I am in crisis, you've got to do this*'. It is unclear whether she was offering this as a suggestion to those who might experience a crisis with their mental health or if not, what kind of crisis she was referring to.

### **The need for follow up**

Several women suggested that they would like some follow up support in developing their WRAPs. They said that they thought that it was unlikely that they would work on

these alone, and that they felt that they needed some ring fenced time, and importantly, facilitation to assist them<sup>16</sup>.

## **Cultural issues**

We asked if the women felt that there were any issues of cultural significance in any future training to BME communities.

In response, several reflected on how South Asian women can be quite private and reserved about their personal lives and how they are feeling, and for this reason they suggested that training should be taken to existing groups rather than convened with a group of strangers. For example:

*You don't know what's happening you know. It would have been a bit hard, especially in Asian community they don't open up very easily, we don't. And that, you need the group to know each other and see if you trust before you go further with the group because new people together, that will not work well.*

Mixed views were expressed however on the issue of whether groups should comprise BME individuals only. Some felt that there would be advantages in attending a South Asian-only group where participants were more likely to share similar backgrounds, gendered expectations and roles, and experiences:

*Asians should be together I think for the type of training because they have a better understanding of each other, cultural, religious and like gender differences. They have more in common and their understanding is much better, language is similar. So, I think someone from the outside, may find it a little bit - they won't benefit as much, from that type of group.*

Another highlighted how difficult it would be for people with limited English to attend a mixed group, and how such people may be the ones with greatest need due to the isolation they may experience because of these language barriers:

*See in this situation in a mixed group, for example and if the ladies cannot express themselves in English they will not understand half of the things the other ladies were going to say. It will complicate matter, it's only to bring this programme to them, like we did here. That's okay, but we could have been with a mixed group, everybody understand, we would have been very happy. It would not have changed anything today you know, this training. But for other Asian people, some who, you know, cannot express themselves in English properly or understand, for them it will be more you know, to take this programme to them because they're more in need because they're more isolated and all this.*

In the extract above, the importance is raised of taking the training out to the community. This point was reinforced by another woman: she believed that there is a cultural issue around Asian people and the extent to which they are reliant on others:

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<sup>16</sup> In response to this, a follow up session with the trainer was organised for one month later.



*They are more dependent, our people, Scottish people, or people who are born in this country even, XXXX (name of young participant), anybody here, they go out there and they go, everywhere to the doctor, they go, they read information all the time, but not the Asian ladies or men, or people who are new in this country, not Asian when I say, all the other minority, ethnic minority....*

Finally in this account and from others in the group, there was an acknowledgement that different people would have different preferences, and that younger and/or more assimilated individuals may prefer attending groups that are culturally mixed.

## **Chapter 7: Follow up interviews**

### **Summary**

One-to-one interviews were conducted with all seven training participants approximately eight to nine weeks after the end of the training.

All valued the opportunity to talk about aspects of their lives and strategies to stay well.

Most highlighted some modest changes that they had made in their behaviour since attending WRAP, with three saying that they were now pushing themselves less hard, and three saying they were being more assertive.

The training did not seem to result in purposeful plans to maintain mental health in a woman who, prior to training, talked of just taking every day at a time.

The women said that they liked and valued writing their WRAPs during the training sessions. Only one woman revisited her WRAP after the training while another suggested that she held her WRAP in her head.

Following the training, one woman listed contact details of key people to be informed in a crisis.

The fact that the training was conducted in English was not viewed as problematic.

The women said that they were happy to take part in the evaluation.

Stigmatised attitudes to mental health, personal privacy, the high level of connectedness of the South Asian community and women's roles were all identified as key cultural issues. All felt that the training should be offered more widely within BME communities.

One-to-one interviews were conducted with the women approximately eight to nine weeks after the end of the training, or two to three weeks after the additional follow up session that was attended by five of the women.

These post-WRAP interviews focused on women's views of the training, including its (perceived) usefulness for BME communities and sought to identify whether the training had affected them in any way e.g. in terms of their knowledge, attitudes or behaviour.

All seven women attended for these interviews which ranged in length from 31 to 46 minutes. This chapter presents the analysis of these interviews.

## The value of talking

The women were unequivocal in their praise for the training. All said that it was extremely useful. Such feedback was consistent with that provided in the focus group that took place immediately after the training had finished.

Overwhelmingly, the aspect of the training that the women valued most highly was in providing the opportunity for discussion: all the women described the training as useful in providing opportunities for them to talk and, importantly, to hear what the other participants had to say.

