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Mapping mad maps and recovery tools developed by mental health service users and survivors of psychiatry: A scoping review

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3 **Mapping mad maps and recovery tools developed by mental health**
4 **service users and survivors of psychiatry: A scoping review**
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Abstract

Objectives: Since 1997, several tools based on the experiences of users and survivors of psychiatry have been developed with the goal of promoting self-determination in recovery, empowerment, and wellbeing. The aims of this study were to identify these tools and their distinctive features, and to know how they were created, implemented, and evaluated.

Design: Scoping review.

Methods: Five search strategies were used, including contact with user and survivor networks, academic database searching (Cochrane, CINAHL, PsycINFO, PsycARTICLES, SCOPUS, PubMed, and Web of Science), grey literature searching, google scholar searching, and reference harvesting. Both descriptive analysis and thematic analysis were conducted.

Results: Six tools and 35 studies were identified, most of them originating in the United States of America (USA) and United Kingdom (UK). Thematic analysis indicated that the tools had a total of six goals: Improving wellness, navigating crisis, promoting recovery, promoting empowerment, facilitating mutual support, and coping with oppression. Five of the tools were specifically designed to be used in a group setting with peers.

All the studies, but one, corresponded to applications of one tool, the Wellness Recovery Action Plan (WRAP). All of them, but one, evaluated group workshops implementations. Only 16 studies informed that the workshops were offered by peers or with peers in the training team. The most common objective of the studies was to evaluate symptom improvement. Only eight studies included users and survivors as part of the research team.

Conclusions: Only one of the tools (WRAP) has been widely disseminated and investigated. Despite the tools were designed to be implemented by peers, it seems they have been usually implemented without them as trainers. Even when these tools are not aimed to promote clinical recovery, in practice the most disseminated recovery tool is being used in this way.

Strengths and limitations of this study

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- The scoping review included both mad maps and recovery tools, and the publications that evaluated or explored these resources.
- Users and survivors' networks were consulted, including those of international scope, in order to obtain any potentially relevant material for inclusion.
- The scoping review included published articles and grey literature.
- Although different networks of users and survivors in every continent were contacted, the researchers obtained no answer from any African network or organization.

Introduction

In recent decades, mental health policy in many countries has undergone a paradigm shift towards a recovery-oriented approach. This is especially evident among Anglophone countries (1), although a similar path has been followed by several countries in northern Europe (2), and more recently by some countries or regions of southern Europe (3)(4)(5). This shift, which has been driven by international policy on mental health (6)(7), is based on the social model of disability (8)(9) and aims to comply with the Convention on the Rights of Persons with Disabilities (10), a primary goal being to promote user empowerment in mental health, both on a social/structural and individual level (11).

Although very different interventions have been implemented under the umbrella of recovery (12)(13), the main aim of all recovery-oriented programs is to enable individuals to achieve a meaningful and satisfactory life in accordance with their own preferences and values, regardless of the presence of symptoms (14)(15)(16). This feature differentiates recovery-oriented interventions from those based on the biomedical model, which is mainly oriented toward symptom control (17)(18)(19), as well as from psychiatric/psychosocial rehabilitation, the usual aim of which is the functional adaptation of the person to society (20)(21).

As recovery means living according to one's own values and preferences, promotion and respect of self-determination have been identified as "*the sine qua non of recovery-oriented practice* (p.359)"(22). Self-determination has come to be regarded as a prerequisite for personal empowerment and recovery, and for regaining control over one's own life (23)(24)(25). Accompanying a recovery process therefore implies

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3 promoting self-determination and providing people with the tools they need to direct
4 their own process and make their own decisions.
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7 In 1997, and with this goal in mind, Mary Ellen Copeland published the
8 *Wellness Recovery Action Plan (WRAP)*(26), which was followed two years later by
9 Laurie Ahern's and Daniel Fisher's *Personal Assistance in Community Existence*
10 *(PACE): A Recovery Guide* (27). Both are practical tools designed to promote self-
11 determination and the active participation of people in their own recovery process (28).
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16 Since WRAP and PACE were published, a number of new tools have been
17 developed. One of them is *Madness and Oppression* (29), that has been defined by the
18 authors as a Mad Maps Guide, rather than a recovery tool. Specifically, they described
19 them as follows:
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24 *“Mad Maps are documents that we create for ourselves as reminders of our*
25 *goals, what is important to us, our personal signs of struggle, and our strategies*
26 *for self-determined well-being (p. 1).” (29)*
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29 Both, mad maps and recovery tools are resources that were created by users and
30 survivors of psychiatry, and they were born from the systematization of the experience
31 lived by people who dealt with emotional distress, mental health crisis or psychosocial
32 diversity. Nowadays, both the users and survivors’ movements and the WHO highlight
33 the importance of the recovery tools and mad maps. From the mad activism perspective,
34 to put in value *“the knowledge based on lived experience (experiential knowledge) that*
35 *people with mental health problems can bring (p. 1).”*(30). From the WHO, the recovery
36 tools are considered essential for *“adopting recovery and human rights approaches (p.*
37 *11).”* (31). That’s why, as part of their QualityRights Initiative, in 2019 the WHO
38 published *“Person-centred recovery planning for mental health and well-being self-help*
39 *tool”* (31), a tool that *“draw substantially from WRAP (p. 2).”*(31).
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49 Despite there are different tools oriented to these objectives, only the WRAP has
50 been widely disseminated and investigated (32). Other tools are less well known, either
51 because they have not, unlike the WRAP, been used in mental health research, or
52 because they have not been applied outside the context of certain user and survivor
53 movements. Given this situation, there is a need to explore the literature to identify what
54 tools are available in addition to the well-established WRAP and beyond those
55 published in English. The scoping review method is an ideal approach for exploring and
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3 identifying programs aimed at promoting self-determination and people's active
4 participation in their recovery processes. The advantage of this method is that it
5 involves a broader exploration of the literature, integrating multiple research designs
6 and addressing questions beyond intervention efficacy (33). More specifically, it allows
7 us to explore and describe research activity, identifying gaps in relation to a particular
8 topic, before summarizing and disseminating the findings. It should also be noted that
9 integrating multiple research designs is especially useful in fields which have not been
10 systematically examined or disciplines with emerging evidence (33), as is the case of
11 the tools referred to above. Therefore, the primary aim of this study was to identify
12 existing tools, produced by users and survivors, aimed at promoting recovery,
13 empowerment, and wellness in mental health. The secondary objectives were to explore
14 the distinctive features of these tools, including how they have been created and
15 implemented. The research questions guiding this scoping review were therefore as
16 follows:
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27 (a) What tools, created by people with personal experience of mental health
28 problems and recovery, are currently available for developing personal recovery plans
29 and promoting the self-management of wellbeing?
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32 (b) What are their distinctive features?
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35 (c) How have they been created and implemented?
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39 **Methods**

40 We conducted a scoping study in accordance with a published protocol (34) and the
41 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)
42 extension for scoping reviews (35). The framework used was that developed by Arksey
43 and O'Malley (2005)(36), along with recommendations designed to enhance each phase
44 (33). This approach suggests five stages to a scoping review:
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49 Stage 1: Identifying the research question

50 As recommended by Arksey and O'Malley (2005)(36), we formulated a broad research
51 question aimed at identifying any tools created by people with any experience of mental
52 health issues. As a scoping review is an iterative process, our original research question,
53 set out in the protocol (34), was reformulated and expanded into the three questions
54 listed above: What tools, created by people with personal experience of mental health
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problems and recovery, are currently available for developing personal recovery plans and promoting the self-management of wellbeing? What are their distinctive features? How have they been created and implemented?

Stage 2: Identifying relevant studies

We started the searching process contacting networks of users and survivors, as well as some international mental health organizations. In addition, we asked them for suggestions about new networks, organizations, activists, or academics to which we could send our query. Out of the 29 networks and entities contacted, 20 responded it (69%). Contact was made by email, from July 21 to September 3, 2021. Details in Supplementary Table 1 and Supplementary Table 2.

We conducted a literature search of the following databases: Cochrane database, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, PsycARTICLES, SCOPUS, Pubmed, and Web of Science. The key search terms initially selected were: *action plan, crisis plan, crisis program, empowerment, making choice, mapping madness, Mapping Our Madness, own pace, Personal Assistance in Community Existence, taking action, Transformative Mutual Aid Practices, self-determination, self-management, recovery program, wellness, Wellness Recovery Action Plan, wellness recovery action planning*. These were tested in order to refine and add, if necessary, new terms to the search strategy (33), as a result of which we incorporated *madness* and *oppression*. The search strategy used in the Web of Science was as follows: ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative Mutual Aid Practices" OR "madness and oppression" OR "madness & oppression") in topic. A grey literature search was also conducted in the databases EThOS and System for Information on Grey Literature in Europe (SIGLE). Only the most relevant titles were extracted for the following terms: Wellness Recovery Action Plan, Personal Assistance in Community Existence, Mapping Our Madness, Transformative Mutual Aid Practices, T-MAPS, madness and oppression, and madness & oppression. The search process in these databases was conducted between 4 and 7 September, 2021.

A search for relevant articles was also conducted using Google Scholar (on 17 and 18 September, 2021), applying the same search strategy and criteria as were used for grey literature databases. Only the first 100 search results were examined. We also examined the reference lists of included articles and conducted a manual search of

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specialized journals between 19 and 22 September, 2021 (details in Supplementary Table 3). Note that all searches were conducted without date restriction and covered records from any country or reported in any language, although the reports retrieved were mostly in English. The end date for all searches was 22 September, 2021.

More details about the searching strategy and its results are given in Supplementary material.

Stage 3: Study selection

A total of 181 potentially interesting abstracts were retrieved through the aforementioned search strategies, after identifying and removing duplicates. The process of study selection involved two main stages. First, two researchers independently inspected all the records and selected those whose title and/or abstract suggested they should be included. Next, copies of the full articles were obtained and examined to assess their relevance to the research question, while also considering the inclusion criteria (see below). Any disagreement at the point of full-text screening was resolved through discussion and consensus involving a third reviewer. Our initial focus, described in the protocol (34), was refined to: Research papers, conference papers, Master's and PhD dissertations, books and book chapters, manuals, and research reports. The original inclusion criteria were also refined and resulted in the following inclusion criteria for tools:

- (a) They are aimed at promoting self-determination and empowerment of people in their mental health recovery process. Manuals, original presentation of a tool or workbooks were considered for inclusion.
- (a) They are based on the recovery model.
- (b) They are created to elaborate a personalized strategy or plan.
- (c) They are comprehensive tools for improving wellbeing and recovery, that is, they are more than just a crisis plan.
- (d) They have been developed by people who are experiencing or have experienced a mental health issue and/or by user and survivor movements.
- (e) They may be used by any person who wishes to achieve health and wellbeing.

In the case of studies about tool applications, we considered the following inclusion criteria:

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3 (a) They are documents reporting the main applications of tools in people who
4 experience any form of emotional distress and who wish to enhance their
5 wellbeing.
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9 (a) They are studies involving participants aged 18 or over.
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11 We excluded opinion articles, editorials, and protocols. Meta-analyses and reviews were
12 also excluded, although their reference lists were screened at the previous stage. Tools
13 not developed from the perspective of users and survivors of psychiatry were also
14 excluded.
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17 18 Stage 4: Data charting 19

20 A preliminary data charting framework involving 39 categories was described in the
21 study protocol (34). This included a set of categories for describing the record (e.g., type
22 of document: manual, research report), characteristics of the tool (e.g., type of
23 application: individual, group), and characteristics of the study (e.g., sample: type of
24 participant). Consistent with the fact that data charting is an iterative process in which
25 researchers extract and update data, we added one new category, *focus on*, to the
26 previous framework so as to record the main aspects addressed by each tool.
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33 In order to determine whether the resulting approach was suitable for answering
34 the research questions and could be applied consistently (33), it was tested in a sample
35 comprising 10% of the included documents. Two members of the team, working
36 independently, charted each document. Any disagreement in the process was resolved in
37 a consensus meeting involving all team members.
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42 Stage 5: Collating, summarizing, and reporting the results 43

44 As described in the framework proposed by Arksey and O'Malley (2005)(36), we
45 conducted both descriptive analysis and thematic analysis. Descriptive analysis
46 involved the calculation of numerical frequencies regarding the tools identified (year of
47 creation, countries and entities involved, and distinctive characteristics) and studies
48 describing their application (tool used, study characteristics, participants'
49 characteristics). This analysis allowed us to identify the geographical locations of the
50 literature and the main research methods used (33). In order to identify the primary
51 focus of each tool, a thematic analysis was carried out. Tools (manuals and descriptive
52 material) were organized thematically by recurring themes and points of agreement and
53 disagreement (37)(38). All documents were reviewed independently by two researchers
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and summarized to extract information on tools and their implementation. Six themes were identified: Improving wellness, navigating crisis, promoting recovery, promoting empowerment, facilitating mutual support, and coping with oppression.

Patient and Public Involvement

The study is a collaboration between an association of users and survivors of psychiatry, a university, and the local Mental Health Services Administration. The research design and development has been led by members of the user and survivors' associations. This characteristic has been crucial to contact with the representatives of the networks of users and survivors described at Stage 2.

Results

Descriptive analysis

A total of 62 records were retrieved from all the search strategies. Of these, 53 documents met the inclusion criteria: 8 were the tool itself (6 different tools in total), 8 were descriptions/dissemination of a tool, and 37 were studies reporting the main applications of these tools. Three of these 37 studies were carried out by the same research group with the same population but with different goals, and hence they were considered as a single contribution in the descriptive analysis. The selection process is illustrated in Figure 1.

Please insert Figure 1 about here.

Tools

The six tools identified were developed between 1997 and 2018, and were as follows: Wellness Recovery Action Plan (WRAP)(26), Personal Assistance in Community Existence (PACE)(27), Mapping our Madness (MoM)(39), Madness & Oppression: Paths to Personal Transformation & Collective Liberation (M&O)(29), T-MAPs, Transformative Mutual Aid Practices (T-MAPs)(40), and *Manual per a la Recuperació i Autogestió del Benestar* (MRAB; in English: Manual for Recovery and Self-Management of Wellbeing)(41). With the exception of the MRAB, all tools were developed in the USA and published in English. The MRAB was created in Catalonia (Spain) and was originally published in Catalan, with a Spanish version being published in 2020. Only the WRAP and PACE were identified through publications in indexed

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3 academic databases, with the remaining tools being found through contact with users
4 and survivors' networks.
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7 All six tools are linked to users and survivors' movements, mutual aid groups or
8 peer support services. The MoM, M&O, and T-MAPs define themselves as Mad Maps,
9 and they emerged under the umbrella of The Icarus Project network. While, the WRAP,
10 PACE, and MRAB presents themselves as recovery tools, and they are associated with,
11 respectively, the Copeland Center for Wellness and Recovery, the National
12 Empowerment Center, and the *ActivaMent Catalunya Associació*. The WRAP and
13 MRAB were created in collaboration with mental health service providers, whereas the
14 PACE, MoM, and T-MAPs were developed exclusively by their authors, who
15 systematized their own experience as members of a community of users and survivors.
16 The M&O was a collective creation, involving 77 authors and "...dozens of people who
17 wish to remain anonymous..." (p. 4)"(29). Both the WRAP and the MRAB were
18 developed through a participatory process. In the case of the WRAP, this included a
19 recovery skills seminar (30 participants) and a survey (125 respondents)(28)(42),
20 whereas the MRAB resulted from a process involving five focus groups (37
21 participants), a questionnaire (209 respondents), a one-day series of thematic debates
22 (48 participants), and ten meetings of a coordinating committee (19 members)(41).
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35 The tools include information about resources that people may wish to use in
36 developing their recovery plans. The MRAB provides links to various websites so that
37 people can explore the resources available to them locally, and it also includes a
38 workbook as supplementary material; the WRAP, MoM, M&O, and T-MAPs
39 incorporate a workbook within the manual itself. The purpose of these workbooks,
40 which include questions and answer boxes, is to help people draw up their recovery
41 plans. All the tools can, in theory, be used individually, although the WRAP, T-MAPs,
42 and MRAB have been designed to be implemented in a group workshop format with
43 peers; the PACE has also been adapted for use in this format. In the case of M&O, this
44 tool was developed exclusively for collective use. The MoM is the only tool designed to
45 be used solely on an individual basis, with or without support from others. Regarding
46 their application, the most common format for the WRAP is 8-12 sessions, whereas
47 MRAB workshops are designed for 12 sessions. T-MAPs workshops include four
48 modules, with a flexible number of sessions. The number of sessions is not specified or
49 the PACE and M&O (Table 1).
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Table 1: Tools and descriptive material

Tool	Year	Author(s)	Material included in the review	Institution and country	Objectives	Focus on
Wellness Recovery Action Plan (WRAP)	1997	M. E. Copeland	Guide and Workbook (26), tool presentations (28)(24)(42)	Copeland Center, USA	To identify the resources that each person has available to use for their recovery, and then using those tools to develop a guide to successful living that they feel will work for them (Copeland, 2004).	Recovery, wellness, crisis
Personal Assistance in Community Existence (PACE)	1999	L. Ahern and D. Fisher	Guide (27), tool presentation (43)	National Empowerment Center, USA	To facilitate a consumers' complete recovery from "mental illness" at their own pace, with an alternative noncoercive program based on the principles of recovery, peer support, empowerment, and self-help. (Ahern & Fisher, 2001)	Empowerment, recovery
Mapping our Madness (MoM)	2015	Momo	Workbook (39)	The Icarus Project, USA	To help folks map, plan, and navigate crisis, madness, or just foul moods	Crisis, wellness
Madness & Oppression (M&O)	2015	The Icarus Project	Manual and workbook (29)	The Icarus Project, USA	To create your own Mad Map, which serves as a reminder document for	Oppression, wellness, empowerment

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5						yourself and the people	
6						around you about your	
7						wellness goals, warning	
8						signs, strategies for health,	
9						and who you trust to look out	
10						for your best interests when	
11						you're struggling.	
12							
13							
14	Transformative	2018	J. McNamara	Manual and workbook	The Icarus	To offer a set of tools that	Wellness,
15	Mutual Aid		and S.	(40), tool presentations	Project, USA	provide space for building a	resilience,
16	Practices (T-		DuBrul	(44)(45)(46)		personal 'map' of wellness	oppression
17	MAPs)					strategies, resilience	
18						practices, unique stories, and	
19						community resources.	
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22							
23	Manual per a la	2018	H. M.	Manual, workbook and	Activa't per la	Facilitate the identification,	Recovery,
24	Recuperació i		Sampietro	workshops' guide	Salut Mental,	organization and management	wellness, crisis
25	Autogestió del		and C.	(41)(47)(48)	ActivaMent	of the strategies and resources	
26	Benestar		Gavaldà-		Catalunya	that people have at their	
27	(MRAB)		Castet		Associació,	disposal to develop their own	
28					Catalonia, Spain	personalized recovery and	
29						wellness plan.	
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Studies

The studies identified were published between 2005 and 2020, and all but one of them corresponded to applications of the WRAP; the other study referred to the PACE. The USA and the UK accounted, respectively, for 45.94% and 27.02% of this research output, which involved a total of 58 institutions or organizations, mainly universities (38 contributions) and mental health service providers or related government agencies (12 contributions). Only seven mutual support and peer organizations participated in the studies identified, notably the Copeland Center for Wellness and Recovery, and the Mental Health Recovery and WRAP.