These interactions were seen to be useful in a number of ways. First, several felt that it was reassuring to hear that others shared similar experiences:

*It was good to see that when you looked across the table, others had the same feelings or the same ways of coping with their life as you had, and you suddenly stop and think that you're not the only one who's feeling this way.*

While some valued the training for bringing them to the realisation that they were not alone in their experiences and feelings, for others the opposite was the case: two women reflected that hearing how *different* their experiences were to others served to make them feel fortunate and therefore more positive about themselves. For example:

So thinking about the content of the training, what did you find useful then?  
[Interviewer]  
*First of all you know you think you're the only one. That's the first thing. And then I found myself very lucky, because I've seen worse cases than me. And I'm thinking I am a survivor... I'm quite happy because I'm out of their situation so that makes me happy that I am stronger mentally.*

Thus, irrespective of the extent to which women felt that they currently shared feelings and experiences, the fact that the training engendered discussion *in itself* seemed to contribute to feelings of personal affirmation among the women.

In addition to the self-affirming value of the discussions, many of the women talked of the 'ideas' that they obtained from hearing how other participants looked after themselves:

*What I found useful was having different points of view... and when someone said something you think, oh yes, that would be useful or that's a good way of looking at it.*

*I think it's because when you sit in a group, and you see all the people around you, and you listen to how they try and help themselves, at this period of lowness, or depression or whatever, mental health, condition they're going through, you yourself want to uplift yourself too, and you think of different ways of doing it. ....So that encouraged me too, you know. It was hearing everybody talk about, how and what helps them during their periods of lowness.*

The fact that such sharing took place was, at least in part, a *deliberate* attempt by some women to help others. In their interviews, a few individuals said that they purposefully shared experiences or ideas in the hope that doing so would be useful to others:

*I was happy to talk about my situation. And just share because I knew it would help other people, the other women that were there. ... I felt happy to share my experiences, to a point. I didn't share everything, just a little bit about what I'm doing to keep well and it helped other people and they said, "oh yes I do this certain thing, and I do a certain thing". So, you know it helps people see a different side to recovery.*

This quote also illustrates the internal process of carefully judging what and how much to share within the group.

Allied to the value that the women placed on talking to other women was the preference that many had for those parts of the training that involved group discussion.

*The group discussion was good because it sparks off discussion or points from everybody that's there. So somebody will say something and then you remember an offshoot of what they're saying, and you'll come out and once they've finished talking obviously, then you'll come out and say your point as well. Or add to it or whatever. So I found the group discussions good because everybody gets a chance to contribute.*

In contrast, more mixed or ambivalent views were expressed in relation to the work that was conducted in pairs with some women feeling that this created less potential to hear ideas that might be personally useful.

As such, we wonder whether this issue may be a reflection of the fact that the group comprised women with very different personal experiences, and as a consequence, some pairings may not have provided opportunities for mutual learning that was felt to be personally relevant or useful.

Despite these minor misgivings then, the women were unanimous in their view that the discussions engendered throughout the training were extremely useful. Therefore the training *process* was seen as helpful for all the women whatever their mental health needs.

### **WRAP as a self-management tool**

WRAP training is intended to help individuals:

- stay as well as possible;
- keep track of difficult feelings and behaviors;
- develop action plans that should/will make them feel better; and
- tell others what to do for them when they are so ill that they are unable to make decisions, take care of themselves and keep safe.

In this section we present the analysis of the follow-up interviews in relation to each of these training objectives

### **Staying well**

In their follow up interviews, the women provided examples of changes that they said that they had made to their lives since attending the training. These were: doing less (mentioned by three women); increased physical activity; making more of an effort to get out of bed; and for three, engaging in more positive and 'polite' communications.

Of the three women who said that since attending the WRAP training, they were doing less, two said that cutting back in this way was a deliberate attempt to be kinder to themselves and to not put themselves under too much pressure. These changes were directly attributed to the training. For example:

Is there anything that you think you do differently? Since the training?  
[Interviewer]

*A bit more, kinder to myself. I don't judge myself as much, you know harshly, as I did before, and so, it helps with you know things aren't as rigid. Even if they're written down and they seem... or whatever, I'm not as rigid about them, if they don't get done, it's not the end of the world, you know. I can do something tomorrow, or during that week. It's always there.*

So being a bit kinder to yourself and not being so rigid with what you've got written down. How did the training help you with that, with those differences?  
[Interviewer]

*Well that's- I mean that's, the training helped me because we explored that avenue, when we were writing up on how to be kinder to ourselves, and the different ways in which you look after yourself and that was one of those things, that you have to be non-judgmental, you have to be kinder, you have to have me-time, you have to have time to take time out for yourself. I know you'd mentioned that, and it just kind of stuck. Yeah.*

In the case of the woman who had increased her levels of physical activity, this represented a *planned/purposeful* strategy which she took with the clear intent of helping her to feel better. However, the impetus for this change was attributed to an influence outwith the WRAP training.

One of the three women who talked about engaging in more assertive communications, one explained how training had brought this about:

*It helped me to ask, to tell people how I feel. That was one barrier I think, lifted. .... I only say, in case I annoyed somebody you keep your thoughts to yourself. But this meeting and everything, it did open me up, I can see myself, and I can say things which I couldn't say before because it helped.... it helped me how to say my thoughts, which is I think quite good. Now, maybe people think I'm more assertive now, maybe that- it helped me because it- I think it gave me the right to say, right, which I think I didn't have....now I say listen, I don't agree with that. And I give my thoughts, and I used to think that if I say something they would get annoyed and the situation would go out of hand, it's nothing like that, I mean - sometimes there is, I mean because people who's*

*not- who's used to not listening, know when they've listen more, it's shocking anyway. But then if you say firmly I think it does have effective, and I'm no going to do it, I don't believe in it, if you want - you can go ahead. So that made them think, where I stand.*

As is evident in the account above, this woman makes reference to tangible ways in which the training affected her, not only in terms of increased assertiveness but also improved self knowledge and an enhanced sense of self-efficacy.

For the other two women who talked of their improved communications, these changes were either mentioned within the context of wider discourse about the WRAP training (thereby with an *inference* that these changes had come about as a consequence of this intervention) or were tentatively attributed to the WRAP training.

Importantly one of the women who talked of her increased assertiveness said that this was coupled with a sense of discomfort at behaving in a disrespectful manner to her elders. We pick up this issue in a subsequent section that focuses on cultural norms and the implications of these for training.

Finally, one woman spoke of being careful choosing to which friends she disclosed personal and sensitive matters, and although she did not attribute this to the training, her account suggests that the training helpfully *reinforced* what she was doing:

*Well again we discussed it in the training, and we had said that sometimes you have to avoid- not avoid but not see certain people, or not do certain things, that are harmful to your health, to your mental health, emotional health. And sometimes it's physical danger, you know it depends. So you don't do it. You just- because you're looking after yourself and it's okay to do that. So that's how it helped.*

The examples above relate to what the women said they did differently in relation to staying well following the training.

For the six women who were interviewed before the training and then again at follow-up, we were also able to compare their accounts at the two points in time with a view to identifying any changes. However, it is important to acknowledge here that in the interviews that were conducted prior to the WRAP training, five women provided expansive accounts of their structured, routine and purposeful activities to look after their mental health i.e. to stay well. Therefore, for these women, there may have been limited opportunity, or indeed *need*, for changes in their daily or weekly maintenance plans. Indeed, comparison of interviews before and after the training provided no evidence of changes in the nature of maintenance activities, except the mention by some (3) that they were not pushing themselves so hard.

One woman however listed reams of health-related and social activities which explicitly attributed to the training. However, all of these activities, including some of a highly specific nature, had been mentioned in her pre-training interview leaving us to wonder whether she was trying to please us - the researchers. We return to this possibility in a later section.

The woman who had talked in her first interview about how she '*just like(s) to go day by day*', and whose account suggested very little purposeful activity to stay well showed no evidence of change in relation to her (narrow) repertoire of maintenance activities. In her follow up interview, she reiterated:

Do you have a kind of daily or weekly plan or structure that you know helps you? [Interviewer]

*I just go day by, by day. You know I don't- that's one thing as well, I've tried it so many times to plan something, and like for instance if I plan something for tomorrow, and when tomorrow comes, I end up changing my mind for some reason, I don't know. Again it depends the way I've woken up in the morning.*

### **Keeping track of difficult feelings and behaviors**

One woman talked of having a 'wee book' in which she wrote down what annoyed her. While we know that she had previously used this as a diary in this way, it was not clear from the interview whether re-engaging with this activity pre-dated or followed the WRAP training.

### **Developing action plans**

In the training sessions, the women started to develop their own WRAPs. Writing these personal WRAPs was seen as useful. For example:

*I'm glad I was there for the training, and I'm glad I've got it all on paper. Like I said it's my personal reference book for me to refer back to.*

What did you find you know, most personally useful in the training? [Interviewer]

*To write the journal, you know what did we call that (laughing) the- The WRAP? [Interviewer]*

*The WRAP yeah, and to put your own personal you know, how you are as a person, before you're not- when you're well. And how you, you know, other people should perceive you when you know like, we had an example, if you're a talkative person before, and you go quiet, so if you had that in your journal, people would know yeah maybe there is something wrong with her you know. And that was quite good, you know.*

However the intention is that these WRAPs are used as active tools, and are revisited and refined over time. As such, WRAPS are intended to be tools for life.