The study regarding the PACE (49) was the only one to involve a self-administered application of the tool, whereas all studies of the WRAP were carried out in group workshops. Twenty-two studies reported information on how workshops were delivered: In 13 studies the workshops were offered by peers, in six they were facilitated by non-peer professionals, and three used a mixed professional/peer format.

In terms of study type, there were 20 quantitative studies, 12 qualitative studies, and three that used mixed methods. Quasi-experimental and pre/post-test studies were the most common designs in quantitative research, whereas qualitative studies mainly used Braun and Clarke's approach to thematic analysis (37)(38) or grounded theory. Data collections were carried out through questionnaires (19 studies), interviews (15 studies), focus groups (eight studies), and surveys (five studies). The most commonly used questionnaire was the Recovery Assessment Scale (50).

Only eight studies were designed and conducted by or with the participation of users and survivors in the research team (49)(51)(52)(53)(54)(55)(56)(57)(58) and a Leo McIntyre's unpublished paper (see Table 2). The remaining studies were designed and carried out exclusively from an academic or professional perspective. Research was mainly aimed at assessing symptom improvement (16 studies) or exploring self-perceived recovery (11 studies), knowledge and beliefs about recovery (6 studies), and the level of hope in recovery (6 studies).

Most of the studies focused on symptoms were conducted solely from a professional or academic perspective; the exception are three studies made by the Judith

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Cook's team (52)(56)(55)(57). Attitudes and knowledge about recovery were the main topic in studies designed or carried out in collaboration with users and survivors.

All but one of the studies assessing the efficacy of the WRAP found significant improvements in most of the variables measured. The exception was the study conducted in Hong Kong by Mak et al. (2016)(59), who only found significant improvement in perceived social support after WRAP workshops. This means that they did not observe any significant enhancement in relation to commonly measured variables such as empowerment, hope, self-stigma, social network size, symptom severity, and subjective recovery.

Fourteen studies used a psychiatric diagnosis as an inclusion criterion, and they were all conducted from a professional perspective only. The criterion in 12 of these studies was a diagnosis of a severe mental disorder, which among participants was mainly bipolar disorder, major depression, or schizophrenia. Of the remaining studies, 13 included users from mental health services. Seven studies included people with any form of emotional distress or who were interested in enhancing their wellbeing, and these participants did not self-identify as mental health service users. Three studies defined their participants as people with any experience of a mental health problem. Finally, three studies involved participants defined as from an ethnic minority and with psychosocial difficulties. More information in Supplementary Table 4.

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Table 2: Studies of the implementation of the tools

Authors	Country	Tool
Afzal, Bashir, & Perveen, 2020 (60)	Pakistan	WRAP
Ali, 2013 (61)	Palestine	WRAP
Aljeesh & Shawish, 2018 (62)	Palestine	WRAP
Ashman, Halliday, & Cunnane, 2017 (63)	UK	WRAP
Ben-Zeev et al., 2018 (64)	USA	WRAP
Carpenter-Song, Jonathan, Brian, & Ben-Zeev, 2020 (65)	USA	WRAP
Cook et al., 2009 (52)	USA	WRAP
Cook et al., 2010 (53)	USA	WRAP
Cook, Copeland, Floyd, et al., 2012 (55); Cook, Copeland, Jonikas, et al., 2012 (56); Jonikas, Grey, Copeland, et al., 2013 (57)	USA	WRAP
Cook et al., 2013 (58)	USA	WRAP
Davidson, 2018 (66)	Scotland	WRAP
Doughty, Tse, Duncan, & McIntyre, 2008 (51)	New Zealand	WRAP
Elhelou, 2018 (67)	Palestine	WRAP
Fukui et al., 2011 (68)	USA	WRAP
Gordon & Cassidy, 2009 (69)	USA	WRAP
Higgins et al., 2012 (70)	Ireland, UK	WRAP
Horan & Fox, 2016 (71)	Ireland	WRAP
Jung, Ju, Kim, & Heo, 2019 (72)	Korea	WRAP
Katayama, Morita, & Mori, 2019 (73)	Japan	WRAP
Keogh et al., 2014 (74)	Ireland, UK	WRAP
Mak et al., 2016 (59)	China	WRAP

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Matsuoka, 2015 (75)	Canada	WRAP
McIntyre, 2005 ^a	New Zealand	WRAP
O'Dwyer, 2015 (76)	UK	WRAP
O'Keeffe et al., 2016 (77)	Ireland, UK	WRAP
Olney & Emery-Flores, 2017 (78)	USA	WRAP
Petros, 2017 (79)	USA	WRAP
Petros & Solomon, 2020 (80)	USA	WRAP
Pratt, Macgregor, Reid, & Given, 2012 (81)	Scotland, USA	WRAP
Pratt, Macgregor, Reid, & Given, 2013 (82)	Scotland, USA	WRAP
Starnino et al., 2010 (83)	USA	WRAP
Stokoe & Bradbury, 2013 (84)	England	WRAP
Wilson, Hutson, & Holston, 2013 (85)	USA	WRAP
Zahniser, Ahern, & Fisher, 2005 (49)	USA	PACE
Zhang, Wong, Li, Yeh, & Zhao, 2010 (54)	New Zealand	WRAP

^a McIntyre L. WRAP around New Zealand. Unpublished Paper. Wellington: Victoria University of Wellington; 2005.

Thematic analysis

Improving Wellness

The tools identified are aimed at promoting wellness. The WRAP associates wellness with happiness, rather than with the absence of illness (26). Specifically, this tool defines wellness as the experience of feeling physically and emotionally well despite life's daily challenges (42). In the MRAB, wellness is defined as being satisfied with one's life or feeling comfortable with oneself (41). The M&O links wellness to participation in the community and its transformation (29). The T-MAPs similarly defines wellness from a social perspective, and it involves collectively building a world in which to live (46)(45). Finally, the PACE and MoM do not define the concept of

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wellness, although they include several examples of activities and resources for promoting it.

The WRAP, T-MAPs, and MRAB include a specific section for working on wellness, and some sections of the MoM and M&O are likewise aimed at helping users to reflect on or compile self-care or wellness resources. As for the PACE, it does not offer a specific section on wellness; however, under 'Recovery Skills' it addresses *Self-Care Techniques*, that is, things that people can do for themselves that make them feel good (27).

Navigating Crisis

The tools are also designed to help avoid or navigate crises, the meaning of which goes beyond the appearance of symptoms. In the WRAP, the concept of crisis refers to a loss of control over one's life (26), and symptoms come to represent a crisis when people's thoughts and feelings affect their ability to make decisions, take care of themselves, or stay safe (28). The PACE defines a crisis as overwhelming stress, difficulties in integrating experiences, and an interrupted development (43). The MoM similarly considers crises to be highly intense emotional states that affect thinking and communication (39). In the MRAB, a distinction is made between crisis as a synonym for clinical symptoms or relapse and life crises that profoundly affect a person's way of life (41). The T-MAPs conceptualizes crises both as experiences of emotional distress and as an opportunity for growth and transformation (40). Although the M&O does not define the concept of crisis, it gives several examples in sections such as: *How does oppression affect your behavior?* or *How does oppression make you sick?* (29). Regarding the MoM, it defines itself on its cover as a *Workbook for navigating crisis* (39). The WRAP, MoM, M&O, T-MAPs, and MRAB all regard crises as a fundamental issue for people to consider when drawing up their own recovery plan or map. The M&O and the T-MAPs contain specific sections oriented to reflecting on the social and structural causes of crises.

All tools, except the PACE, include specific sections dealing with knowing what to do (or not to do) to avoid a crisis, recognizing the factors that can precipitate it, and identifying red flags when it starts. The WRAP, MoM, T-MAPs, and M&O also have a section aimed at explaining to friends and relatives how the person needs and wants to

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3 be accompanied during a crisis. Another feature of the WRAP, MoM, T-MAPs, and
4 MRAB is a section on developing advance directives. Finally, the WRAP and MRAB
5 include, respectively, sections headed *Post-Crisis Plan* and *Learning Agenda*. Both are
6 focused on learning from crises, identifying what was useful and what was not.
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10 Promoting Recovery

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13 The tools are aimed at promoting recovery. The WRAP, PACE, and MRAB describe
14 themselves as a recovery plan, guide or manual, and they each include sections on
15 defining recovery and what is needed to promote it. The WRAP defines recovery as a
16 process that helps people to improve their health and general wellness, lead an
17 independent life, and reach their full potential (26). For the PACE, recovery is a healing
18 process that "*allows people to (re)capture their dreams* (p. 5)"(27) and to have an adult
19 identity and a major social role (86). The MRAB use Anthony's definition of recovery,
20 that is, a process through which a person develops new meaning and purpose in life
21 such that it becomes satisfying (14).
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30 The WRAP defines five key concepts associated with recovery: Hope, personal
31 responsibility, self-advocacy, education, and support (26). In the PACE, beliefs,
32 relationships, skills, identity, and community are considered the most important aspects
33 to work on to promote a person's recovery (27). The MRAB follows the ten guiding
34 principles of recovery set out by SAMHSA: Hope, person-driven, many pathways,
35 holistic, peer support, relationships, culturally based, trauma-based, strengths and
36 responsibilities, and respect (87).
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43 Although the WRAP stresses that recovery goes beyond the clinical or
44 functional dimension, it nonetheless defines itself as "a system for monitoring, reducing
45 and eliminating uncomfortable or dangerous physical symptoms and emotional
46 feelings" (28). Conversely, the PACE and MRAB make clear that recovery is not a
47 clinical outcome, in other words, it is not synonymous with symptom remission (41). As
48 for the T-MAPs, it does not aim to help the person return to a previous state of health,
49 and instead it uses the concepts of transformation and resilience practices and promotes
50 "*a process of transformation and growth* (p. 3)"(40). The MoM and M&O do not use
51 the concept of recovery or any equivalent. In the case of the MoM, users are encouraged
52 to question interventions that seek to return them to some form of normality, rather than
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accepting and supporting “*the different ways that all of our minds and bodies may function (p. 2)*”(39).

Promoting Empowerment

The tools are resources that help to promote a process of empowerment. The PACE is specifically “*based on the Empowerment Model of Recovery (p. 16)*”(27), while the MRAB is described as a model of self-management, self-determination, and self-control aimed at promoting empowerment. The latter tool includes a section called *Personal Growth Plan*, defined as “*the personal strategy of empowerment (p. 18)*”(41).

For the PACE, empowerment means “*moving from dependence to self-determination (p. 91)*”(86), such that people take control of the important decisions that affect their lives and come to see themselves as competent members of society.

Four tools are primarily aimed at promoting empowerment on a personal level, which includes: Promotion of self-determination, self-management, and taking responsibilities (WRAP, PACE, MRAB); self-awareness, self-help, self-advocacy (WRAP, PACE); building self-esteem and personal confidence (WRAP, PACE); developing a positive sense of identity (not a sick role), challenging self-stigma (WRAP, PACE, MoM, MRAB); and creation of a meaningful life (WRAP, MRAB). By contrast, the M&O and T-MAPs seek primarily to promote empowerment at the social level, including identification of and reflection on the social structures of power, privilege, and oppression, in addition to promoting participation in transformative collective practices in the community (29)(40).

Facilitating Mutual Support

All tools highlight the importance of mutual support or peer support practices for recovery, resilience, empowerment, and/or the social change processes they seek to promote. This is made explicit in the name given to one of the tools, Transformative Mutual Aid Practices (T-MAPs), whose authors describe it as “*our attempt to help create a concrete framework for mutual aid (p. 33)*”(40).

The PACE, M&O, T-MAPs, and MRAB dedicate a section to exploring and promoting participation in mutual support or peer activities. The WRAP, in its updated edition, also includes a section called *Appendix B: Peer Support* (26). As for the MoM,

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3 although it highlights the value and importance of mutual support, it does not include a
4 specific section on this.
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7 The M&O and T-MAPs suggest that users share their own maps with other
8 people in mutual support meetings.
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11 Coping with Oppression 12 13

14 Some of the tools aim to encourage reflection on the axes of oppression that affect
15 emotional wellbeing. For instance, the M&O and T-MAPs include different sections for
16 people to work individually and collectively on the specific axes of oppression that
17 affect them (racism, sexism, ableism, classism, etc.). In the case of the M&O, all the
18 material is aimed at identifying the different forms of oppression that people encounter
19 in life, and at helping them to recognize both how this oppression affects their wellness
20 and how it can be responded to.
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28 The PACE and MoM do not have a specific section dedicated to oppression,
29 although they do include some reflection on the role of social, economic, and cultural
30 factors in the incidence of mental disorder and in recovery processes, highlighting the
31 pathological effects of different forms of oppression. The PACE, M&O, MoM, and T-
32 MAPs consider the institution of psychiatry itself as an axis of oppression.
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38 **Discussion** 39 40

41 This study aimed to identify and characterize tools developed by users and survivors of
42 psychiatry and aimed at promoting recovery, empowerment, and wellness. The scoping
43 process identified six tools developed between 1997 and 2018, and a total of 37 studies
44 published between 2005 and 2020. Five of the six tools originated in the USA and were
45 originally published in English, the exception being the MRAB, which was developed
46 in Catalonia (Spain) and published in Catalan. Three tools present themselves as a Mad
47 Map and the other three as a Recovery Guide or Manual. Contact with networks of
48 users and survivors proved crucial to discovering the tools, because only the WRAP and
49 PACE were found in database searching. All tools emerged within the context of user
50 and survivor movements, although their process of development varied depending on
51 the movement. In addition to users and survivors, mental health service providers were
52 also involved in developing the WRAP and the MRAB.
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3 Of the 37 studies identified, they all, with the exception of one that involved the
4 PACE, used the WRAP program and were delivered as group workshops. The latter was
5 a crucial aspect of the WRAP program for many studies (69)(54)(81)(82)(78)(63)(79), it
6 being considered that a group setting offers specific benefits: “...*mutual identification,*
7 *validation and support that emerges from delivering WRAP in a group environment* (p.
8 576)”(63). Several studies also regard peer-run workshops as being a key aspect of the
9 WRAP (76)(78)(66)(72), it being argued that peer facilitators serve as models and
10 examples of recovery, improving participants' hope (66). However, fewer than half of
11 the studies reported that workshops were delivered by peers or with peers in the team.
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20 Anglophone countries, primarily the USA and the UK, were the main
21 contributors to research in this field. Only seven studies were carried out in non-
22 English-speaking countries, namely Palestine (61)(62)(67), China (59), Japan (73),
23 Korea (72), and Pakistan (60). Contrary to most findings, one of these studies (59) only
24 observed a significant improvement in perceived social support after WRAP workshops.
25 It should also be noted that only three studies aimed to explore the applicability of the
26 WRAP program in an ethnic minority (69)(54)(75). Two of these (69)(75) suggest
27 integrating a critical analysis of oppression and a gender perspective in workshops, a
28 focus which is not incorporated in the WRAP.
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36 Quasi-experimental and pre/post-test studies were the predominant designs in
37 quantitative research, whereas qualitative studies were mainly characterized by the use
38 of grounded theory or Braun and Clarke's approach to thematic analysis. Sample sizes
39 varied across the studies, as did the criterion for inclusion, with some authors requiring
40 an established diagnosis, while others included people reporting any kind of emotional
41 distress. Universities and mental health services were the main institutions involved in
42 the research. Although user and survivor organizations, such as the Copeland Center for
43 Wellness and Recovery, and the Mental Health Recovery and WRAP, also contributed
44 to research output, the professional and academic perspective was predominant. Thus,
45 while the tools themselves are the result of survivor research (30), most of the studies
46 were designed and conducted without the participation of users and survivors.
47 Moreover, even though recovery-oriented resources are not aimed at clinical recovery
48 (14)(15)(16), the predominant focus of these studies was symptom reduction; notably,
49 the few studies that did incorporate the perspective of users and survivors were focused
50 instead on attitudes and knowledge about recovery. In a similar vein, although there are
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3 numerous psychometric instruments aimed at measuring recovery (88)(89), only two of
4 those used in the studies were designed by or in conjunction with users and survivors as
5 part of the research team: Doughty et al. (51), and the Minnesota' Survey in Cook et al.
6 (53). This illustrates how the perspective adopted by most of the studies does not take
7 into account the epistemological and theoretical background of the tools used. Indeed,
8 the studies tend to use the tools in a way akin to a psycho-educational program, rather
9 than as tools built from people's experiential knowledge of their recovery processes.
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16 Thematic analysis identified a total of six goals that form the primary focus of
17 the tools: Improving wellness, navigating crisis, promoting recovery, promoting
18 empowerment, facilitating mutual support, and coping with oppression. The first two of
19 these goals, improving wellness and navigating crisis, are common to all tools, each of
20 which acknowledges their importance and includes sections dedicated to working on
21 these goals and/or strategies and examples of how to achieve them. The importance of
22 mutual support for recovery, empowerment, and/or coping with oppression is also
23 highlighted by all six tools, and five of them were specifically designed to be used in a
24 group setting with peers. Although some tools do not explicitly use the concept of
25 *empowerment*, they all aim to promote it on some level (11); the WRAP, PACE, MoM,
26 and MRAB promote certain aspects of personal empowerment, while the M&O and T-
27 MAPs do the same with social empowerment. As regards the other two goals (i.e.,
28 promoting recovery and coping with oppression), the tools differ in the stance they take.
29 The M&O and MoM do not use the concept of recovery, and the T-MAPs refers to
30 resilience rather than recovery, the reason being that these tools consider that the idea of
31 'recovery' suggests a return to a previous stage or to some state of supposed normality.
32 Other tools (the MRAB) do refer to recovery but explicitly state that it does not mean
33 going back to the past or being *normal*. Finally, coping with oppression is a specific
34 focus of the M&O and T-MAPs, and it is also referred to at some point by the MoM and
35 PACE. By contrast, the WRAP and MRAB do not offer any kind of reflection on the
36 mental health system as a possible axis of oppression or on the negative effects of
37 different kinds of oppression on people's wellbeing. Coincidentally, these are the only two
38 tools to have been created in collaboration with mental health service providers.
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57 Although the search process allowed us to identify and characterize tools created
58 by users and survivors, certain gaps and limitations emerged. Notably, although this
59 scoping review applied broad parameters and used several search strategies to map tools
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3 and their associated studies, the tools identified were developed, and most of the studies
4 were conducted, in high-income countries with a recovery-oriented mental health
5 system, in which there are well-established networks of users and survivors, and an
6 Anglo-Saxon/Protestant cultural background that highlights individual freedom and
7 self-determination (90). Therefore, the trends identified in the literature should be
8 considered as representative of these kinds of contexts. More studies are needed to
9 clarify the applicability and utility of the tools identified in other cultural contexts and
10 for ethnic minorities. Furthermore, although we contacted different networks of users
11 and survivors, including those of international scope, in every continent, we obtain no
12 answer from any African network or organization. This hindered the possible
13 identification of additional material and the opportunity both to compare the recovery
14 strategies used in non-Western contexts and to explore the extent to which the concept
15 of recovery itself is applicable in those contexts.
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26 Further research is likewise needed to examine the application and outcomes
27 achieved with tools other than the WRAP. Once such studies begin to be conducted, it
28 would be also be interesting to observe how they conceptualize recovery, wellness,
29 crisis, empowerment, oppression, and mutual support, and to see if they follow the
30 original proposals of the tools' authors or focus on evaluating different variables.
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36 The underlying philosophy of the disability rights movement worldwide,
37 "*Nothing About Us Without Us*" (91), is the foundation of the tools built by user and
38 survivor movements. However, very few studies have included users and survivors as
39 subjects of knowledge, recognizing and valuing their personal and collective experience
40 as a source of learning, rather than seeing them as objects of intervention. A priority for
41 future research is therefore to ensure the participation of users and survivors in the
42 design, implementation, and assessment of mental health recovery tools. Given that
43 existing tools have come about thanks to the initiative of user and survivor networks, it
44 is also important that this research is carried out from the perspective of survivor
45 research and mad studies.
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54 **Contributors:**

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57 HMS developed the conceptual framework, carried out the thematic analysis and wrote
58 the first draft of the manuscript. VRC conceived the methodological framework and
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assisted with subsequent drafts of the manuscript. HMS and VRC performed the search process and the study selection, coded the data, and developed the descriptive analysis. JG-B assisted in the study selection and the process of coding. JG-B and JER supervised and provided regular feedback on each of these steps and contributed to revision of the final manuscript.