In practice this did not happen: although the women said that they intended to look at their WRAPs some time in the future, at the time of the follow-up interviews (eight to nine weeks after the training), only one of them had done so, and only briefly. No-one had actively developed /written more in their WRAP. No-one was using it on a regular basis.

Women cited a range of reasons for having not revisited their WRAPs. Explanations included being too busy, being on holiday, feeling low, and feeling good.

Some suggested that the WRAP document per se was not what was important to them. Rather, it was the *learning* that mattered:

In the training, you all had an opportunity to develop a document, called a WRAP. What have you done with your WRAP since the training? [Interviewer]  
*What do you mean by that?*

I mean in terms of the document that you were writing in, the folder. Have you looked at it, or have you written anything else in it? [Interviewer]

*No, I think, no I haven't really no. But I- something in my mind I got it, not in the paper. Because it's really good, like tools and things like that- very good, it's lying on my bookshelf. Never had the chance to look at there, but I think, I might one day I don't know but now, what I learn is here (taps her head) it's the confidence, that's what I think.*

One said that to look at her WRAP just now would be emotionally difficult for her:

*I'll be quite honest, I haven't looked at the WRAP training. But that's a good sign for me because I'm feeling very positive at the moment. And I don't want to look at it, because there's a lot of issues there, that bring back, how it feels when I'm unwell... And because I've been so well and I've been in such a positive mood ... I'm just enjoying that period what I can, and I'm not going to look at the WRAP training.*

Two women had recorded the types of information that might be considered as *WRAP- relevant* in other places: thus, as mentioned above, one talked of having a 'wee book' in which she wrote down what annoyed her. Another had added an extended list of emergency contacts to her diary.

In summary then, there was no evidence to suggest that the women had used or refined their WRAPs, or described specific intentions or plans to do so. Many women said however that they would like future sessions to be run so that they could further develop these.

### **Tell others what to do for them when they are ill**

This last WRAP objective is of relevance to those with serious mental health problems, and therefore for two women in this evaluation. Both said that they found the crisis planning part of the training relevant, with one saying that this part of the training taught her something new:

*.... If you're ill, you just need sentences, clearly marked about what to do, how you feel, how you get out of a situation and also instructions for the doctors, what you like, what you don't like, what you... how you don't want to be treated, what you don't, who you don't want involved in your treatment and things like that, write all that down. ....That was new .... who you don't want involved you can write that, that was new. You have instructions to the doctor, and you have instructions to yourself, but you keep them simple and keep them precise, but keep them few. Fewer, fewest as possible, minimal, so that*



*you can just go to it and concentrate and read them. And that's useful to you. That idea was new.*

This woman gave a tangible example of a change in her crisis planning:

*Before the training I didn't have everybody's address and contacts, I just had one number, two numbers on my phone, but now I've got a diary with all the addresses and then names and the contact numbers and everything, so I've done that differently.*

Neither of the women had done anything after the training in terms of telling others what to do when they are so ill that they are unable to make decisions, take care of themselves and keep safe. One woman who disclosed the dramatic and upsetting circumstances that surrounded her previous admission to hospital was directly asked whether there was anyone who would know where she kept the WRAP and crisis plan that she developed in her training. She said that they would not and that she *'would have to really, go into it myself first before I could involve them'*.

## **Language**

We explored whether the women felt that they experienced any language barriers. Here too, the women were extremely positive about the training, saying that they experienced no comprehension difficulties whatsoever. In fact, even those whose English was less fluent asserted that they understood the trainer and the materials. For example:

*I'm no very good in English or maybe I think- but everything I don't need anybody explaining me, own language I could understand that very well.*  
So you understood everything then? [Interviewer]  
*Every word.*

The above quote illustrates however that this expressed confidence in ability to comprehend was at times at odds with how this was communicated to the researchers in the interviews.

In large part, the women's ability to understand the materials was directly attributed to the trainer's ability to explain difficult concepts and to the opportunities that the women had to seek clarification.

Similarly, it seemed that most, if not all, the women seemed comfortable and talking in English, and so the fact that the training was conducted in English was not described as creating problems. In fact, the general view was that the interpreter, although translating a few complex concepts, was not really needed by this group.