Competing interests:

No competing interests.

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Data sharing statement:

Data are available upon reasonable request. Contact email: projectes@activament.org.
Data available: results of database searching, grey literature searching, Google Scholar searching, list of journals reviewed, networks of users and survivors contacted, and data analysis tables. Reuse of data is permitted.

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3 **Ethics Approval:**
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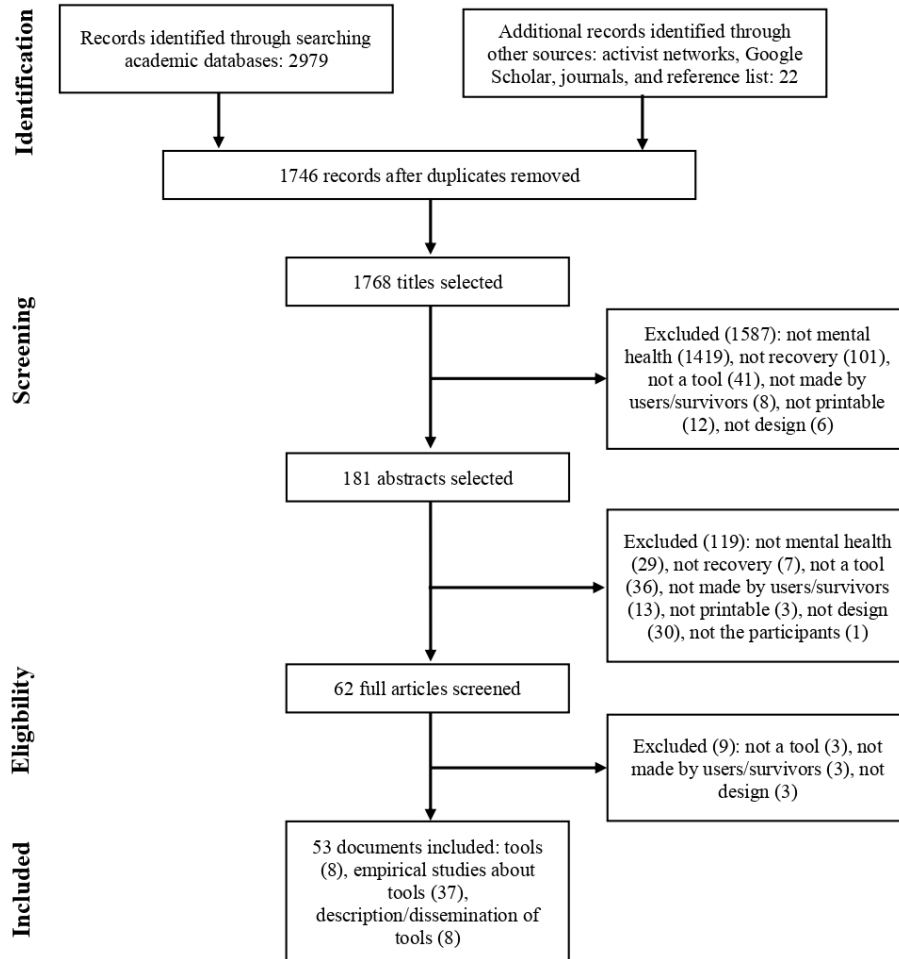
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6 This study does not require ethical approval because the data used are from publicly
7 available materials.
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10 **Figure Legend**
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13 Figure 1 - Selection process for study inclusion.
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Prisma Scoping Review-Figure 1

89x98mm (300 x 300 DPI)

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Mapping mad maps and recovery tools developed by mental health service users and survivors of psychiatry: A scoping review

Supplemental material: (a) Complete data collection strategy and study selection detailed; (b) Descriptive characteristics of the studies

From July 21 to September 3, 2021, we started the searching process contacting international and national **networks of users and survivors**, and international **mental health organizations**, with the aim of identifying suggested tools to be included in our Scoping Review. In addition, we ask for suggestions from new networks, organizations, activists, or academics to whom we could send our query.

Finally, we contacted 29 networks or entities, of which 20 responded (69%). We also contacted at least one of the authors of each of the identified tools (except Mary Ellen Copeland).

Supplementary Table 1: International organizations and networks of users and survivors contacted

International Mental Health Organizations contacted		
1	World Health Organization	Michelle Funk
2	Mental Health Europe	Catherine Brogan
3	Disability Rights International	Laurie Ahern ¹
Organizations and networks of users and survivors contacted		
4	World Network of Users and Survivors of Psychiatry	Salam Gómez
5	European Network of Users and Survivors of Psychiatry	Olga Kalina
6	Redesfera Latinoamericana de la Diversidad Psicosocial	Cecilia Guillén
7	Transforming Communities for Inclusion – Asia Pacific	Bhargavi Davar
8	Center for the Human Rights of Users and Survivors of Psychiatry	Tina Minkowitz
9	Global Mental Health Peer Network	Charlene Sunkel
10	Taiwan Mad Alliance	Lee Yun
11	Korean Alliance for Mobilizing Inclusion of the people with psychosocial disabilities	Oh Yong Kweon

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12	Inclusive Asia, Hong Kong	Chine Chan Yan
13	Fireweed Collective, USA	Agustina Vidal ²
14	The Icarus Project NYC, USA	Kevin Mark
15	Balance Aotearoa, New Zealand	Leo McIntyre
16	Intentional Peer Support	Chris Hansen
17	Hearing Voices Network	Olga Runciman
18	We shall overcome, Norway	Mette Ellingsdalen
19	Sagatun Brukerstyrt Senter, Norway	Kårhild Husom Løken
20	ActivaMent Catalunya Associació, Spain	Carla Gavaldà-Castet ³
Other activists and academics contacted		
21	Mapping our Madness (author)	Momo
22	Personal Assistance in Community Existence (author)	Laurie Ahern* ¹
23	Madness & Oppression (author)	Agustina Vidal* ²
24	Transformative Mutual Aid Practices (author)	Sascha Altman DuBrul
25	Manual per a la Recuperació i Autogestió del Benestar (author)	Carla Gavaldà-Castet* ³
26	Peer Services and Research, Yale School of Medicine	Chyrell Bellamy
27	Collaborative Support Programs of New Jersey	Margaret Peggy Swarbrick
28	University of Nottingham	Mike Slade
29	University of Pittsburgh	Nev Jones
30	Mental Health Engagement & Recovery Office, Ireland	Michael John Norton
Other Organizations contacted (without answer)		
31	Pan African Network of People with Psychosocial Disabilities	
32	Users and Survivors of Psychiatry in Kenya	
33	Tanzania Users and Survivors of Psychiatry Organization	
34	Advocacy Centre of Persons with Psychosocial Disability, Japan	
35	Copeland Center for Wellness and Recovery	

¹ Laurie Ahern, co-author of Personal Assistance in Community Existence, and President of Disability Rights International

² Agustina Vidal, coordinator of Madness & Oppression, and contact of Fireweed Collective.

³ Carla Gavaldà-Castet, co-author of Manual per a la Recuperació i Autogestió del Benestar, and member of the research team of ActivaMent Catalunya Associació.

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36	National Empowerment Center
37	Monash University
38	UKE Hamburg
39	OnTrack NY

At this step, 9 tools (with 12 documents) were suggested for the Scoping Review.

Supplementary Table 2: Tools suggested, and decisions made

	Tool suggested	Inclusion	
1	Wellness Recovery Action Plan (Copeland, 1997)	Yes	1
2	Personal Assistance in Recovery Existence (Ahern & Fisher, 1999)	Yes	1
3	Madness & Oppression (The Icarus Project, 2015)	Yes	1
4	Mapping our Madness (Momo, 2015)	Yes	1
5	Transformative Mutual Aid Practices. (McNamara & Dubrul, 2018)	Yes	2
6	Manual per a la Recuperació i Autogestió del Benestar (Sampietro & Gavalda Castet, 2018)	Yes	3
7	Pathways to Recovery: A Strengths Recovery Self-Help Workbook (Ridgway et al., 2011)	No	1
8	Better Days - A Mental Health Recovery Workbook (Lewis, 2013)	No	1
9	The Toolbox of Sagatun User-Led Centre (n.d.)	No	1

Two of these suggested materials did not meet the inclusion criteria. Pathways to Recovery (Ridgway et al., 2011) is not a tool developed by people who are experiencing or have experienced a mental health issue and/or by users, ex-users and survivors' movements. Better Days (Lewis, 2013) it is a tool designed to promote a personal reflection and self-learning, but it is not made to elaborate a personalized strategy or a plan (that can be implemented and evaluated). Finally, the Toolbox of Sagatun User-Led Centre (n.d.) was suggested, but it is not available for private use or download, and we could not assess its inclusion in our research.

From September 4 to September 7, 2021, we made a searching using Boolean operators, in 7 **academic electronic databases** and 2 **grey literature databases**. The following separate searches were performed:

Database: **Scopus**. Data searched: 2021-09-04.

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1
2
3 Search terms: (Search in Title, Abstract, Keywords) ("Wellness Recovery Action Plan*"
4 OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR
5 "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness
6 and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR
7 TITLE ("empower*" OR "self determination" OR "self-determination" OR
8 "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak*
9 choice*" OR "tak* action") AND TITLE-ABS-KEY ("crisis plan*" OR "action
10 plan*" OR "action program*" OR "crisis program*" OR "recovery plan*" OR
11 "recovery program*" OR "map* mad*" OR "own pace") AND NOT TITLE
12 ("diabetes" OR "asthma" OR "epilep*" OR "Dementia" OR "pulmonary disease"
13 OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease" OR
14 "Bowel disease" OR "cultural").

15
16
17 Database: **PsycInfo**. Data searched: 2021-09-04.

18
19 Search terms (Search in Abstract): ("Wellness Recovery Action Plan*" OR "Personal
20 Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative
21 mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression"
22 OR "Manual per a la Recuperació i Autogestió del Benestar") OR ("empower*" OR
23 "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR
24 "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis
25 plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery
26 plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes"
27 OR "asthma" OR "epilep*" OR "Dementia" OR "pulmonary disease" OR "COPD" OR
28 "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

29
30 Database: **PsycArticles**. Data searched: 2021-09-04.

31
32 Search terms (Search in Abstract): ("Wellness Recovery Action Plan*" OR "Personal
33 Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative
34 mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression"
35 OR "Manual per a la Recuperació i Autogestió del Benestar") OR ("empower*" OR
36 "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR
37 "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis
38 plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery
39 plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes"
40 OR "asthma" OR "epilep*" OR "Dementia" OR "pulmonary disease" OR "COPD" OR
41 "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

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plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes"
OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR "COPD" OR
"Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

Database: **PubMed**. Data searched: 2021-09-04.

Search terms (Search in Title, Abstract): ("Wellness Recovery Action Plan*" OR
"Personal Assistance in Community Existence" OR "Mapping Our Madness" OR
"Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness
and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR
("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self
manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action")
AND ("crisis plan*" OR "action plan*" OR "action program*" OR "crisis program*"
OR "recovery plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT
("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR
"COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

Database: **CINAHL**. Data searched: 2021-09-05.

Search terms (Search in Topic + Search in Abstract):

- a- In Topic ("Wellness Recovery Action Plan*" OR "Personal Assistance in
Community Existence" OR "Mapping Our Madness" OR "Transformative
mutual aid practices" OR "Madness & Oppression" OR "Madness and
Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") NOT
("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR
"COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").
- b- In Abstract ("Wellness Recovery Action Plan*" OR "Personal Assistance in
Community Existence" OR "Mapping Our Madness" OR "Transformative
mutual aid practices" OR "Madness & Oppression" OR "Madness and
Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR
("empower*" OR "self determination" OR "self-determination" OR "wellness"
OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR
"tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*"
OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map*
mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*"

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"Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR
 "Parkinson" OR "Cardiovascular disease").

Database: **Cochrane Library**. Data searched: 2021-09-06

Search terms (Search in Title, Abstract, Keywords):

- a- ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar").
- b- ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

Database: **Web of Science**. Data searched: 2021-09-07.

Search terms (Search in Topic + Search in Abstract):

- a- In Topic ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") NOT ("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").
- b- In Abstract ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*")

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OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map*
mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*"
"Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR
"Parkinson" OR "Cardiovascular disease").

Database: **Ethos**. Data searched: 2021-09-07.

Search terms (Search in Abstract): ("Transformative mutual aid practices" OR
"Mapping our Madness" OR "Wellness Recovery Action Plan" OR "Wellness
Recovery Action Planning" OR "Personal Assistance in Community Existence" OR
"Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la
Recuperació i Autogestió del Benestar").

Database: **SIGLE**. Data searched: 2021-09-07.

Search terms (Search in all): "Transformative mutual aid practices", "Mapping our
Madness", "Wellness Recovery Action Plan", "Wellness Recovery Action Planning",
"Personal Assistance in Community Existence", "Madness & Oppression", "Madness
and Oppression", "Manual per a la Recuperació i Autogestió del Benestar".

Results:

268 documents = Scopus

325 documents = PsycInfo

045 documents = PsycArticles

743 documents = PubMed

352 documents. (27 + 325) = CINAHL

448 documents (17 + 431) = Cochrane Library

795 documents (47 + 748) = Web of Science

002 documents = Ethos

001 document = SIGLE

At this step, a list of **2.979 potentially relevant documents** retrieved from
electronic databases and grey literature databases was created.

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On September 8, 2021, the **1,233 duplicate** documents were removed from academic and grey literature databases, and **1,746 documents were included** to be reviewed by title.

Decisions made:

0. Included.
1. Not included. **It is not the object of study** = it is not mental health
2. Not included. **It is not the topic** = it is about mental health, but not about recovery, empowerment, and self-determination (in relation to mental health).
3. Not included. **It is not a tool** = it is about mental health, it talks about recovery, empowerment, and self-determination (in relation to mental health), but it does not talk about materials and/or workshops to promote personalized plans.
4. Not included. **It is not made by users and survivors** = it is about mental health, it talks about recovery, empowerment, and self-determination (in relation to mental health), it talks about materials and/or workshops to promote personalized plans, but the tool was not created by users and survivors of psychiatry,
5. Not included. **It is not a printed or printable material** = It is an App or an Internet intervention.
6. Not included. **It is not the design** = they are systematic reviews, metanalysis, essays, clinical trial registrations, books reviews, tools presentation (without new information), letters to the editor, etc.
7. Not included. **It is not the participants** = The study was not made with adult people or/and with users of mental health services or with mental health problems.

From September 9 to September 10, 2021, 1,746 documents were **reviewed by title**. At this step, **159 documents were included** and 1,587 were discarded.

0 = 0159 included
1 = 1419 discarded
2 = 0101 discarded
3 = 0041 discarded
4 = 0008 discarded
5 = 0012 discarded

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6 = 0006 discarded

From September 13 to September 14, 2021, 159 documents were **reviewed by Abstract**. At this step, **40 documents were included** and 119 were discarded.

0 = 40 included

1 = 29 discarded

2 = 07 discarded

3 = 36 discarded

4 = 13 discarded

5 = 03 discarded

6 = 30 discarded

7 = 01 discarded

From September 10 to September 16, 2021, 40 documents were **reviewed by complete text**. At this step, **31 documents were included** and 9 were discarded.

0 = 31 included

3 = 03 discarded

4 = 03 discarded

6 = 03 discarded

From September 17 to September 18, 2021, we conducted a search in **Google Scholar**, with no date restriction, any language, ordered by relevance. Only the first 100 outcomes were included.

Search terms: “Transformative mutual aid practices”, “Mapping our Madness”, “Wellness Recovery Action Plan”, “Wellness Recovery Action Planning”, “Personal Assistance in Community Existence”, “Madness & Oppression”, “Madness and Oppression”, “Manual per a la Recuperació i Autogestió del Benestar”.

Results:

WRAP: 1.510 results (first 100 results included)

PACE: 161 results (first 100 results included)

MoM: 14 results

T-MAPs: 4 results

M&O: 5 results

MRAB: 0 result

At this step, a complementary list of **233 potentially relevant documents** retrieved from Google Scholar was created. Of them, 9 duplicate documents were

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removed, and 224 documents were included to be **reviewed by title and abstract**. At this step, **48 documents were included**, and 176 were discarded.

0 = 48

1 = 08

2 = 55

3 = 67

4 = 07

5 = 03

6 = 25

7 = 01

Of these 48 documents, **28 were repeated** with the ones included at the academic databases search. They were discarded. The last 20 documents were **reviewed by complete text**. At this step, **11 documents were included** and 9 were discarded.

0 = 11

3 = 01

4 = 01

6 = 07

From September 19 to September 20, 2021, we conducted a **manual review of journals**. All the numbers published in 2021, of the 24 journals in which a paper was previously found were reviewed.

Supplementary Table 3: Manually reviewed journals

1	American Journal of Psychiatric Rehabilitation	Vol. (Issue)	-
2	Aotearoa New Zealand Social Work	33(2) 33(1)	-
3	Australasian Psychiatry	29(1) 29(2) 29(3) 29(4)	-
4	British Journal of Mental Health Nursing	10(1) 10(2) 10(3)	-
5	British Journal of Social Work	51(1) 51(2) 51(3) 51(4) 51(5)	-
6	Community Mental Health Journal	57(1) 57(2) 57(3) 57(4) 57(5)	-

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		57(6) 57(7)	
7	Ethical Human Psychology and Psychiatry	23(1)	-
8	Evaluation Studies in Social Sciences	10(1) 10(2)	-
9	International Journal of Psychiatry	6(1)	
10	International Journal of Psychosocial Rehabilitation	25(1) 25(2) 25(3)	-
11	Irish journal of psychological medicine	38(1) 38(2) 38(3)	-
12	Issues in Mental Health Nursing	42(1) 42(2) 42(3) 42(4) 42(5) 42(6) 42(7) 42(8) 42(9)	-
13	Journal of Advanced Nursing	77(1) 77(2) 77(3) 77(4) 77(5) 77(6) 77(7) 77(8) 77(9) 77(10)	-
14	Journal of Humanistic Psychology	61(1) 61(2) 61(3) 61(4) 61(5)	-
15	Journal of Psychiatric and Mental Health Nursing	28(1) 28(2) 28(3) 28(4) 28(5)	-
16	Journal of Psychosocial Nursing & Mental Health Services	59(1) 59(2) 59(3) 59(4) 59(5) 59(6) 59(7) 59(8) 59(9)	-

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17	Occupational Therapy in Mental Health	37(1) 37(2) 37(3)	-
18	Psychiatric Rehabilitation Journal	44(1) 44(2) 44(3)	-
19	Psychiatric Services	72(1) 72(2) 72(3) 72(4) 72(5) 72(6) 72(7) 72(8) 72(9)	1
20	Qualitative Health Research	31(1) 31(2) 31(3) 31(4) 31(5) 31(6) 31(7) 31(8) 31(9) 31(10)	1
21	Rehabilitation Counselling Bulletin	64(2) 64(3) 64(4) 65(1)	-
22	Schizophrenia Bulletin	47(1) 47(2) 47(3) 47(4) 47(5)	-
23	The Scientific World Journal	Vol. 2021	-
24	Journal of Future Social Work Research - 미래사회복지연구	12(1) 12(2)	-

Two papers were found at the **manual review of journals**, but both of them were repeated with the papers previously found in the academic databases and they were discarded.

From September 21 to September 22, 2021. the **list of references** of all the documents already included were revised. At this step, 23 references were found to be reviewed. Of these new documents, **2 accomplished the criteria to be included**.

0 = 4

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3 = 1

6 = 17

7 = 1

N = 2

R = 2

After all these steps, finally **53 documents** were included to the scoping review:
37 publications from 35 studies and 6 tools (with 8 documents) and 8 tools presentations.

For peer review only

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Supplementary Table 4: Descriptive characteristics of the studies

Authors	Country	Tool	Design	Data collection/Data analysis	Participant definitions ^a /Sample characteristics
Afzal, Bashir, & Perveen, 2020 (60)	Pakistan	WRAP	Pre-post-test	Questionnaire/Descriptive and inferential statistical analysis	8 patients with psychiatric disorders, 50% female, aged from 26 to 55 years.
Ali, 2013 (61)	Palestine	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	33 chronic female schizophrenic patients (WRAP:15, Usual care:18), 69.00% more than 30
Aljeesh & Shawish, 2018 (62)	Palestine	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	8 Patients with major depressive disorder (WRAP: 4, Usual treatment: 4), 50.00% female
Ashman, Halliday, & Cunnane, 2017 (63)	United Kingdom	WRAP	Qualitative	Semi-structured interview /Interpretative phenomenological analysis	6 adults with at least one episode of crisis care from Mental Health Crisis Resolution and Home Treatment Teams, 66.66% female, aged from 25 to 59 years, 83.33% Caucasian
Ben-zeev et al., 2018 (64)	USA	WRAP	RCT	Questionnaire/Descriptive and inferential statistical analysis	163 adults with serious mental illness (WRAP: 81, FOCUS: 82), 49 mean age, 61.00% High School or less, 41.11% female, 68.19% African American

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5	Carpenter-	USA	WRAP	Qualitative	In-depth semi structured	31 adults with serious mental illness (WRAP: 15,
6	Song,				interviews/ Braun and	FOCUS: 16), 58.06% High School or less, 35.48%
7	Jonathan,				Clarke thematic analysis	female, 48,39% African American
8	Brian, &					
9	Ben-Zeev,					
10	2020 (65)					
11						
12						
13	Cook et al.,	USA	WRAP	Pre-post-test	Questionnaire/Descriptive	80 individuals with serious mental illness, 63.75%
14	2009 (55)				and inferential statistical	female, 46.60 mean age, 81.25% High School
15					analysis	diploma, 66.25% Caucasian
16						
17						
18	Cook et al.,	USA	WRAP	Pre-post-test	Survey/Descriptive and	381 consumers or survivors of psychiatric services
19	2010 (53)				inferential statistical	(Vermont: 147, Minnesota: 234), 64.32% female,
20					analysis	32.8% aged from 41 to 50, 66.00% Caucasian
21						
22						
23	Cook,	USA	WRAP	RCT	Questionnaire/Descriptive	519 individuals with serious mental illness (WRAP:
24	Copeland,				and inferential statistical	251, Usual services and waiting list: 268), 66.00%
25	Jonikas, et				analysis	female, 45.80 mean age, 47.00% college or more,
26	al., 2012					63.00% Caucasian
27	(56); Cook,					
28	Copeland,					
29	Floyd, et					
30	al., 2012					
31	(57);					
32	Jonikas et					
33	al., 2013					
34	(58)					
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5	Cook et al.,	USA	WRAP	RCT	Questionnaire/Descriptive	143 individuals with serious mental illness (WRAP:72,
6	2013 (66)				and inferential statistical	Choosing Wellness: 71), 50.30% female, 45.90 mean
7					analysis	age, 37.80% High School, 67.10% African American
8						
9	Davidson,	Scotland	WRAP	Cross-	Questionnaire/Descriptive	109 participants, 66.66% people who have experienced
10	2018 (67)			Sectional	and inferential statistical	mental health challenges, 55.96% mental health
11					analysis	services professionals, 30.27% WRAP facilitators,
12						17.43% relatives, 46.46 mean age, 66.97% female,
13						29.35% bachelor's degree
14						
15						
16	Doughty,	New	WRAP	Pre-post-test	Questionnaire/Descriptive	157 participants, 31.84% consumers of mental health
17	Tse,	Zealand			and inferential statistical	services, 47.77% mental health services professionals,
18	Duncan, &				analysis	86% aged from 31 to 60
19	McIntyre,					
20	2008 (52)					
21						
22						
23						
24	Elhelou,	Palestine	WRAP	Quasi-	Questionnaire/Descriptive	36 chronic depressed patients, 100% women, 58.33%
25	2018 (68)			experimental	and inferential statistical	more than 30, 47.22% university education, 66.66%
26					analysis	married
27						
28						
29	Fukui et al.,	USA	WRAP	Quasi-	Questionnaire/Descriptive	114 people with severe mental illness (EG: 58, CG:
30	2011 (69)			experimental	and inferential statistical	56), 62.28% female, 44.50 mean age, 67.50% High
31					analysis	School or less, 64.90% White people
32						
33						
34	Gordon &	USA	WRAP	Qualitative	Semi-structured interview,	7 women linked to the Scottish Recovery Network
35	Cassidy,				focus group/Inductive	and/or National Health System services, more than 18,
36	2009 (70)				thematic analysis	Black and South Asian (Pakistani or Indian
37						background)
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5	Higgins et	Ireland,	WRAP	Mixed	Questionnaire, focus	194 participants who attended the WRAP education
6	al., 2012	United		methods	group/Descriptive and	programmes, with different profiles, including 31.00%
7	(71)	Kingdom			inferential statistical	Mental health practitioner only, 25.00% people with
8					analysis, Braun and Clarke	self-experience only, 64.94% female, most participants
9					thematic analysis	aged from 30 to 59
10						
11						
12	Horan &	Ireland	WRAP	Qualitative	Semi-structured interview/	4 individuals with mental health difficulties who
13	Fox, 2016				Attride-Stirling thematic	attended to WRAP programme, 25.00% female, aged
14	(72)				analysis	from 35 to 61
15						
16						
17	Jung, Ju,	Korea	WRAP	Quasi-	Questionnaire/Descriptive	20 users from a club house (community recovery
18	Kim, &			experimental	and inferential statistical	service) (WRAP: 10, usual care:10, 40.00% younger
19	Heo, 2019				analysis	than 40, 70.00% university degree, 30.00% women,
20	(73)					100% Korean people
21						
22						
23	Katayama,	Japan	WRAP	Qualitative	Survey/Sato's qualitative	5 students from University of Nagano who had
24	Morita, &				analysis based on five key	multiple difficulties in their student life and wanted <i>to</i>
25	Mori, 2019				recovery concepts from	<i>have well-being</i> , mean age 22.00, 60% female,
26	(74)				WRAP (hope, personal	undergraduate students
27					responsibility, education,	
28					self- advocacy, support)	
29						
30						
31	Keogh et	Ireland,	WRAP	Qualitative	Focus group/Braun and	22 group participants (who participated in study by
32	al., 2014	United			Clarke thematic analysis	Higgins et al. 2011), including 36.00% mental health
33	(75)	Kingdom				practitioner only, 18.00% person with self-experience
34						only, 45.00% self-experience of mental health
35						difficulties, 63.63% female
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Mak et al., 2016 (59)	China	WRAP	Matched controls	Questionnaire/Descriptive and inferential statistical analysis	118 Chinese mental health consumers (WRAP: 59, No WRAP: 59), 57.63% female, 42.90 mean age, 77.90% secondary education
Matsuoka, 2015 (76)	Canada	WRAP	Qualitative	Questionnaire, interview, participant observation/Thematic analysis based on constructivist version of grounded theory	8 Japanese-Canadian older adults from community, 75.00% female, aged from 64 to 89, first generation of post-Second World War immigrants
McIntyre, 2005 ^b	New Zealand	WRAP	Pre-post-test	Questionnaire/Descriptive and inferential statistical analysis	76 participants, 51.11% identified as having personal experience of mental illness, 66.00% employed in mental health related jobs, and of those 44% also identified as having personal experience of mental illness, 86.00% aged from 31 to 60
O'Dwyer, 2015 (77)	United Kingdom	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	WRAP1: 30 adults with acquired brain injury, aged from 19 to 59; WRAP2: 27 mental health services users, aged from 19 to 65; Mental health wait list: 31, aged from 22 to 55
O'Keeffe et al., 2016 (78)	Ireland, United Kingdom	WRAP	RCT	Questionnaire/Descriptive and inferential statistical analysis	36 inpatients and outpatients with a diagnosis of a mental or behavioural disorder, 48.11 mean age, 52.70% higher education, 52.80% female

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5	Olney &	USA	WRAP	Qualitative	Semi-structured	10 adults who had a psychiatric diagnosis and received
6	Emery-				interview/Phenomenology	employment services, that had completed 8 weeks of
7	Flores,				and grounded theory	WRAP training, aged from 48 to 69, 50.00% college
8	2017 (79)					degrees, 60.00% women, 80.00% White
9						
10						
11	Petros,	USA	WRAP	Qualitative	In-depth interview, focus	36 adults, self-identify as having experienced serious
12	2017 (80)			design (from a	group/Braun and Clarke	mental illness, who have completed WRAP
13				mixed method	thematic analysis	programming and WRAP facilitator training, 47.22%
14				study)		female, mean age 50.60, 77.78% black people
15						
16						
17	Petros &	USA	WRAP	Cross sectional	Survey/Descriptive and	82 adults with serious mental illness who had
18	Solomon,			design (from a	inferential statistical	completed WRAP in the previous 6–24 months,
19	2020 (81)			mixed method	analysis	68.20% women, mean age 46.80, 43.90% African
20				study)		American
21						
22						
23	Pratt,	Scotland,	WRAP	Qualitative	Interview, focus	8 WRAP facilitators, 87.50% female
24	Macgregor,	USA			group/Thematic analysis	
25	Reid, &				based on constructivist	
26	Given, 2012				version of grounded theory	
27	(82)					
28						
29						
30	Pratt,	Scotland,	WRAP	Mixed	Interview, focus groups,	21 WRAP groups participants, members of Self-Help
31	Macgregor,	USA		methods	questionnaires/Descriptive	and Mutual Support Groups, at the Scottish Recovery
32	Reid, &				analysis based on	Network
33	Given, 2013				frequencies and means,	
34	(83)				Thematic analysis based on	
35					constructivist version of	
36					grounded theory	
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5	Starnino et	USA	WRAP	Pre-post-test	Questionnaire/Descriptive	30 participants who had attended WRAP workshops,
6	al., 2010				and inferential statistical	mean age 41.60, 60.00% female, 66.66% equal to or
7	(84)				analysis	less than High School, 93.30% White people
8						
9	Stokoe &	England	WRAP	Pre-post-test	Questionnaire/Descriptive	26 adults with a mental health diagnosis receiving
10	Bradbury,				and inferential statistical	treatment in a community mental health service, 39.6
11	2013 (85)				analysis	mean age, 76.92% female.
12						
13						
14	Wilson,	USA	WRAP	Mixed	Survey,	26 outpatients of mental health facility that uses
15	Hutson, &			methods	interview/Descriptive and	WRAP, 18 of them made the Qualitative Interviews,
16	Holston,				inferential statistical	50.00% women, 42.23 mean age, 60.00% Caucasian
17	2013 (86)				analysis, content analysis by	
18					Corbin and Strauss	
19						
20						
21	Zahniser,	USA	PACE	Qualitative	Survey (open ended	70 participants: 37.14% consumers/survivors, 37.53%
22	Ahern, &				questions)/Qualitative	administrators, 30.43% direct providers, 24.28%
23	Fisher,				content analysis	family members (some respondents identified with
24	2005 (49)					more than one category)
25						
26						
27	Zhang,	New	WRAP	Qualitative	Semi-structured interviews,	17 participants, including 47.06% Chinese mental
28	Wong, Li,	Zealand			focus group/Analysis not	health consumers, 17.64% mental health professionals
29	Yeh, &				specified	and 35.30% family members, 50.00% of the
30	Zhao, 2010					consumers aged from 36 to 60, 75.00% female
31	(54)					
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^a Corresponds to definitions made by the authors regarding study participants

^b McIntyre L. WRAP Around New Zealand. Unpublished Paper. Wellington: Victoria University of Wellington; 2005. p. 28

FOCUS: a smartphone-delivered intervention; RCT: Randomized controlled trial

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Mapping mad maps and recovery tools developed by mental health service users and survivors of psychiatry: A scoping review

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3 **Mapping mad maps and recovery tools developed by mental health**
4 **service users and survivors of psychiatry: A scoping review**
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Abstract

Background: Since 1997, several tools based on the experiences of users and survivors of psychiatry have been developed with the goal of promoting self-determination in recovery, empowerment, and wellbeing.

Objectives: The aims of this study were to identify these tools and their distinctive features, and to know how they were created, implemented, and evaluated.

Method: This work was conducted in accordance with a published Scoping Review protocol, following the Arksey and O'Malley approach and the PRISMA Extension for Scoping Reviews (PRISMA-ScR). Five search strategies were used, including contact with user and survivor networks, academic database searching (Cochrane, CINAHL, PsycINFO, PsycARTICLES, SCOPUS, PubMed, and Web of Science), grey literature searching, google scholar searching, and reference harvesting. We focused on tools, elaborated by users and survivors, and studies reporting the main applications of them. The searches were performed between July 21 and September 22, 2022. Two approaches were used to display the data: descriptive analysis and thematic analysis.

Results: Six tools and 35 studies were identified, most of them originating in the United States and United Kingdom. Thematic analysis identified six goals of the tools: Improving wellness, navigating crisis, promoting recovery, promoting empowerment, facilitating mutual support, and coping with oppression. Of the 35 studies identified, 34 corresponded to applications of the Wellness Recovery Action Plan (WRAP). All of them, but one, evaluated group workshops implementations. The most common objective was to evaluate symptom improvement. Only eight studies included users and survivors as part of the research team.

Conclusions: Only the WRAP has been widely disseminated and investigated. Despite the tools were designed to be implemented by peers, it seems they have been usually implemented without them as trainers. Even when these tools are not aimed to promote clinical recovery, in practice the most disseminated recovery tool is being used in this way.

Strengths and limitations of this study

- The scoping review included both mad maps and recovery tools, and the publications that evaluated or explored these resources.

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- Users and survivors' networks were consulted, including those of international scope, in order to obtain any potentially relevant material for inclusion.
- The scoping review included published articles and grey literature.
- Although different networks of users and survivors in every continent were contacted, the researchers obtained no answer from any African network or organization.

Introduction

In recent decades, mental health policy in many countries has undergone a paradigm shift towards a recovery-oriented approach. This is especially evident among Anglophone countries (1), although a similar path has been followed by several countries in northern Europe (2), and more recently by some countries or regions of southern Europe (3)(4)(5). This shift, which has been driven by international policy on mental health (6)(7), is based on the social model of disability (8)(9) and aims to comply with the Convention on the Rights of Persons with Disabilities (10), a primary goal being to promote user empowerment in mental health, both on a social/structural and individual level (11).

Although very different interventions have been implemented under the umbrella of recovery (12)(13), the main aim of all recovery-oriented programs is to enable individuals to achieve a meaningful and satisfactory life in accordance with their own preferences and values, regardless of the presence of symptoms (14)(15)(16). This feature differentiates recovery-oriented interventions from those based on the biomedical model, which is mainly oriented toward symptom control (17)(18)(19), as well as from psychiatric/psychosocial rehabilitation, the usual aim of which is the functional adaptation of the person to society (20)(21).

As recovery means living according to one's own values and preferences, promotion and respect of self-determination have been identified as "*the sine qua non of recovery-oriented practice* (p.359)"(22). Self-determination has come to be regarded as a prerequisite for personal empowerment and recovery, and for regaining control over one's own life (23)(24)(25). Accompanying a recovery process therefore implies promoting self-determination and providing people with the tools they need to direct their own process and make their own decisions.