Again, even those whose English was less fluent felt this to be the case as illustrated in the following account from the woman who used the interpreter most frequently in the training:

Did you feel that your group needed the interpreter? [Interviewer]

*No, I don't think I need it. Maybe she clear a couple of things. I was thinking oh that's good, at least she told us. But, most of the times I don't think I need it.*

Because I just wonder what it was like, taking part in the training, when English isn't your first language? [Interviewer]

*That's right, uh-huh.*

Some of the concepts were quite difficult, how was that for you? [Interviewer]

*Yeah, okay. But sometimes if the interpreter is there, it is useful, but she came couple of days. So we just managed. But there should be.*

When you write normally, would you write in your own language or do you write in English? [Interviewer]

*In English.*

English, you write in English always? [Interviewer]

*I always write in English.*

So if you're writing a shopping list, you would do it in English? [Interviewer]

*I write in English. I don't write my own language at all in this country. No. No, no, no, no. See if somebody give me the books to read, and there are two books are lying there, in Indian language and in English, I would pick English one, .... I do everything in English. So, I can read my language, I can read, I can write. But I'm getting- I'm forgetting that language now.*

## **Cultural issues**

The women identified a number of issues that they felt were of cultural significance.

First, many talked of mental health problems being highly stigmatised. Such stigma was felt to be more acute within the South Asian community than in the wider (white) community. In particular, women talked about the stigma resulting in people with serious mental health problems being shunned and/or damaging not only personal marriage prospects but also those of family members.

Second, many talked being part of a South Asian community. Importantly this community was felt to be small and 'very connected' such that many could be linked through friends or (extended) family members, or were known through places of prayer. Thus, although the women lived in different parts of the city and its environs, there was a recognition, and importantly – concerns – that their personal business may become widely known. As a consequence, the women said that they carefully guarded their personal privacy, and were extremely circumspect regarding their choice of confidantes.

Given the highly stigmatised attitudes to mental health and their far reaching repercussions, the women talked about how, in their day to day lives, they chose to maintain their privacy about many aspects of their own mental health and that of their family members.

One woman talked at length about such concerns regarding personal disclosure in the training:

*Only thing was bothering me, there should be a confidentiality...When somebody wants to take advantage of this training, and whatever is*

*happening in the past in their lives, or in their children's life, or their circumstance, they got to be honest. ....there should be some binding, written binding, legal thing.. nobody's allowed to tell, anything outside, something like that should be there, because there's people who are taking part in that, that's their personal things. And, suppose I know I'd never mention my personal story, but we are nearly close to tell everything, our personal things. ...sometimes you're too scared in case I told this, I told that, maybe that may go in the community.*

From this account it would seem that this woman either did not understand the confidentiality agreement that the trainer wrote up at the start of the session and to which the women apparently agreed, or she did not have confidence in it. Rather, the level at which she was prepared to engage with the training appeared to be dictated not by the norms set by the trainer, but by wider cultural considerations. This was clearly a significant issue for this individual as she disclosed personal material in her interviews which she was extremely anxious that the researchers kept private from the group and which she did not share in the training: this was due to acute concerns about possible ramifications within her community.

The next cultural issue that was identified concerned women's role in the South Asian community, and as a consequence, the relevance of WRAP to their lives was called into question:

*Is different, totally different and doing something for yourself for example, like I explained that day as well that for the Asian ladies it's not easy. ....They have to cope in a different way. They will have to look after their family. People will come and go in their house as they will, you know the family. So they have to find another way to cope with that.*

More specifically some WRAP concepts such as self-advocacy and assertiveness presented challenges for the women. For example, we have already highlighted that one woman who said that following the training, while she stood up for herself, she was concerned that this might have been construed as disrespectful to her elders. Another woman reflected on the subordinate position of South Asian women within their communities, and therefore the more limited possibilities to take control of their lives:

*I think, the main difference in our culture and the Western, is the men dominate. Doesn't matter how good your husband is, he's the head of the family, you have to understand that. And then, even though we have all the rice and everything, .... It's still the second class citizen, they (women) are treated as, because what man say, that goes.*

So what implications does that have for the training? [Interviewer]

*... it's a conflict, because we see something else. Like I've been working all my life with the Asia- Scottish people, and I have so many Scottish friends as well. You want to compare yourself, you don't intend to but you want to compare their relationship with their husbands and their in-laws and things like that and with mine. And then you want to feel that, it's not fair. So that does effect- and I mean you've got to know, that can't change.*

### **'Experimenter' effects**

We asked women how they felt about taking part in the evaluation, and specifically, how they felt about being asked questions of a personal, possibly invasive nature, and how they felt about being observed as they participated in the training.

All the women said that they were quite happy to be involved, with some mentioning that they trusted that the researchers would protect their anonymity, and that they enjoyed the opportunity to open up and talk to the researchers about their feelings.

All said that they forgot about the researchers sitting in the corner observing their training.

Notably however, one woman commented:

*I don't mind at all, because I know, you people have put so much effort in it, you want to see the result as well.*

This remark suggests that she felt that the researchers, rather than being objective, had a vested interest in WRAP and were keen that it should be viewed as worthwhile training.

### **Women's ideas for future training with BME communities**

The women all said that the training should be offered to others in the BME community.