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3 In 1997, and with this goal in mind, Mary Ellen Copeland published the
4 *Wellness Recovery Action Plan (WRAP)*(26), which was followed two years later by
5 Laurie Ahern's and Daniel Fisher's *Personal Assistance in Community Existence*
6 *(PACE): A Recovery Guide* (27). Both are practical tools designed to promote self-
7 determination and the active participation of people in their own recovery process (28).
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12 Since WRAP and PACE were published, a number of new tools have been
13 developed. One of them is *Madness and Oppression* (29), that has been defined by the
14 authors as a Mad Maps Guide, rather than a recovery tool. Specifically, they described
15 them as follows:
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20 “*Mad Maps are documents that we create for ourselves as reminders of our*
21 *goals, what is important to us, our personal signs of struggle, and our strategies*
22 *for self-determined well-being (p. 1).” (29)*
23
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25 Both, mad maps and recovery tools are resources that were created by users and
26 survivors of psychiatry, and they were born from the systematization of the experience
27 lived by people who dealt with emotional distress, mental health crisis or psychosocial
28 diversity. Nowadays, both the users and survivors’ movements and the WHO highlight
29 the importance of the recovery tools and mad maps. From the mad activism perspective,
30 to put in value “*the knowledge based on lived experience (experiential knowledge) that*
31 *people with mental health problems can bring (p. 1).” (30). From the WHO, the recovery*
32 *tools are considered essential for “adopting recovery and human rights approaches (p.*
33 *11).” (31). That’s why, as part of their QualityRights Initiative, in 2019 the WHO*
34 *published “Person-centred recovery planning for mental health and well-being self-help*
35 *tool” (31), a tool that “draw substantially from WRAP (p. 2).” (31).*
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45 Despite there are different tools oriented to these objectives, only the WRAP has
46 been widely disseminated and investigated (32). Other tools are less well known, either
47 because they have not, unlike the WRAP, been used in mental health research, or
48 because they have not been applied outside the context of certain user and survivor
49 movements. Given this situation, there is a need to explore the literature to identify what
50 tools are available in addition to the well-established WRAP and beyond those
51 published in English. The scoping review method is an ideal approach for exploring and
52 identifying programs aimed at promoting self-determination and people's active
53 participation in their recovery processes. The advantage of this method is that it
54 involves a broader exploration of the literature, integrating multiple research designs
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3 and addressing questions beyond intervention efficacy (33). More specifically, it allows
4 us to explore and describe research activity, identifying gaps in relation to a particular
5 topic, before summarizing and disseminating the findings. It should also be noted that
6 integrating multiple research designs is especially useful in fields which have not been
7 systematically examined or disciplines with emerging evidence (33), as is the case of
8 the tools referred to above. Therefore, the primary aim of this study was to identify
9 existing tools, produced by users and survivors, aimed at promoting recovery,
10 empowerment, and wellness in mental health. The secondary objectives were to explore
11 the distinctive features of these tools, including how they have been created and
12 implemented. The research questions guiding this scoping review were therefore as
13 follows:
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23 (a) What tools, created by people with personal experience of mental health
24 problems and recovery, are currently available for developing personal recovery plans
25 and promoting the self-management of wellbeing?
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28 (b) What are their distinctive features?
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30 (c) How have they been created and implemented?
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33 **Methods**

34 We conducted a scoping study in accordance with a published protocol (34) and the
35 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)
36 extension for scoping reviews (35). The framework used was that developed by Arksey
37 and O'Malley (2005)(36), along with recommendations designed to enhance each phase
38 (33). This approach suggests five stages to a scoping review:
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45 Stage 1: Identifying the research question

46 As recommended by Arksey and O'Malley (2005)(36), we formulated a broad research
47 question aimed at identifying any tools created by people with any experience of mental
48 health issues. As a scoping review is an iterative process, our original research question,
49 set out in the protocol (34), was reformulated and expanded into the three questions
50 listed above: What tools, created by people with personal experience of mental health
51 problems and recovery, are currently available for developing personal recovery plans
52 and promoting the self-management of wellbeing? What are their distinctive features?
53 How have they been created and implemented?
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Stage 2: Identifying relevant studies

We started the searching process contacting networks of users and survivors, as well as some international mental health organizations. In addition, we asked them for suggestions about new networks, organizations, activists, or academics to which we could send our query. Out of the 29 networks and entities contacted, 20 responded it (69%). Contact was made by email, from July 21 to September 3, 2021. Details in Supplementary Table 1 and Supplementary Table 2.

We conducted a literature search of the following databases: Cochrane database, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, PsycARTICLES, SCOPUS, Pubmed, and Web of Science. The key search terms initially selected were: *action plan*, *crisis plan*, *crisis program*, *empowerment*, *making choice*, *mapping madness*, *Mapping Our Madness*, *own pace*, *Personal Assistance in Community Existence*, *taking action*, *Transformative Mutual Aid Practices*, *self-determination*, *self-management*, *recovery program*, *wellness*, *Wellness Recovery Action Plan*, *wellness recovery action planning*. These were tested in order to refine and add, if necessary, new terms to the search strategy (33), as a result of which we incorporated *madness* and *oppression*. The search strategy used in the Web of Science was as follows: ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative Mutual Aid Practices" OR "madness and oppression" OR "madness & oppression") in topic. A grey literature search was also conducted in the databases EThOS and System for Information on Grey Literature in Europe (SIGLE). Only the most relevant titles were extracted for the following terms: Wellness Recovery Action Plan, Personal Assistance in Community Existence, Mapping Our Madness, Transformative Mutual Aid Practices, T-MAPS, madness and oppression, and madness & oppression. The search process in these databases was conducted between 4 and 7 September, 2021.

A search for relevant articles was also conducted using Google Scholar (on 17 and 18 September, 2021), applying the same search strategy and criteria as were used for grey literature databases. Only the first 100 search results were examined. We also examined the reference lists of included articles and conducted a manual search of specialized journals between 19 and 22 September, 2021 (details in Supplementary Table 3). Note that all searches were conducted without date restriction and covered

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records from any country or reported in any language, although the reports retrieved were mostly in English. The end date for all searches was 22 September, 2021.

More details about the searching strategy and its results are given in Supplementary material.

Stage 3: Study selection

The interesting abstracts were retrieved through the aforementioned search strategies, after identifying and removing duplicates. The process of study selection involved two main stages. First, two researchers independently inspected all the records and selected those whose title and/or abstract suggested they should be included. Next, copies of the full articles were obtained and examined to assess their relevance to the research question, while also considering the inclusion criteria (see below). Any disagreement at the point of full-text screening was resolved through discussion and consensus involving a third reviewer. Our initial focus, described in the protocol (34), was refined to: Research papers, conference papers, Master's and PhD dissertations, books and book chapters, manuals, and research reports. The original inclusion criteria were also refined and resulted in the following inclusion criteria for tools:

- (a) They are aimed at promoting self-determination and empowerment of people in their mental health recovery process. Manuals, original presentation of a tool or workbooks were considered for inclusion.
- (b) They are based on the recovery model.
- (c) They are created to elaborate a personalized strategy or plan.
- (d) They are comprehensive tools for improving wellbeing and recovery, that is, they are more than just a crisis plan.
- (e) They have been developed by people who are experiencing or have experienced a mental health issue and/or by user and survivor movements.
- (f) They may be used by any person who wishes to achieve health and wellbeing.

In the case of studies about tool applications, we considered the following inclusion criteria:

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3 (a) They are documents reporting the main applications of tools in people who
4 experience any form of emotional distress and who wish to enhance their
5 wellbeing.
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9 (a) They are studies involving participants aged 18 or over.
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11 We excluded opinion articles, editorials, and protocols. Meta-analyses and reviews were
12 also excluded, although their reference lists were screened at the previous stage. Tools
13 not developed from the perspective of users and survivors of psychiatry were also
14 excluded.
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17 18 Stage 4: Data charting 19

20 A preliminary data charting framework involving 39 categories was described in the
21 study protocol (34). This included a set of categories for describing the record (e.g., type
22 of document: manual, research report), characteristics of the tool (e.g., type of
23 application: individual, group), and characteristics of the study (e.g., sample: type of
24 participant). Consistent with the fact that data charting is an iterative process in which
25 researchers extract and update data, we added one new category, *focus on*, to the
26 previous framework so as to record the main aspects addressed by each tool.
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33 In order to determine whether the resulting approach was suitable for answering
34 the research questions and could be applied consistently (33), it was tested in a sample
35 comprising 10% of the included documents. Two members of the team, working
36 independently, charted each document. Any disagreement in the process was resolved in
37 a consensus meeting involving all team members.
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42 Stage 5: Collating, summarizing, and reporting the results 43

44 As described in the framework proposed by Arksey and O'Malley (2005)(36), we
45 conducted both descriptive analysis and thematic analysis. Descriptive analysis
46 involved the calculation of numerical frequencies regarding the tools identified (year of
47 creation, countries and entities involved, and distinctive characteristics) and studies
48 describing their application (tool used, study characteristics, participants'
49 characteristics). This analysis allowed us to identify the geographical locations of the
50 literature and the main research methods used (33). In order to identify the primary
51 focus of each tool, a thematic analysis was carried out and the topics were identified.
52 Tools (manuals and descriptive material) were organized thematically by recurring
53 themes and points of agreement and disagreement (37)(38). All documents were
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reviewed independently by two researchers and summarized to extract information on tools and their implementation.

Patient and Public Involvement

The study is a collaboration between an association of users and survivors of psychiatry, a university, and the local Mental Health Services Administration. The research design and development has been led by members of the user and survivors' associations. This characteristic has been crucial to contact with the representatives of the networks of users and survivors described at Stage 2.

Results

Search findings

A list of 1758 registers was retrieved from the six search strategies utilized, after identifying and removing duplicate documents. Of them, 1587 documents were discarded by title and 119 were excluded by abstract. Finally, of the 62 full articles screened, 53 accomplished all the inclusion criteria and were included in this Scoping Review. The selection process is illustrated in Figure 1.

Please insert Figure 1 about here.

Descriptive analysis

A total of 62 records were retrieved from all the search strategies. Of these, 53 documents met the inclusion criteria: 8 were the tool itself (6 different tools in total), 8 were descriptions/dissemination of a tool, and 37 were studies reporting the main applications of these tools. Three of these 37 studies were carried out by the same research group with the same population but with different goals, and hence they were considered as a single contribution in the descriptive analysis.

Tools

The six tools identified were developed between 1997 and 2018, and were as follows: Wellness Recovery Action Plan (WRAP)(26), Personal Assistance in Community Existence (PACE)(27), Mapping our Madness (MoM)(39), Madness & Oppression: Paths to Personal Transformation & Collective Liberation (M&O)(29), T-MAPs, Transformative Mutual Aid Practices (T-MAPs)(40), and *Manual per a la Recuperació i Autogestió del Benestar* (MRAB; in English: Manual for Recovery and Self-

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3 Management of Wellbeing)(41). With the exception of the MRAB, all tools were
4 developed in the USA and published in English. The MRAB was created in Catalonia
5 (Spain) and was originally published in Catalan, with a Spanish version being published
6 in 2020. Only the WRAP and PACE were identified through publications in indexed
7 academic databases, with the remaining tools being found through contact with users
8 and survivors' networks.
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14 All six tools are linked to users and survivors' movements, mutual aid groups or
15 peer support services. The MoM, M&O, and T-MAPs define themselves as Mad Maps,
16 and they emerged under the umbrella of The Icarus Project network. While, the WRAP,
17 PACE, and MRAB presents themselves as recovery tools, and they are associated with,
18 respectively, the Copeland Center for Wellness and Recovery, the National
19 Empowerment Center, and the *ActivaMent Catalunya Associació*. The WRAP and
20 MRAB were created in collaboration with mental health service providers, whereas the
21 PACE, MoM, and T-MAPs were developed exclusively by their authors, who
22 systematized their own experience as members of a community of users and survivors.
23 The M&O was a collective creation, involving 77 authors and "...dozens of people who
24 wish to remain anonymous... (p. 4)"(29). Both the WRAP and the MRAB were
25 developed through a participatory process. In the case of the WRAP, this included a
26 recovery skills seminar (30 participants) and a survey (125 respondents)(28)(42),
27 whereas the MRAB resulted from a process involving five focus groups (37
28 participants), a questionnaire (209 respondents), a one-day series of thematic debates
29 (48 participants), and ten meetings of a coordinating committee (19 members)(41).
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42 The tools include information about resources that people may wish to use in
43 developing their recovery plans. The MRAB provides links to various websites so that
44 people can explore the resources available to them locally, and it also includes a
45 workbook as supplementary material; the WRAP, MoM, M&O, and T-MAPs
46 incorporate a workbook within the manual itself. The purpose of these workbooks,
47 which include questions and answer boxes, is to help people draw up their recovery
48 plans. All the tools can, in theory, be used individually, although the WRAP, T-MAPs,
49 and MRAB have been designed to be implemented in a group workshop format with
50 peers; the PACE has also been adapted for use in this format. In the case of M&O, this
51 tool was developed exclusively for collective use. The MoM is the only tool designed to
52 be used solely on an individual basis, with or without support from others. Regarding
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3 their application, the most common format for the WRAP is 8-12 sessions, whereas
4 MRAB workshops are designed for 12 sessions. T-MAPs workshops include four
5 modules, with a flexible number of sessions. The number of sessions is not specified or
6 the PACE and M&O (Table 1).
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Table 1: Tools and descriptive material

Tool	Year	Author(s)	Material included in the review	Institution and country	Objectives	Focus on
Wellness Recovery Action Plan (WRAP)	1997	M. E. Copeland	Guide and Workbook (26), tool presentations (28)(24)(42)	Copeland Center, USA	To identify the resources that each person has available to use for their recovery, and then using those tools to develop a guide to successful living that they feel will work for them (Copeland, 2004).	Recovery, wellness, crisis
Personal Assistance in Community Existence (PACE)	1999	L. Ahern and D. Fisher	Guide (27), tool presentation (43)	National Empowerment Center, USA	To facilitate a consumers' complete recovery from "mental illness" at their own pace, with an alternative noncoercive program based on the principles of recovery, peer support, empowerment, and self-help. (Ahern & Fisher, 2001)	Empowerment, recovery
Mapping our Madness (MoM)	2015	Momo	Workbook (39)	The Icarus Project, USA	To help folks map, plan, and navigate crisis, madness, or just foul moods	Crisis, wellness
Madness & Oppression (M&O)	2015	The Icarus Project	Manual and workbook (29)	The Icarus Project, USA	To create your own Mad Map, which serves as a reminder document for	Oppression, wellness, empowerment

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5						yourself and the people	
6						around you about your	
7						wellness goals, warning	
8						signs, strategies for health,	
9						and who you trust to look out	
10						for your best interests when	
11						you're struggling.	
12							
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14	Transformative	2018	J. McNamara	Manual and workbook	The Icarus	To offer a set of tools that	Wellness,
15	Mutual Aid		and S.	(40), tool presentations	Project, USA	provide space for building a	resilience,
16	Practices (T-		DuBrul	(44)(45)(46)		personal 'map' of wellness	oppression
17	MAPs)					strategies, resilience	
18						practices, unique stories, and	
19						community resources.	
20							
21							
22							
23	Manual per a la	2018	H. M.	Manual, workbook and	Activa't per la	Facilitate the identification,	Recovery,
24	Recuperació i		Sampietro	workshops' guide	Salut Mental,	organization and management	wellness, crisis
25	Autogestió del		and C.	(41)(47)(48)	ActivaMent	of the strategies and resources	
26	Benestar		Gavaldà-		Catalunya	that people have at their	
27	(MRAB)		Castet		Associació,	disposal to develop their own	
28					Catalonia, Spain	personalized recovery and	
29						wellness plan.	
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Studies

The studies identified were published between 2005 and 2020, and all but one of them corresponded to applications of the WRAP; the other study referred to the PACE. The USA and the UK accounted, respectively, for 45.94% and 27.02% of this research output, which involved a total of 58 institutions or organizations, mainly universities (38 contributions) and mental health service providers or related government agencies (12 contributions). Only seven mutual support and peer organizations participated in the studies identified, notably the Copeland Center for Wellness and Recovery, and the Mental Health Recovery and WRAP.

The study regarding the PACE (49) was the only one to involve a self-administered application of the tool, whereas all studies of the WRAP were carried out in group workshops. Twenty-two studies reported information on how workshops were delivered: In 13 studies the workshops were offered by peers, in six they were facilitated by non-peer professionals, and three used a mixed professional/peer format.

In terms of study type, there were 20 quantitative studies, 12 qualitative studies, and three that used mixed methods. Quasi-experimental and pre/post-test studies were the most common designs in quantitative research, whereas qualitative studies mainly used Braun and Clarke's approach to thematic analysis (37)(38) or grounded theory. Data collections were carried out through questionnaires (19 studies), interviews (15 studies), focus groups (eight studies), and surveys (five studies). The most commonly used questionnaire was the Recovery Assessment Scale (50).

Only eight studies were designed and conducted by or with the participation of users and survivors in the research team (49)(51)(52)(53)(54)(55)(56)(57)(58) and a Leo McIntyre's unpublished paper (see Table 2). The remaining studies were designed and carried out exclusively from an academic or professional perspective. Research was mainly aimed at assessing symptom improvement (16 studies) or exploring self-perceived recovery (11 studies), knowledge and beliefs about recovery (6 studies), and the level of hope in recovery (6 studies).

Most of the studies focused on symptoms were conducted solely from a professional or academic perspective; the exception are three studies made by the Judith

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Cook's team (52)(56)(55)(57). Attitudes and knowledge about recovery were the main topic in studies designed or carried out in collaboration with users and survivors.

All but one of the studies assessing the efficacy of the WRAP found significant improvements in most of the variables measured. The exception was the study conducted in Hong Kong by Mak et al. (2016)(59), who only found significant improvement in perceived social support after WRAP workshops. This means that they did not observe any significant enhancement in relation to commonly measured variables such as empowerment, hope, self-stigma, social network size, symptom severity, and subjective recovery.

Fourteen studies used a psychiatric diagnosis as an inclusion criterion, and they were all conducted from a professional perspective only. The criterion in 12 of these studies was a diagnosis of a severe mental disorder, which among participants was mainly bipolar disorder, major depression, or schizophrenia. Of the remaining studies, 13 included users from mental health services. Seven studies included people with any form of emotional distress or who were interested in enhancing their wellbeing, and these participants did not self-identify as mental health service users. Three studies defined their participants as people with any experience of a mental health problem. Finally, three studies involved participants defined as from an ethnic minority and with psychosocial difficulties.