It was suggested that men should be targeted, not only for the sake of their own mental health but in order that they could better understand women and their mental health needs.

Although the women felt that they personally had little need for an interpreter, they were of the view that many people, particularly older generations, would require one. A distinction was drawn between a translator and an interpreter: as such, there was a recognition that an interpreter should be fully conversant with the training and associated concepts:

*It would help if the interpreter, had done WRAP with the people, then they could be the other tutor kind of thing, so, they weren't just interpreting, they would understand WRAP, so it would be like a partnership, in a two kind of pronged approach. Somebody speaking English, somebody speaking Urdu or Hindi or whatever language that they could speak, for the, you know interpret that way. But that they would understand the concepts of WRAP, they weren't just interpreting.*

Women held mixed views about whether WRAP should be delivered to groups of only BME individuals or to more heterogeneous groups with some saying that they would welcome the opportunity to hear non-Asian perspectives. There was a view that men would only attend men-only groups and that women, particularly first generation women, would be more comfortable in same-sex groups too.

## **Chapter 8: Discussion and reflections**

In this chapter we consider findings across the evaluation, and offer our reflections on these. In addition and as appropriate, we provide recommendations for future delivery of WRAP training to South Asian participants.

### **The evaluation in context**

Our discussion is informed by the principle of ‘realistic evaluation’ posited by Ray Pawson and Nick Tilley<sup>17</sup> who argue that the focus of evaluations, particularly those focusing on public health or social interventions should not be addressing the black and white question ‘does it work?’ Their argument is that seldom do interventions simply ‘work’ or ‘not work’. Rather most things work for some people under some circumstances, and a more fruitful line of enquiry is to uncover what works (or is likely to work) for whom and in what situations, and *why*. In this chapter therefore, we attempt to go beyond assessing whether WRAP ‘worked’ for the women in this evaluation, but get beneath the surface and consider what are the key features of WRAP that were associated with positive outcomes, and identify areas where the planned activities did not translate into the intended outcomes. By adopting this approach, we hope that our reflections and recommendations will assist in future decisions about how WRAP might be rolled out.

First however, it is important to set this evaluation in context. We consider that this evaluation has some important strengths, most notably in the depth of data that were collected and the fact that these data were gathered from different sources (focus groups, interviews, observations) and over time. Furthermore, the evaluation benefited from the fact that there were a number of opportunities to hear the views of the group’s co-ordinator, the WRAP trainer, the interpreter, as well as another member of the research steering group who performed a strategic role in relation to ethnicity and equalities issues. The fact that information from various sources could not only be triangulated (to identify common themes) but also discussed with professionals with different types of expertise was an undoubted strength.

Notwithstanding these strong points, it is important to acknowledge key limitations of this evaluation. These take two forms: the fact that an in-depth exploration of the views of a small group of women (and as such, a ‘convenience’ sample as is the case here) can never be assumed as producing conclusions that one can confidently generalise to a wider population; and the absence of a point of comparison or reference means that we are unable to consider the extent to which the findings of the evaluation of WRAP are specific to this group, or indeed a feature of the participants being BME.

As a consequence of the arguments above, we feel that there are areas where the evaluation raises important considerations for future delivery of WRAP training to BME communities, highlights which individuals and conditions are most likely to be associated with positive outcomes, and identifies areas where further enquiry would be useful.

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<sup>17</sup> Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*. Sage, London.

## Triangulated findings and implications

From our focus group (with just four women) and one-to-one interviews (with six) prior to the training it was evident that this group already had some grasp of the notion of recovery, including its central principles of hope and optimism. In some respects then the WRAP training did not introduce the women to these ideas, but rather served to restate them. However, the fact that the training was delivered by an individual with mental health difficulties and who somehow embodied the concept of recovery was taken as a key source of inspiration for the women. In turn, this reinforced the key message of hope that is central to WRAP and recovery.

Before the training, the majority of the women articulated clear steps that they already took to stay well (mentally) and realised the importance of doing these on a regular basis. Within this context it is noteworthy that these women were attending recovery/carer groups (where we anticipate some of these supports were learned). In light of this we recognise that several of the women already experienced good mental health and in fact only two members had recent experience of acute mental health problems. These group characteristics provide an important context for understanding the evaluation findings, in particular in relation to the modest changes in behaviour reported. Furthermore we suggest that in the future (and given the inevitability that finite resources will be available), consideration should be given to who are the priority target groups for future roll out.

The women consistently reported valuing the experience of this WRAP training. In particular, they liked the opportunity to hear what other women had to say including those experiences that were quite culturally specific. WRAP training engendered this helpful process. Furthermore, women enjoyed being able to contribute their ideas and experiences in order to *help others*. Other commentators have similarly observed the benefits that can be accrued by helping in this way: an increased sense of self competence, developing a sense of equality through giving as well as taking, and receiving social approval from assisting others have all been highlighted elsewhere<sup>18</sup>.

However, this leads us to wonder how useful WRAP as a tool is for these women. Within this there are two dimensions. One is around the cultural appropriateness of the key concepts underpinning and promoted within WRAP. The other is around the notion that WRAP is a written personal action plan for life.

The concept of self advocacy is one which stood out as being particularly culturally relevant, with the women providing very real examples of the difficulties they faced in applying this principle. Such difficulties can be understood, in part at least, by women's accounts of culturally proscribed roles and the dominant position held by men in their communities and families. This leads us to reflect on the cultural *relevance* of this notion for BME women. As a consequence we suggest that any future delivery of WRAP training (in its current format) to the BME community provides ample space to fully explore the possibilities and limitations of putting such

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<sup>18</sup> Salzer, M.S., & Liptzin Shear, S. (2002). Identifying Consumer-Provider Benefits in Evaluations of Consumer-Delivered Services. *Psychiatric Rehabilitation Journal*, 25(3), 281-288.

a concept into practice. In turn this prompts to reflect that if WRAP had been a tool developed *by* the BME community, would self advocacy be one of its key concepts? At the very least, it would be important that future delivery of the existing WRAP training should be purposefully aligned with women's real experience in order to strengthen personal relevance.

The second issue is that WRAP in its current format has a central emphasis on individuals developing a personal written 'tool'. While the women in this evaluation were saying clearly that where they experienced real benefit and engagement was in the process of mutual sharing and hearing from each other, none had gone on to actively develop their written WRAPs following the training. While it should be noted that the participants had been meeting for some time to consider issues of recovery and wellbeing, the sessions on WRAP in all likelihood engendered discussions on some issues (e.g. self advocacy) which might otherwise not have taken place.

Given that our interviews were conducted eight to nine weeks after the end of training we suggest it is unlikely that women will go on to develop their WRAPS independently: if this was going to happen we would have expected the women to have felt more confidence to do so soon after the training. Further support for this comes from the findings that the women expressed a desire for subsequent help with the process of developing their own WRAPS. Again this leads us to wonder if it is the *process* of coming together which was more helpful than the written tool per se and that certainly for this particular group it would better meet their needs to continue to work on their WRAPs within a supported group arrangement. Broader questions around the utility of WRAP for South Asian women would require some point of comparison, for example, research on the use and development of WRAPs by non BME individuals.

We are conscious that in any training there will be elements which are more or less useful for some participants. Within this group of women there were only two members who had recently experienced acute episodes of mental health difficulty. The Copeland Centre asserts that WRAP is useful for anyone. However, our observation that the language around 'when things are breaking down' and 'crisis planning' required a lot of clarification and work by the trainer to try to find a point of applicability for all the group members. There seemed to be a point of divergence within the training, between where WRAP could be useful for anyone, and where it becomes specifically relevant to those with more severe and/or enduring mental health problems. We suggest this issue is considered in relation to the make up of future groups, specifically the appropriateness of delivering the WRAP package as it stands to a mixed group of participants, some who have previous experience of crisis and using mental health services, and some who do not. We suggest that those likely to benefit from the current full 'WRAP package' may be those with more serious mental health problems. Therefore this particular target group (both in BME communities and more generally) should be prioritised in any future delivery. Alternatively if WRAP is to be used as a tool for a wider population, the package needs to be modified from the point at which the focus moves to ill health.

Personal privacy was identified as a key issue within the South Asian community, in particular because of the highly stigmatised attitudes to mental health problems. Throughout the evaluation, confidentiality concerns were a recurring feature. Within

this context, it was notable that some women disclosed highly personal experiences to us in their interviews that they said they had not shared with other group members, or in one case, anyone at all. Importantly, these women did not go on to share their personal experiences in the training despite there being opportunities to do so. Furthermore, in her post training interview one woman spontaneously described how her lack of trust in the confidentiality agreement recorded on the flip chart held her back from telling more of her story.

We suggest that any future training to South Asian groups acknowledges the particular confidentiality concerns that are endemic within their community, and takes strident measures to engage participants in setting and agreeing the meaning and parameters of confidentiality within the training context, and crucially, *engendering trust in this confidentiality agreement*.

This leads us to conclude that issues of confidentiality and trust should be named as a core concern at the outset of training and clearly set within a cultural context. Furthermore, time needs spent on exploring what steps must be taken as a group to create a secure enough boundary in which group members can trust, and which in turn will engender a level of participation which is meaningful for individuals. Notwithstanding these considerations we acknowledge that these cultural norms may limit the level of sharing that is likely to take place within such a group.