Table 2: Studies of the implementation of the tools

Authors	Country	Tool
Afzal, Bashir, & Perveen, 2020 (60)	Pakistan	WRAP
Ali, 2013 (61)	Palestine	WRAP
Aljeesh & Shawish, 2018 (62)	Palestine	WRAP
Ashman, Halliday, & Cunnane, 2017 (63)	UK	WRAP
Ben-Zeev et al., 2018 (64)	USA	WRAP
Carpenter-Song, Jonathan, Brian, & Ben-Zeev, 2020 (65)	USA	WRAP
Cook et al., 2009 (52)	USA	WRAP

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4	Cook et al., 2010 (53)	USA	WRAP
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6	Cook, Copeland, Floyd, et al., 2012 (55);	USA	WRAP
7	Cook, Copeland, Jonikas, et al., 2012 (56);		
8	Jonikas, Grey, Copeland, et al., 2013 (57)		
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11	Cook et al., 2013 (58)	USA	WRAP
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13	Davidson, 2018 (66)	Scotland	WRAP
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15	Doughty, Tse, Duncan, & McIntyre, 2008 (51)	New Zealand	WRAP
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18	Elhelou, 2018 (67)	Palestine	WRAP
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20	Fukui et al., 2011 (68)	USA	WRAP
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23	Gordon & Cassidy, 2009 (69)	USA	WRAP
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25	Higgins et al., 2012 (70)	Ireland, UK	WRAP
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28	Horan & Fox, 2016 (71)	Ireland	WRAP
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30	Jung, Ju, Kim, & Heo, 2019 (72)	Korea	WRAP
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33	Katayama, Morita, & Mori, 2019 (73)	Japan	WRAP
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35	Keogh et al., 2014 (74)	Ireland, UK	WRAP
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37	Mak et al., 2016 (59)	China	WRAP
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40	Matsuoka, 2015 (75)	Canada	WRAP
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42	McIntyre, 2005 ^a	New Zealand	WRAP
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44	O'Dwyer, 2015 (76)	UK	WRAP
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47	O'Keefe et al., 2016 (77)	Ireland, UK	WRAP
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49	Olney & Emery-Flores, 2017 (78)	USA	WRAP
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51	Petros, 2017 (79)	USA	WRAP
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54	Petros & Solomon, 2020 (80)	USA	WRAP
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56	Pratt, Macgregor, Reid, & Given, 2012 (81)	Scotland, USA	WRAP
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58	Pratt, Macgregor, Reid, & Given, 2013 (82)	Scotland, USA	WRAP
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Starnino et al., 2010 (83)	USA	WRAP
Stokoe & Bradbury, 2013 (84)	England	WRAP
Wilson, Hutson, & Holston, 2013 (85)	USA	WRAP
Zahniser, Ahern, & Fisher, 2005 (49)	USA	PACE
Zhang, Wong, Li, Yeh, & Zhao, 2010 (54)	New Zealand	WRAP

^a McIntyre L. WRAP around New Zealand. Unpublished Paper. Wellington: Victoria University of Wellington; 2005.

More information in [Supplementary Table 4](#) and [Supplementary Table 5](#).

Thematic analysis

Below, the Table 3 summarizes the main objectives of the tools.

Table 3: Emerging Topics from Thematic Analysis

Goals	Tools that included
Improving wellness	All tools
Navigating crisis	All tools
Promoting Empowerment	All tools (personal or social empowerment)
Facilitating mutual support	All tools
Promoting recovery	Some tools
Copping with oppression	Some tools

Improving Wellness

The tools identified are aimed at promoting wellness. The WRAP associates wellness with happiness, rather than with the absence of illness (26). Specifically, this tool defines wellness as the experience of feeling physically and emotionally well despite life's daily challenges (42). In the MRAB, wellness is defined as being satisfied with one's life or feeling comfortable with oneself (41). The M&O links wellness to participation in the community and its transformation (29). The T-MAPs similarly defines wellness from a social perspective, and it involves collectively building a world in which to live (46)(45). Finally, the PACE and MoM do not define the concept of

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wellness, although they include several examples of activities and resources for promoting it.

The WRAP, T-MAPs, and MRAB include a specific section for working on wellness, and some sections of the MoM and M&O are likewise aimed at helping users to reflect on or compile self-care or wellness resources. As for the PACE, it does not offer a specific section on wellness; however, under 'Recovery Skills' it addresses *Self-Care Techniques*, that is, things that people can do for themselves that make them feel good (27).

Navigating Crisis

The tools are also designed to help avoid or navigate crises, the meaning of which goes beyond the appearance of symptoms. In the WRAP, the concept of crisis refers to a loss of control over one's life (26), and symptoms come to represent a crisis when people's thoughts and feelings affect their ability to make decisions, take care of themselves, or stay safe (28). The PACE defines a crisis as overwhelming stress, difficulties in integrating experiences, and an interrupted development (43). The MoM similarly considers crises to be highly intense emotional states that affect thinking and communication (39). In the MRAB, a distinction is made between crisis as a synonym for clinical symptoms or relapse and life crises that profoundly affect a person's way of life (41). The T-MAPs conceptualizes crises both as experiences of emotional distress and as an opportunity for growth and transformation (40). Although the M&O does not define the concept of crisis, it gives several examples in sections such as: *How does oppression affect your behavior?* or *How does oppression make you sick?* (29). Regarding the MoM, it defines itself on its cover as a *Workbook for navigating crisis* (39). The WRAP, MoM, M&O, T-MAPs, and MRAB all regard crises as a fundamental issue for people to consider when drawing up their own recovery plan or map. The M&O and the T-MAPs contain specific sections oriented to reflecting on the social and structural causes of crises.

All tools, except the PACE, include specific sections dealing with knowing what to do (or not to do) to avoid a crisis, recognizing the factors that can precipitate it, and identifying red flags when it starts. The WRAP, MoM, T-MAPs, and M&O also have a section aimed at explaining to friends and relatives how the person needs and wants to

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3 be accompanied during a crisis. Another feature of the WRAP, MoM, T-MAPs, and
4 MRAB is a section on developing advance directives. Finally, the WRAP and MRAB
5 include, respectively, sections headed *Post-Crisis Plan* and *Learning Agenda*. Both are
6 focused on learning from crises, identifying what was useful and what was not.
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10 Promoting Recovery

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13 The tools are aimed at promoting recovery. The WRAP, PACE, and MRAB describe
14 themselves as a recovery plan, guide or manual, and they each include sections on
15 defining recovery and what is needed to promote it. The WRAP defines recovery as a
16 process that helps people to improve their health and general wellness, lead an
17 independent life, and reach their full potential (26). For the PACE, recovery is a healing
18 process that "*allows people to (re)capture their dreams* (p. 5)"(27) and to have an adult
19 identity and a major social role (86). The MRAB use Anthony's definition of recovery,
20 that is, a process through which a person develops new meaning and purpose in life
21 such that it becomes satisfying (14).
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30 The WRAP defines five key concepts associated with recovery: Hope, personal
31 responsibility, self-advocacy, education, and support (26). In the PACE, beliefs,
32 relationships, skills, identity, and community are considered the most important aspects
33 to work on to promote a person's recovery (27). The MRAB follows the ten guiding
34 principles of recovery set out by SAMHSA: Hope, person-driven, many pathways,
35 holistic, peer support, relationships, culturally based, trauma-based, strengths and
36 responsibilities, and respect (87).
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43 Although the WRAP stresses that recovery goes beyond the clinical or
44 functional dimension, it nonetheless defines itself as "a system for monitoring, reducing
45 and eliminating uncomfortable or dangerous physical symptoms and emotional
46 feelings" (28). Conversely, the PACE and MRAB make clear that recovery is not a
47 clinical outcome, in other words, it is not synonymous with symptom remission (41). As
48 for the T-MAPs, it does not aim to help the person return to a previous state of health,
49 and instead it uses the concepts of transformation and resilience practices and promotes
50 "*a process of transformation and growth* (p. 3)"(40). The MoM and M&O do not use
51 the concept of recovery or any equivalent. In the case of the MoM, users are encouraged
52 to question interventions that seek to return them to some form of normality, rather than
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3 accepting and supporting “*the different ways that all of our minds and bodies may*
4 *function (p. 2)*”(39).

7 Promoting Empowerment

10 The tools are resources that help to promote a process of empowerment. The PACE is
11 specifically “*based on the Empowerment Model of Recovery (p. 16)*”(27), while the
12 MRAB is described as a model of self-management, self-determination, and self-control
13 aimed at promoting empowerment. The latter tool includes a section called *Personal*
14 *Growth Plan*, defined as “*the personal strategy of empowerment (p. 18)*”(41).

17 For the PACE, empowerment means “*moving from dependence to self-*
18 *determination (p. 91)*”(86), such that people take control of the important decisions that
19 affect their lives and come to see themselves as competent members of society.

22 Four tools are primarily aimed at promoting empowerment on a personal level,
23 which includes: Promotion of self-determination, self-management, and taking
24 responsibilities (WRAP, PACE, MRAB); self-awareness, self-help, self-advocacy
25 (WRAP, PACE); building self-esteem and personal confidence (WRAP, PACE);
26 developing a positive sense of identity (not a sick role), challenging self-stigma
27 (WRAP, PACE, MoM, MRAB); and creation of a meaningful life (WRAP, MRAB). By
28 contrast, the M&O and T-MAPs seek primarily to promote empowerment at the social
29 level, including identification of and reflection on the social structures of power,
30 privilege, and oppression, in addition to promoting participation in transformative
31 collective practices in the community (29)(40).

34 Facilitating Mutual Support

37 All tools highlight the importance of mutual support or peer support practices for
38 recovery, resilience, empowerment, and/or the social change processes they seek to
39 promote. This is made explicit in the name given to one of the tools, Transformative
40 Mutual Aid Practices (T-MAPs), whose authors describe it as “*our attempt to help*
41 *create a concrete framework for mutual aid (p. 33)*”(40).

44 The PACE, M&O, T-MAPs, and MRAB dedicate a section to exploring and
45 promoting participation in mutual support or peer activities. The WRAP, in its updated
46 edition, also includes a section called *Appendix B: Peer Support* (26). As for the MoM,
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3 although it highlights the value and importance of mutual support, it does not include a
4 specific section on this.
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7 The M&O and T-MAPs suggest that users share their own maps with other
8 people in mutual support meetings.
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11 Coping with Oppression

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14 Some of the tools aim to encourage reflection on the axes of oppression that affect
15 emotional wellbeing. For instance, the M&O and T-MAPs include different sections for
16 people to work individually and collectively on the specific axes of oppression that
17 affect them (racism, sexism, ableism, classism, etc.). In the case of the M&O, all the
18 material is aimed at identifying the different forms of oppression that people encounter
19 in life, and at helping them to recognize both how this oppression affects their wellness
20 and how it can be responded to.
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28 The PACE and MoM do not have a specific section dedicated to oppression,
29 although they do include some reflection on the role of social, economic, and cultural
30 factors in the incidence of mental disorder and in recovery processes, highlighting the
31 pathological effects of different forms of oppression. The PACE, M&O, MoM, and T-
32 MAPs consider the institution of psychiatry itself as an axis of oppression.
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38 Discussion

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41 This study aimed to identify and characterize tools developed by users and survivors of
42 psychiatry and aimed at promoting recovery, empowerment, and wellness. The scoping
43 process identified six tools developed between 1997 and 2018, and a total of 37 studies
44 published between 2005 and 2020. Five of the six tools originated in the USA and were
45 originally published in English, the exception being the MRAB, which was developed
46 in Catalonia (Spain) and published in Catalan. Three tools present themselves as a Mad
47 Map and the other three as a Recovery Guide or Manual. Contact with networks of
48 users and survivors proved crucial to discovering the tools, because only the WRAP and
49 PACE were found in database searching. All tools emerged within the context of user
50 and survivor movements, although their process of development varied depending on
51 the movement. In addition to users and survivors, mental health service providers were
52 also involved in developing the WRAP and the MRAB.
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3 Of the 37 studies identified, they all, with the exception of one that involved the
4 PACE, used the WRAP program and were delivered as group workshops. The latter was
5 a crucial aspect of the WRAP program for many studies (69)(54)(81)(82)(78)(63)(79), it
6 being considered that a group setting offers specific benefits: "...*mutual identification,*
7 *validation and support that emerges from delivering WRAP in a group environment* (p.
8 576)"(63). Several studies also regard peer-run workshops as being a key aspect of the
9 WRAP (76)(78)(66)(72), it being argued that peer facilitators serve as models and
10 examples of recovery, improving participants' hope (66). However, fewer than half of
11 the studies reported that workshops were delivered by peers or with peers in the team.
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20 Anglophone countries, primarily the USA and the UK, were the main
21 contributors to research in this field. Only seven studies were carried out in non-
22 English-speaking countries, namely Palestine (61)(62)(67), China (59), Japan (73),
23 Korea (72), and Pakistan (60). Contrary to most findings, one of these studies (59) only
24 observed a significant improvement in perceived social support after WRAP workshops.
25 It should also be noted that only three studies aimed to explore the applicability of the
26 WRAP program in an ethnic minority (69)(54)(75). Two of these (69)(75) suggest
27 integrating a critical analysis of oppression and a gender perspective in workshops, a
28 focus which is not incorporated in the WRAP.
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36 Quasi-experimental and pre/post-test studies were the predominant designs in
37 quantitative research, whereas qualitative studies were mainly characterized by the use
38 of grounded theory or Braun and Clarke's approach to thematic analysis. Sample sizes
39 varied across the studies, as did the criterion for inclusion, with some authors requiring
40 an established diagnosis, while others included people reporting any kind of emotional
41 distress. Universities and mental health services were the main institutions involved in
42 the research. Although user and survivor organizations, such as the Copeland Center for
43 Wellness and Recovery, and the Mental Health Recovery and WRAP, also contributed
44 to research output, the professional and academic perspective was predominant. Thus,
45 while the tools themselves are the result of survivor research (30), most of the studies
46 were designed and conducted without the participation of users and survivors.
47 Moreover, even though recovery-oriented resources are not aimed at clinical recovery
48 (14)(15)(16), the predominant focus of these studies was symptom reduction; notably,
49 the few studies that did incorporate the perspective of users and survivors were focused
50 instead on attitudes and knowledge about recovery (49)(51)(54) (and the unpublished
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3 paper by McIntyre, 2005). In a similar vein, although there are numerous psychometric
4 instruments aimed at measuring recovery (88)(89), only two of those used in the studies
5 were designed by or in conjunction with users and survivors as part of the research
6 team: Doughty et al. (51), and the Minnesota' Survey in Cook et al. (53). This illustrates
7 how the perspective adopted by most of the studies does not take into account the
8 epistemological and theoretical background of the tools used. Indeed, the studies tend to
9 use the tools in a way akin to a psycho-educational program, rather than as tools built
10 from people's experiential knowledge of their recovery processes.
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18 Thematic analysis identified a total of six goals that form the primary focus of
19 the tools: Improving wellness, navigating crisis, promoting recovery, promoting
20 empowerment, facilitating mutual support, and coping with oppression. The first two of
21 these goals, improving wellness and navigating crisis, are common to all tools, each of
22 which acknowledges their importance and includes sections dedicated to working on
23 these goals and/or strategies and examples of how to achieve them. The importance of
24 mutual support for recovery, empowerment, and/or coping with oppression is also
25 highlighted by all six tools, and five of them were specifically designed to be used in a
26 group setting with peers. Although some tools do not explicitly use the concept of
27 *empowerment*, they all aim to promote it on some level (11); the WRAP, PACE, MoM,
28 and MRAB promote certain aspects of personal empowerment, while the M&O and T-
29 MAPs do the same with social empowerment. As regards the other two goals (i.e.,
30 promoting recovery and coping with oppression), the tools differ in the stance they take.
31 The M&O and MoM do not use the concept of recovery, and the T-MAPs refers to
32 resilience rather than recovery, the reason being that these tools consider that the idea of
33 'recovery' suggests a return to a previous stage or to some state of supposed normality.
34 Other tools (the MRAB) do refer to recovery but explicitly state that it does not mean
35 going back to the past or being *normal*. Finally, coping with oppression is a specific
36 focus of the M&O and T-MAPs, and it is also referred to at some point by the MoM and
37 PACE. By contrast, the WRAP and MRAB do not offer any kind of reflection on the
38 mental health system as a possible axis of oppression or on the negative effects of
39 different kinds of oppression on people's wellbeing. Coincidentally, these are the only two
40 tools to have been created in collaboration with mental health service providers.
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Although the search process allowed us to identify and characterize tools created by users and survivors, certain gaps and limitations emerged. Notably, although this

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3 scoping review applied broad parameters and used several search strategies to map tools
4 and their associated studies, the tools identified were developed, and most of the studies
5 were conducted, in high-income countries with a recovery-oriented mental health
6 system, in which there are well-established networks of users and survivors, and an
7 Anglo-Saxon/Protestant cultural background that highlights individual freedom and
8 self-determination (90). Therefore, the trends identified in the literature should be
9 considered as representative of these kinds of contexts. More studies are needed to
10 clarify the applicability and utility of the tools identified in other cultural contexts and
11 for ethnic minorities. Furthermore, although we contacted different networks of users
12 and survivors, including those of international scope, in every continent, we obtain no
13 answer from any African network or organization. This hindered the possible
14 identification of additional material and the opportunity both to compare the recovery
15 strategies used in non-Western contexts and to explore the extent to which the concept
16 of recovery itself is applicable in those contexts.
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28 Further research is likewise needed to examine the application and outcomes
29 achieved with tools other than the WRAP. Once such studies begin to be conducted, it
30 would be also be interesting to observe how they conceptualize recovery, wellness,
31 crisis, empowerment, oppression, and mutual support, and to see if they follow the
32 original proposals of the tools' authors or focus on evaluating different variables.
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38 The underlying philosophy of the disability rights movement worldwide,
39 "*Nothing About Us Without Us*" (91), is the foundation of the tools built by user and
40 survivor movements. However, very few studies have included users and survivors as
41 subjects of knowledge, recognizing and valuing their personal and collective experience
42 as a source of learning, rather than seeing them as objects of intervention. A priority for
43 future research is therefore to ensure the participation of users and survivors in the
44 design, implementation, and assessment of mental health recovery tools. Given that
45 existing tools have come about thanks to the initiative of user and survivor networks, it
46 is also important that this research is carried out from the perspective of survivor
47 research and mad studies.
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56 **Contributors:**
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HMS developed the conceptual framework, carried out the thematic analysis and wrote the first draft of the manuscript. VRC conceived the methodological framework and assisted with subsequent drafts of the manuscript. HMS and VRC performed the search process and the study selection, coded the data, and developed the descriptive analysis. JG-B assisted in the study selection and the process of coding. JG-B and JER supervised and provided regular feedback on each of these steps and contributed to revision of the final manuscript.

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Data sharing statement:

Data are available upon reasonable request. Contact email: projectes@activament.org. Data available: results of database searching, grey literature searching, Google Scholar searching, list of journals reviewed, networks of users and survivors contacted, and data analysis tables. Reuse of data is permitted.

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Ethics Approval:

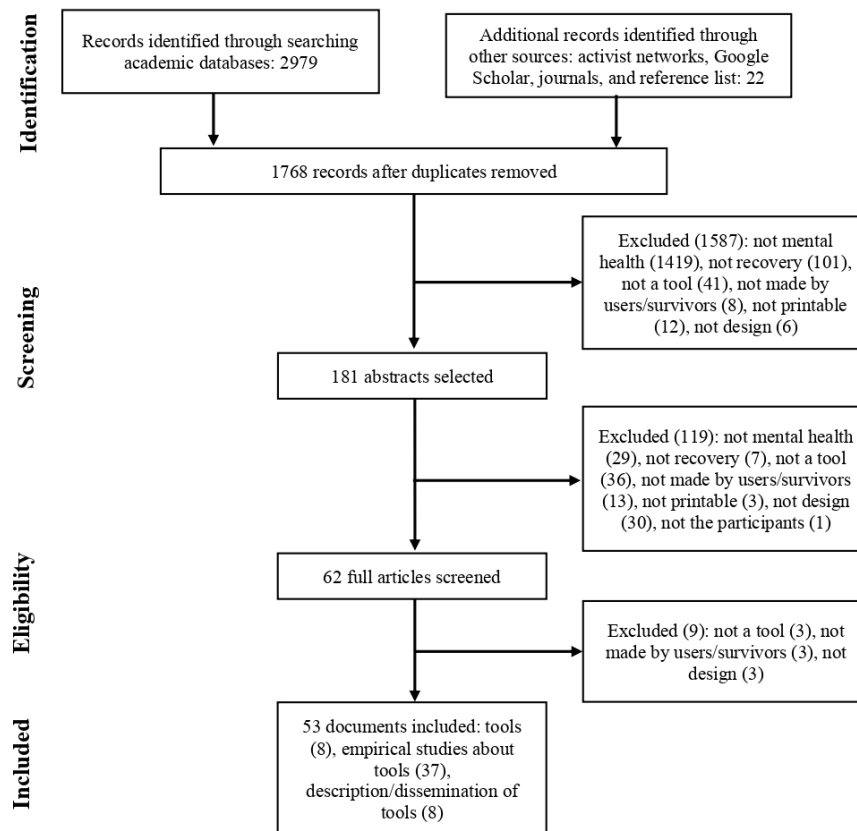
This study does not require ethical approval because the data used are from publicly available materials.