Some women identified cultural resources, particularly spirituality and prayer, as key resources. Given the centrality of religion within their lives, we wonder whether future training to BME women should more explicitly identify spirituality as a possible force in individuals' lives.

Prior to taking part in the training, some women said that they hoped that they would learn what services are available in their community. As such, their lack of knowledge about existing services is backed up as a common phenomenon reported in previous research<sup>19</sup>. As a consequence, future WRAP training to BME communities might usefully (where feasible) integrate information about existing services and sources of local support.

The women in this evaluation felt that they did not require an interpreter. However, some seemed to have not fully grasped the meaning of some of the WRAP concepts. While we acknowledge that this may reflect difficulties in some women's abilities to communicate complex ideas rather than problems with comprehension, there was a recognition from across the evaluation that the intervention would be strengthened by including a trainer /co-facilitator from the BME community who was fully conversant with the WRAP concepts and can explain these fully and accurately to the participants. We recommend that any future training to BME communities addresses this important issue. A further advantage of including a BME trainer is that s/he may be more attuned to cultural and religious issues.

Furthermore, we suggest that before training is delivered, there should be an assessment of the group members' language and interpretation needs in order that

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<sup>19</sup> Netto, G, Gaag, S, Thanki, M, Bondi, L and Munro, M. (2001) *A suitable space: improving counselling services for Asian people*. York: Joseph Rowntree Foundation.



an interpreter can be brought in as required. Where the services of an interpreter are deemed necessary or desirable, their role should be clear defined at the outset. As part of this role, the interpreter should keep the trainer informed of any difficulties that participants are experiencing i.e. the communication should be two-way such that the interpreter is not simply translating for the participant, but acts as a conduit from the participant to the trainer as well.

The WRAP trainer highlighted her usual practice of holding an introductory session with a group prior to training commencing. This did not occur with this group and on reflection, may have provided an opportunity to assess interpreter needs as well as explain the purpose of the training. Again, in future training with BME groups we suggest such a session takes place.

All participants said that the training should be offered to the BME community but differed in their views regarding whether the training groups should comprise only BME individuals or should be mixed. While efforts should be made to accommodate personal preferences in this regard, we suggest that a mixed group will not serve participants well where any of the individuals have language and interpretation needs. As a consequence, we suggest that the language needs of participants are considered prior to training, and on this basis, decisions can be made about whether individuals would benefit from attending a group that is supported by a BME trainer and/or interpreter.

We were struck by the overwhelmingly positive views expressed by the women in terms of the training process and the effects on them, and the fact that two women talked of being keen that they did not let the evaluation down. In view of a recent report from NHS Health Scotland<sup>20</sup> which highlights the pressure within some BME communities to present a positive face, we wonder whether the positivism that we experienced was, in part at least, explained by cultural norms and a desire to please the evaluators and trainer. We suggest that any future training recognises the heightened likelihood of positivism among some BME participants, and guards against colluding with this. For example, trainers should consider proactively encouraging participants to share not only what they like about the training, but also what they do not like so that in turn this could be used to refine their input. Given the centrality of self advocacy within WRAP training we feel the sessions themselves could be used to provide a supported opportunity for women to experiment with expressing their needs and preferences in relation to the training.

## **Final reflections**

On the basis of this evaluation we identified a real value in providing opportunity for BME women to come together to share their experiences and ideas of how to stay well. Crucially, women's experiences can only be discussed and understood in relation to the context in which they live, including the cultural norms that are pervasive in their lives.

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<sup>20</sup> NHS Health Scotland (December 2008) *Finding strength from within: Report on three local projects looking at mental health and recovery with people from some of the black and ethnic minority communities in Edinburgh*. NHS Health Scotland.

Accepting the limitations around the generalisability of the findings, we have made a number of recommendations concerning the content of WRAP training (as this related to BME women), and have highlighted considerations around its delivery. These centre on attention to:

- cultural norms within BME communities, in particular around stigma, personal privacy and trust;
- issues around language and communicating meaning; and
- the cultural appropriateness of key WRAP concepts such as self advocacy and the development and use of a personal WRAP tool.

As it stands, the training comprises elements that focus on progression to episodes of ill health. As a consequence, future delivery of WRAP training should be targeted at those for whom this full package is directly relevant, whether personally or as a carer. If decisions are taken to extend the training to a wider population, we suggest revisiting the latter sections of the training.

The women in this evaluation said that they liked the training and were keen to come together and continue engaging in facilitated discussion in relation to WRAP. On the basis of this evaluation it would seem that there may need to be some consideration about how BME women can be supported in their ongoing development and refinement of their personal WRAPs even if they simply carry these in their heads.