Figure Legend

Figure 1 - Selection process for study inclusion.

For peer review only

Figure 1. Selection process for study inclusion



94x95mm (300 x 300 DPI)

Running title: MAD MAPS AND RECOVERY TOOLS: A SCOPING REVIEW

Mapping mad maps and recovery tools developed by mental health service users and survivors of psychiatry: A scoping review

Supplemental material: (a) Complete data collection strategy and study selection detailed; (b) Descriptive characteristics of the studies

From July 21 to September 3, 2021, we started the searching process contacting international and national **networks of users and survivors**, and international **mental health organizations**, with the aim of identifying suggested tools to be included in our Scoping Review. In addition, we ask for suggestions from new networks, organizations, activists, or academics to whom we could send our query.

Finally, we contacted 29 networks or entities (numbers 1 to 20 and 31 to 39 in Supplementary Table 1), of which 20 responded (69%). We also contacted at least one of the authors of each of the identified tools (except Mary Ellen Copeland).

Supplementary Table 1: International organizations and networks of users and survivors contacted

International Mental Health Organizations contacted		
1	World Health Organization	Michelle Funk
2	Mental Health Europe	Catherine Brogan
3	Disability Rights International	Laurie Ahern ¹
Organizations and networks of users and survivors contacted		
4	World Network of Users and Survivors of Psychiatry	Salam Gómez
5	European Network of Users and Survivors of Psychiatry	Olga Kalina
6	Redesfera Latinoamericana de la Diversidad Psicosocial	Cecilia Guillén
7	Transforming Communities for Inclusion – Asia Pacific	Bhargavi Davar
8	Center for the Human Rights of Users and Survivors of Psychiatry	Tina Minkowitz
9	Global Mental Health Peer Network	Charlene Sunkel
10	Taiwan Mad Alliance	Lee Yun
11	Korean Alliance for Mobilizing Inclusion of the people with psychosocial disabilities	Oh Yong Kweon

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12	Inclusive Asia, Hong Kong	Chine Chan Yan
13	Fireweed Collective, USA	Agustina Vidal ²
14	The Icarus Project NYC, USA	Kevin Mark
15	Balance Aotearoa, New Zealand	Leo McIntyre
16	Intentional Peer Support	Chris Hansen
17	Hearing Voices Network	Olga Runciman
18	We shall overcome, Norway	Mette Ellingsdalen
19	Sagatun Brukerstyrt Senter, Norway	Kårhild Husom Løken
20	ActivaMent Catalunya Associació, Spain	Carla Gavaldà-Castet ³
Other activists and academics contacted		
21	Mapping our Madness (author)	Momo
22	Personal Assistance in Community Existence (author)	Laurie Ahern* ¹
23	Madness & Oppression (author)	Agustina Vidal* ²
24	Transformative Mutual Aid Practices (author)	Sascha Altman DuBrul
25	Manual per a la Recuperació i Autogestió del Benestar (author)	Carla Gavaldà-Castet* ³
26	Peer Services and Research, Yale School of Medicine	Chyrell Bellamy
27	Collaborative Support Programs of New Jersey	Margaret Peggy Swarbrick
28	University of Nottingham	Mike Slade
29	University of Pittsburgh	Nev Jones
30	Mental Health Engagement & Recovery Office, Ireland	Michael John Norton
Other Organizations contacted (without answer)		
31	Pan African Network of People with Psychosocial Disabilities	
32	Users and Survivors of Psychiatry in Kenya	
33	Tanzania Users and Survivors of Psychiatry Organization	
34	Advocacy Centre of Persons with Psychosocial Disability, Japan	
35	Copeland Center for Wellness and Recovery	

¹ Laurie Ahern, co-author of Personal Assistance in Community Existence, and President of Disability Rights International

² Agustina Vidal, coordinator of Madness & Oppression, and contact of Fireweed Collective.

³ Carla Gavaldà-Castet, co-author of Manual per a la Recuperació i Autogestió del Benestar, and member of the research team of ActivaMent Catalunya Associació.

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36	National Empowerment Center
37	Monash University
38	UKE Hamburg
39	OnTrack NY

At this step, 9 tools (with 12 documents) were suggested for the Scoping Review.

Supplementary Table 2: Tools suggested, and decisions made

	Tool suggested	Inclusion	
1	Wellness Recovery Action Plan (Copeland, 1997)	Yes	1
2	Personal Assistance in Recovery Existence (Ahern & Fisher, 1999)	Yes	1
3	Madness & Oppression (The Icarus Project, 2015)	Yes	1
4	Mapping our Madness (Momo, 2015)	Yes	1
5	Transformative Mutual Aid Practices. (McNamara & Dubrul, 2018)	Yes	2
6	Manual per a la Recuperació i Autogestió del Benestar (Sampietro & Gavalda Castet, 2018)	Yes	3
7	Pathways to Recovery: A Strengths Recovery Self-Help Workbook (Ridgway et al., 2011)	No	1
8	Better Days - A Mental Health Recovery Workbook (Lewis, 2013)	No	1
9	The Toolbox of Sagatun User-Led Centre (n.d.)	No	1

Two of these suggested materials did not meet the inclusion criteria. Pathways to Recovery (Ridgway et al., 2011) is not a tool developed by people who are experiencing or have experienced a mental health issue and/or by users, ex-users and survivors' movements. Better Days (Lewis, 2013) it is a tool designed to promote a personal reflection and self-learning, but it is not made to elaborate a personalized strategy or a plan (that can be implemented and evaluated). Finally, the Toolbox of Sagatun User-Led Centre (n.d.) was suggested, but it is not available for private use or download, and we could not assess its inclusion in our research.

From September 4 to September 7, 2021, we made a searching using Boolean operators, in 7 **academic electronic databases** and 2 **grey literature databases**. The following separate searches were performed:

Database: **Scopus**. Data searched: 2021-09-04.

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Search terms: (Search in Title, Abstract, Keywords) ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR TITLE ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND TITLE-ABS-KEY ("crisis plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map* mad*" OR "own pace") AND NOT TITLE ("diabetes" OR "asthma" OR "epilep*" OR "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease" OR "Bowel disease" OR "cultural").

Database: **PsycInfo**. Data searched: 2021-09-04.

Search terms (Search in Abstract): ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*" OR "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

Database: **PsycArticles**. Data searched: 2021-09-04.

Search terms (Search in Abstract): ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery

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plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

Database: **PubMed**. Data searched: 2021-09-04.

Search terms (Search in Title, Abstract): ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

Database: **CINAHL**. Data searched: 2021-09-05.

Search terms (Search in Topic + Search in Abstract):

- a- In Topic ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") NOT ("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").
- b- In Abstract ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*")

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"Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR
"Parkinson" OR "Cardiovascular disease").

Database: **Cochrane Library**. Data searched: 2021-09-06

Search terms (Search in Title, Abstract, Keywords):

- a- ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar").
- b- ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*" OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map* mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").

Database: **Web of Science**. Data searched: 2021-09-07.

Search terms (Search in Topic + Search in Abstract):

- a- In Topic ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") NOT ("diabetes" OR "asthma" OR "epilep*" "Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR "Parkinson" OR "Cardiovascular disease").
- b- In Abstract ("Wellness Recovery Action Plan*" OR "Personal Assistance in Community Existence" OR "Mapping Our Madness" OR "Transformative mutual aid practices" OR "Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la Recuperació i Autogestió del Benestar") OR ("empower*" OR "self determination" OR "self-determination" OR "wellness" OR "self manag*" OR "self-manag*" OR "get better" OR "mak* choice*" OR "tak* action") AND ("crisis plan*" OR "action plan*" OR "action program*")

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OR "crisis program*" OR "recovery plan*" OR "recovery program*" OR "map*
mad*" OR "own pace") NOT ("diabetes" OR "asthma" OR "epilep*"
"Dementia" OR "pulmonary disease" OR "COPD" OR "Alzheimer" OR
"Parkinson" OR "Cardiovascular disease").

Database: **Ethos**. Data searched: 2021-09-07.

Search terms (Search in Abstract): ("Transformative mutual aid practices" OR
"Mapping our Madness" OR "Wellness Recovery Action Plan" OR "Wellness
Recovery Action Planning" OR "Personal Assistance in Community Existence" OR
"Madness & Oppression" OR "Madness and Oppression" OR "Manual per a la
Recuperació i Autogestió del Benestar").

Database: **SIGLE**. Data searched: 2021-09-07.

Search terms (Search in all): "Transformative mutual aid practices", "Mapping our
Madness", "Wellness Recovery Action Plan", "Wellness Recovery Action Planning",
"Personal Assistance in Community Existence", "Madness & Oppression", "Madness
and Oppression", "Manual per a la Recuperació i Autogestió del Benestar".

Results:

268 documents = Scopus

325 documents = PsycInfo

045 documents = PsycArticles

743 documents = PubMed

352 documents. (27 + 325) = CINAHL

448 documents (17 + 431) = Cochrane Library

795 documents (47 + 748) = Web of Science

002 documents = Ethos

001 document = SIGLE

At this step, a list of **2.979 potentially relevant documents** retrieved from
electronic databases and grey literature databases was created.

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On September 8, 2021, the **1,233 duplicate** documents were removed from academic and grey literature databases, and **1,746 documents were included** to be reviewed by title.

Decisions made:

0. Included.
1. Not included. **It is not the object of study** = it is not mental health
2. Not included. **It is not the topic** = it is about mental health, but not about recovery, empowerment, and self-determination (in relation to mental health).
3. Not included. **It is not a tool** = it is about mental health, it talks about recovery, empowerment, and self-determination (in relation to mental health), but it does not talk about materials and/or workshops to promote personalized plans.
4. Not included. **It is not made by users and survivors** = it is about mental health, it talks about recovery, empowerment, and self-determination (in relation to mental health), it talks about materials and/or workshops to promote personalized plans, but the tool was not created by users and survivors of psychiatry,
5. Not included. **It is not a printed or printable material** = It is an App or an Internet intervention.
6. Not included. **It is not the design** = they are systematic reviews, metanalysis, essays, clinical trial registrations, books reviews, tools presentation (without new information), letters to the editor, etc.
7. Not included. **It is not the participants** = The study was not made with adult people or/and with users of mental health services or with mental health problems.

From September 9 to September 10, 2021, 1,746 documents were **reviewed by title**. At this step, **159 documents were included** and 1,587 were discarded.

0 = 0159 included
1 = 1419 discarded
2 = 0101 discarded
3 = 0041 discarded
4 = 0008 discarded
5 = 0012 discarded

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6 = 0006 discarded

From September 13 to September 14, 2021, 159 documents were **reviewed by Abstract**. At this step, **40 documents were included** and 119 were discarded.

0 = 40 included

1 = 29 discarded

2 = 07 discarded

3 = 36 discarded

4 = 13 discarded

5 = 03 discarded

6 = 30 discarded

7 = 01 discarded

From September 10 to September 16, 2021, 40 documents were **reviewed by complete text**. At this step, **31 documents were included** and 9 were discarded.

0 = 31 included

3 = 03 discarded

4 = 03 discarded

6 = 03 discarded

From September 17 to September 18, 2021, we conducted a search in **Google Scholar**, with no date restriction, any language, ordered by relevance. Only the first 100 outcomes were included.

Search terms: “Transformative mutual aid practices”, “Mapping our Madness”, “Wellness Recovery Action Plan”, “Wellness Recovery Action Planning”, “Personal Assistance in Community Existence”, “Madness & Oppression”, “Madness and Oppression”, “Manual per a la Recuperació i Autogestió del Benestar”.

Results:

WRAP: 1.510 results (first 100 results included)

PACE: 161 results (first 100 results included)

MoM: 14 results

T-MAPs: 4 results

M&O: 5 results

MRAB: 0 result

At this step, a complementary list of **233 potentially relevant documents** retrieved from Google Scholar was created. Of them, 9 duplicate documents were

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removed, and 224 documents were included to be **reviewed by title and abstract**. At this step, **48 documents were included**, and 176 were discarded.

0 = 48
1 = 08
2 = 55
3 = 67
4 = 07
5 = 03
6 = 25
7 = 01

Of these 48 documents, **28 were repeated** with the ones included at the academic databases search. They were discarded. The last 20 documents were **reviewed by complete text**. At this step, **11 documents were included** and 9 were discarded.

0 = 11
3 = 01
4 = 01
6 = 07

From September 19 to September 20, 2021, we conducted a **manual review of journals**. All the numbers published in 2021, of the 24 journals in which a paper was previously found were reviewed.

Supplementary Table 3: Manually reviewed journals

1	American Journal of Psychiatric Rehabilitation	Vol. (Issue)	N°
2	Aotearoa New Zealand Social Work	33(2) 33(1)	-
3	Australasian Psychiatry	29(1) 29(2) 29(3) 29(4)	-
4	British Journal of Mental Health Nursing	10(1) 10(2) 10(3)	-
5	British Journal of Social Work	51(1) 51(2) 51(3) 51(4) 51(5)	-
6	Community Mental Health Journal	57(1) 57(2) 57(3) 57(4) 57(5)	-

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		57(6) 57(7)	
7	Ethical Human Psychology and Psychiatry	23(1)	-
8	Evaluation Studies in Social Sciences	10(1) 10(2)	-
9	International Journal of Psychiatry	6(1)	
10	International Journal of Psychosocial Rehabilitation	25(1) 25(2) 25(3)	-
11	Irish journal of psychological medicine	38(1) 38(2) 38(3)	-
12	Issues in Mental Health Nursing	42(1) 42(2) 42(3) 42(4) 42(5) 42(6) 42(7) 42(8) 42(9)	-
13	Journal of Advanced Nursing	77(1) 77(2) 77(3) 77(4) 77(5) 77(6) 77(7) 77(8) 77(9) 77(10)	-
14	Journal of Humanistic Psychology	61(1) 61(2) 61(3) 61(4) 61(5)	-
15	Journal of Psychiatric and Mental Health Nursing	28(1) 28(2) 28(3) 28(4) 28(5)	-
16	Journal of Psychosocial Nursing & Mental Health Services	59(1) 59(2) 59(3) 59(4) 59(5) 59(6) 59(7) 59(8) 59(9)	-

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17	Occupational Therapy in Mental Health	37(1) 37(2) 37(3)	-
18	Psychiatric Rehabilitation Journal	44(1) 44(2) 44(3)	-
19	Psychiatric Services	72(1) 72(2) 72(3) 72(4) 72(5) 72(6) 72(7) 72(8) 72(9)	1
20	Qualitative Health Research	31(1) 31(2) 31(3) 31(4) 31(5) 31(6) 31(7) 31(8) 31(9) 31(10)	1
21	Rehabilitation Counselling Bulletin	64(2) 64(3) 64(4) 65(1)	-
22	Schizophrenia Bulletin	47(1) 47(2) 47(3) 47(4) 47(5)	-
23	The Scientific World Journal	Vol. 2021	-
24	Journal of Future Social Work Research - 미래사회복지연구	12(1) 12(2)	-

Nº: number of registers identified by each journal

Two papers were found at the **manual review of journals**, but both of them were repeated with the papers previously found in the academic databases and they were discarded.

From September 21 to September 22, 2021, the **list of references** of all the documents already included were revised. At this step, 23 references were found to be reviewed. Of these new documents, **2 accomplished the criteria to be included**.

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0 = 4

3 = 1

6 = 17

7 = 1

New documents = 2

Repeated documents = 2

After all these steps, finally **53 documents** were included to the scoping review:
37 publications from 35 studies and 6 tools (with 8 documents) and 8 tools presentations.

For peer review only

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Supplementary Table 4: Descriptive characteristics of the studies

	Authors	Country	Tool	Design	Data collection/Data analysis	Participant definitions ^a /Sample characteristics
1	Afzal, Bashir, & Perveen, 2020 (60)	Pakistan	WRAP	Pre-post-test	Questionnaire/Descriptive and inferential statistical analysis	8 patients with psychiatric disorders, 50% female, aged from 26 to 55 years, 38.4 mean age (SD: 10.6)
2	Ali, 2013 (61)	Palestine	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	33 chronic female schizophrenic patients (WRAP:15, Usual care:18), 69.0% more than 30
3	Aljeesh & Shawish, 2018 (62)	Palestine	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	8 Patients with major depressive disorder (WRAP: 4, Usual treatment: 4), 50.0% female
4	Ashman, Halliday, & Cunnane, 2017 (63)	UK	WRAP	Qualitative	Semi-structured interview /Interpretative phenomenological analysis	6 adults with at least one episode of crisis care from Mental Health Crisis Resolution and Home Treatment Teams, 66.7% female, aged from 25 to 59 years, 83.3% Caucasian
5	Ben-zeev et al., 2018 (64)	USA	WRAP	RCT	Questionnaire/Descriptive and inferential statistical analysis	163 adults with serious mental illness (WRAP: 81, FOCUS: 82), 49 mean age (SD:9.6), 61.0% High School or less, 41.1% female, 68.2% African American

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6	Carpenter-Song, Jonathan, Brian, & Ben-Zeev, 2020 (65)	USA	WRAP	Qualitative	In-depth semi structured interviews/ Braun and Clarke thematic analysis	31 adults with serious mental illness (WRAP: 15, FOCUS: 16), 58.1% High School or less, 35.5% female, 48.4% African American
7	Cook et al., 2009 (55)	USA	WRAP	Pre-post-test	Questionnaire/Descriptive and inferential statistical analysis	80 individuals with serious mental illness, 63.8% female, 46.6 mean age (SD: 10.4), 81.2% High School diploma, 66.2% Caucasian
8	Cook et al., 2010 (53)	USA	WRAP	Pre-post-test	Survey/Descriptive and inferential statistical analysis	381 consumers or survivors of psychiatric services (Vermont: 147, Minnesota: 234), 64.3% female, 32.8% aged from 41 to 50, 66.0% Caucasian
9	Cook, Copeland, Jonikas, et al., 2012 (56); Cook, Copeland, Floyd, et al., 2012 (57); Jonikas et al., 2013 (58)	USA	WRAP	RCT	Questionnaire/Descriptive and inferential statistical analysis	519 individuals with serious mental illness (WRAP: 251, Usual services and waiting list: 268), 66.0% female, 45.8 mean age (SD: 9.9), 47.0% college or more, 63.0% Caucasian
10	Cook et al., 2013 (66)	USA	WRAP	RCT	Questionnaire/Descriptive and inferential statistical analysis	143 individuals with serious mental illness (WRAP:72, Choosing Wellness: 71), 50.3% female, 45.9 mean age (SD: 11.2), 37.8% High School, 67.1% African American

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11	Davidson, 2018 (67)	Scotland	WRAP	Cross-Sectional	Questionnaire/Descriptive and inferential statistical analysis	109 participants, 66.7% people who have experienced mental health challenges, 56% mental health services professionals, 30.3% WRAP facilitators, 17.4% relatives, 46.5 mean age (SD: 11.79), 67% female, 29.3% bachelor's degree
12	Doughty, Tse, Duncan, & McIntyre, 2008 (52)	New Zealand	WRAP	Pre-post-test	Questionnaire/Descriptive and inferential statistical analysis	157 participants, 31.8% consumers of mental health services, 47.8% mental health services professionals, 86% aged from 31 to 60
13	Elhelou, 2018 (68)	Palestine	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	36 chronic depressed patients, 100% women, 58.3% more than 30, 47.2% university education, 66.7% married
14	Fukui et al., 2011 (69)	USA	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	114 people with severe mental illness (EG: 58, CG: 56), 62.3% female, 44.5 mean age (SD: 11.0), 67.5% High School or less, 64.9% White people
15	Gordon & Cassidy, 2009 (70)	USA	WRAP	Qualitative	Semi-structured interview, focus group/Inductive thematic analysis	7 women linked to the Scottish Recovery Network and/or National Health System services, more than 18, Black and South Asian (Pakistani or Indian background)
16	Higgins et al., 2012 (71)	Ireland, UK	WRAP	Mixed methods	Questionnaire, focus group/Descriptive and inferential statistical	194 participants who attended the WRAP education programmes, with different profiles, including 31.0% Mental health practitioner only,

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					analysis, Braun and Clarke thematic analysis	25.0% people with self-experience only, 64.9% female, most participants aged from 30 to 59
17	Horan & Fox, 2016 (72)	Ireland	WRAP	Qualitative	Semi-structured interview/Attride-Stirling thematic analysis	4 individuals with mental health difficulties who attended to WRAP programme, 25.0% female, aged from 35 to 61
18	Jung, Ju, Kim, & Heo, 2019 (73)	Korea	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	20 users from a club house (community recovery service) (WRAP: 10, usual care:10, 40.0% younger than 40, 70.0% university degree, 30.0% women, 100% Korean people
19	Katayama, Morita, & Mori, 2019 (74)	Japan	WRAP	Qualitative	Survey/Sato's qualitative analysis based on five key recovery concepts from WRAP (hope, personal responsibility, education, self- advocacy, support)	5 students from University of Nagano who had multiple difficulties in their student life and wanted <i>to have well-being</i> , mean age 22.0, 60% female, undergraduate students
20	Keogh et al., 2014 (75)	Ireland, UK	WRAP	Qualitative	Focus group/Braun and Clarke thematic analysis	22 group participants (who participated in study by Higgins et al. 2011), including 36.00% mental health practitioner only, 18.0% person with self-experience only, 45.0% self-experience of mental health difficulties, 63.6% female
21	Mak et al., 2016 (59)	China	WRAP	Matched controls	Questionnaire/Descriptive and inferential statistical analysis	118 Chinese mental health consumers (WRAP: 59, No WRAP: 59), 57.6% female, 42.9 mean age (SD: 11.4), 77.9% secondary education

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22	Matsuoka, 2015 (76)	Canada	WRAP	Qualitative	Questionnaire, interview, participant observation/Thematic analysis based on constructivist version of grounded theory	8 Japanese-Canadian older adults from community, 75.0% female, aged from 64 to 89, first generation of post-Second World War immigrants
23	McIntyre, 2005 ^b	New Zealand	WRAP	Pre-post-test	Questionnaire/Descriptive and inferential statistical analysis	76 participants, 51.1% identified as having personal experience of mental illness, 66.0% employed in mental health related jobs, and of those 44% also identified as having personal experience of mental illness, 86.0% aged from 31 to 60
24	O'Dwyer, 2015 (77)	UK	WRAP	Quasi-experimental	Questionnaire/Descriptive and inferential statistical analysis	WRAP1: 30 adults with acquired brain injury, aged from 19 to 59; WRAP2: 27 mental health services users, aged from 19 to 65; Mental health wait list: 31, aged from 22 to 55
25	O'Keeffe et al., 2016 (78)	Ireland, UK	WRAP	RCT	Questionnaire/Descriptive and inferential statistical analysis	36 inpatients and outpatients with a diagnosis of a mental or behavioural disorder, 48.1 mean age (SD: 10.5), 52.7% higher education, 52.8% female
26	Olney & Emery-Flores, 2017 (79)	USA	WRAP	Qualitative	Semi-structured interview/Phenomenology and grounded theory	10 adults who had a psychiatric diagnosis and received employment services, that had completed 8 weeks of WRAP training, aged from 48 to 69, 50.0% college degrees, 60.0% women, 80.0% White

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5	27	Petros, 2017 (80)	USA	WRAP	Qualitative design (from a mixed method study)	In-depth interview, focus group/Braun and Clarke thematic analysis	36 adults, self-identify as having experienced serious mental illness, who have completed WRAP programming and WRAP facilitator training, 47.2% female, 50.6 mean age (SD: 7.9), 77.8% black people
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12	28	Petros & Solomon, 2020 (81)	USA	WRAP	Cross sectional design (from a mixed method study)	Survey/Descriptive and inferential statistical analysis	82 adults with serious mental illness who had completed WRAP in the previous 6–24 months, 68.2% women, 46.8 mean age (SD: 11.00), 43.9% African American
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18	29	Pratt, Macgregor, Reid, & Given, 2012 (82)	Scotland, USA	WRAP	Qualitative	Interview, focus group/Thematic analysis based on constructivist version of grounded theory	8 WRAP facilitators, 87.5% female
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24	30	Pratt, Macgregor, Reid, & Given, 2013 (83)	Scotland, USA	WRAP	Mixed methods	Interview, focus groups, questionnaires/Descriptive analysis based on frequencies and means, Thematic analysis based on constructivist version of grounded theory	21 WRAP groups participants, members of Self-Help and Mutual Support Groups, at the Scottish Recovery Network
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34	31	Starnino et al., 2010 (84)	USA	WRAP	Pre-post-test	Questionnaire/Descriptive and inferential statistical analysis	30 participants who had attended WRAP workshops, 41.6 mean age (SD: 10.9), 60.0% female, 66.6% equal to or less than High School, 93.3% White people
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32	Stokoe & Bradbury, 2013 (85)	England	WRAP	Pre-post-test	Questionnaire/Descriptive and inferential statistical analysis	26 adults with a mental health diagnosis receiving treatment in a community mental health service, 39.6 mean age (SD: 13.1), 76.9% female.
33	Wilson, Hutson, & Holston, 2013 (86)	USA	WRAP	Mixed methods	Survey, interview/Descriptive and inferential statistical analysis, content analysis by Corbin and Strauss	26 outpatients of mental health facility that uses WRAP, 18 of them made the Qualitative Interviews, 50.0% women, 42.2 mean age (SD: 14.00), 60.0% Caucasian
34	Zahniser, Ahern, & Fisher, 2005 (49)	USA	PACE	Qualitative	Survey (open ended questions)/Qualitative content analysis	70 participants: 37.1% consumers/survivors, 37.5% administrators, 30.4% direct providers, 24.3% family members (some respondents identified with more than one category)
35	Zhang, Wong, Li, Yeh, & Zhao, 2010 (54)	New Zealand	WRAP	Qualitative	Semi-structured interviews, focus group/Analysis not specified	17 participants, including 47.1% Chinese mental health consumers, 17.6% mental health professionals and 35.3% family members, 50.0% of the consumers aged from 36 to 60, 75.0% female

^a Corresponds to definitions made by the authors regarding study participants

^b McIntyre L. WRAP Around New Zealand. Unpublished Paper. Wellington: Victoria University of Wellington; 2005. p. 28

FOCUS: a smartphone-delivered intervention; RCT: Randomized controlled trial

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Supplementary Table 5: Variables and results of the studies

	Authors	Variables measured/explored	Principal findings
1	Afzal, Bashir, & Perveen, 2020 (60)	Symptom's frequency and intensity.	The WRAP is effective in reducing the severity and frequency of psychiatric symptoms.
2	Ali, 2013 (61)	(a) Self-perceived recovery; (b) perceived utility of the course and overall satisfaction.	(a) The WRAP participants improve the self-perceived recovery; (b) Most participants are satisfied with the WRAP workshop and consider it useful for recovery.
3	Aljeesh & Shawish, 2018 (62)	Depression symptoms severity.	The severity of symptom was decreased significantly after intervention using WRAP.
4	Ashman, Halliday, & Cunnane, 2017 (63)	How WRAP supports learning from crisis, and resilience-building.	The WRAP has potential in supporting recovery from crisis, revealing insights into the nature of crisis, and has a positive effect on participants' mental health self-management capacity (reducing possible new crisis).
5	Ben-zeev et al., 2018 (64)	(a) Post-treatment Satisfaction; (b) Clinical symptoms Improvement; (c) Subjective Recovery; (d) Quality of life.	The FOCUS mHealth intervention (experimental group) produced clinical and subjective outcomes and patient satisfaction ratings that are comparable to those of WRAP (control group). Both interventions produced significant gains.
6	Carpenter-Song, Jonathan, Brian, & Ben-Zeev, 2020 (65)	Benefits of participation in two kinds of illness self-management interventions.	Both FOCUS and WRAP participants described gaining new information about mental illness and new skills for managing symptoms. FOCUS participants emphasized the intervention's accessibility, and WRAP participants highlighted the importance of community and shared experiences.

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| 7 | Cook et al., 2009
(55) | (a) Symptom's improvement;
(b) Self-perceived recovery; (c) Hopefulness; (d) Self-advocacy; (e) Empowerment; (f) Perceived social support; (g) Self-perceived physical health. | Study revealed significant improvement in self-reported symptoms, Self-perceived recovery, hopefulness, self-advocacy, and self-perceived physical health; empowerment decreased significantly, and no significant changes were observed in perceived social support. |
| 8 | Cook et al., 2010
(53) | (a) Attitudes, Knowledge, and Skills for Recovery; (b) Satisfaction with the intervention. | (a) WRAP participants reported significant increases in: hopefulness for recovery, awareness of the own early warning signs of decompensation, use of wellness tools in daily life, awareness of the own symptom triggers, having a crisis plan, having a plan for dealing with symptoms, having a social support system, ability to take responsibility for their own wellness; (b) Hight satisfaction with the intervention. |
| 9 | Cook, Copeland, Jonikas, et al., 2012
(56) | (a) Reduction of symptoms of depression and anxiety; (b) Increasing self-perceived recovery. | WRAP is effective to reduce depression and anxiety, and to improve participants' self-perceived recovery. |
| 10 | Cook, Copeland, Floyd, et al., 2012
(57) | (a) Reduction of psychiatric symptoms; (b) Increased hopefulness; (c) Enhanced quality of life. | WRAP is effective to reduce psychiatric symptoms, to enhance participants' hopefulness, and to improve Quality of Life. |
| 11 | Cook et al., 2013
(66) | (a) Self-reported mental health service utilization and need; (b) Level of psychiatric symptom | WRAP is effective to reduce mental health service utilization and need, to reduce the psychiatric symptoms severity, and to improve self-perceived recovery. |

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5		severity; (c) Self-perceived	
6		Recovery.	
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8		(a) Knowledge, attitudes and	
9		beliefs about WRAP; (b)	
10	12	Davidson, 2018	WRAP Knowledge, attitudes and beliefs, social problem solving, and
11		(67)	cognitive defusion all predicted recovery, but social identification with the
12			WRAP group did not significantly predict or mediate recovery.
13		Recovery; (c) Cognitive	
14		Defusion; (d) Social problem	
15		solving; (e) Social	
16		Identification.	
17			
18	13	Doughty, Tse,	The WRAP is effective to change consumers' and mental health professionals'
19		Duncan, &	knowledge and attitudes about recovery.
20		McIntyre, 2008	
21		(52)	
22			
23	14	Elhelou, 2018 (68)	The WRAP program participants reduce the severity of depression from the
24			moderate to mild depression.
25		Depression Symptoms.	
26			
27		(a) Self-report psychological	
28		symptoms; (b) Hope; (c)	
29	15	Fukui et al., 2011	WRAP is effective for symptoms reduction and hope improvement, but non-
30		(69)	significant changes occurred in recovery outcomes.
31		Recovery outcomes (goal-	
32		oriented thinking, self-agency,	
33		self-efficacy, social support,	
34		and basic resources).	
35			
36	16	Gordon & Cassidy,	The BME Women strongly valued the experience of the WRAP training.
37		2009 (70)	Specially, to have the opportunity to hear what other women had to say about
38		(a) The cultural relevance and	their recovery and being able to contribute their ideas and experiences in order
39		appropriateness of the WRAP	to help others. Regarding the cultural appropriateness of the program, it was
40		Programme for Black and	
41		Minority Ethnic (BME)	
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| | | Women; (b) The WRAP effectiveness on improving insight into the own mental health, and to managing the own recovery and wellness. | observed that some key concepts underpinning the WRAP evidence difficulties to be applied. For example, the concept of self-advocacy for women with some roles cultural proscribed, or the emphasis on individuals developing a personal written 'tool'. |
| 17 | Higgins et al., 2012 (71) | Changes in people's Knowledge, skills and attitudes towards recovery. | Training in recovery principles using the WRAP approach leads to positive changes in participants knowledge, skills, and attitudes towards recovery principles, and increases the participants' self-rated ability to manage their own mental health and recovery. |
| 18 | Horan & Fox, 2016 (72) | Participant perspectives on the therapeutic elements of the WRAP, and its role in recovery. | The WRAP was found by participants to foster recovery in three ways; alleviating symptoms, preventing hospitalisation, and reducing service utilisation. The content of the WRAP, the group format of the workshops, and peer support was valued by participants. |
| 19 | Jonikas et al., 2013 (58) | Propensity for patient self-advocacy. | To receipt of the WRAP led to significantly greater propensity to engage in patient self-advocacy behaviours. |
| 20 | Jung, Ju, Kim, & Heo, 2019 (73) | (a) Personal confidence and hope; (b) Willingness to ask for help; (c) Goal and success orientation; (d) Reliance on others; (e) Symptom coping. | The WRAP programme is effective to improve personal confidence and hope, willingness to ask for help, goal and success orientation, and symptom coping; and to reduce reliance on others. |
| 21 | Katayama, Morita, & Mori, 2019 (74) | (a) Hope; (b) Personal Responsibility; (c) Self-Knowledge; (d) Social Support; (e) Self-Advocacy. | The WRAP program is useful to promote a process of reflection and improvement in relation to hope in recovery, the need to take responsibility in the recovery process, the importance of self-knowledge, the existence of other |

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- people who can support the process, and the knowledge of the own rights and the need to defend them.
- 22 Keogh et al., 2014 (75) Participants' experience of participating in a facilitator's WRAP Programme and self-perceived skills to deliver Recovery-based programmes within a community context. Participants were positive about the programme and felt that their knowledge of Recovery and WRAP had improved, but they felt that they still lacked confidence in terms of the presentation skills required for facilitating WRAP programmes.
- 23 Mak et al., 2016 (59) (a) Empowerment; (b) Hope; (c) Self-stigma; (d) Social support and network size; (e) Clinical symptoms; (f) Recovery; (g) Users' perceived usefulness of WRAP. Compared with their matched controls, WRAP participants reported significant increase in perceived social support. No significant change was noted in empowerment, hope, self-stigma, social network size, symptom severity, and recovery.
- 24 Matsuoka, 2015 (76) (a) Applicability of the WRAP to an ethnic/racial minority older adults (Japanese-Canadians); (b) the concept of recovery from the perspective of Japanese-Canadian older adults. (a) Japanese-Canadian participants found WRAP helpful and applicable to their experiences. (b) For Japanese-Canadian older adults recovery means: a process in which they affirmed their sense of self-worth and were able to be positive (hopeful), self-reflective and mindful, to support themselves and others and to advocate for their rights.
- 25 McIntyre, 2005^b Attitudes and knowledge about recovery. The WRAP workshop is effective in presenting the information they contained and has a significant influence on the opinions of the participants regarding

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- recovery concepts. The WRAP workshop is effective in influencing even the strongly held attitudes both for Consumers and Non-Consumers.
- 26 O'Dwyer, 2015 (77)
(a) Severity of anxiety and depression symptoms; (b) Overall knowledge of Recovery and WRAP, in adult users of mental health services or with Acquired Brain Injury.
The WRAP is effective to reduce the anxiety and depression symptoms, and to increase the knowledge of recovery, in both groups.
- 27 O'Keeffe et al., 2016 (78)
(a) Personal recovery; (b) Personal recovery life areas; (c) Quality of life; (d) Anxiety and depression symptoms reduction.
The WRAP improves personal recovery in the areas of addictive behaviour, identity, and self-esteem. WRAP did not have a significant effect on personal recovery, quality of life, or psychiatric symptoms.
- 28 Olney & Emery-Flores, 2017 (79)
(a) How does WRAP impact employment; (b) How are employees using tools or strategies learned through WRAP on the job.
The WRAP has a positive impact on participant employment outcomes. There is a strong relationship between participants' employment success and their use of the tools and strategies learned through WRAP. Being aware of their triggers and knowing how to respond when things were not going well are strategies that contributed to participants' ability to successfully deal with work stresses.
- 29 Petros, 2017 (80)
(a) How participants learn and utilize WRAP's framework; (b) Major facilitators and barriers to learning and using WRAP.
Participants use WRAP to increase self-reflection and insight about their recovery needs and goals; to develop effective strategies to restore, maintain, and advance wellness; and to rebuild a positive outlook of themselves and their interactions with others, augmented by increased hope and empowerment about their abilities to successfully pursue recovery. Problem-solving and

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- social support were identified as major facilitators and barriers to learning and using WRAP.
- 30 Petros & Solomon, 2020 (81) (a) Perceived recovery; (b) Problem-solving appraisal and confidence; (c) Self-reflection and insight; (d) symptoms; (e) social support. The WRAP alone is modestly efficacious to improve perceived recovery and reduce psychiatric symptoms. Problem-solving confidence and social support were associated with degree of perceived recovery. It may be that adding a problem-solving intervention for small groups of adults with serious mental illness will increase the magnitude of change.
- 31 Pratt, Macgregor, Reid, & Given, 2012 (82) Benefits on participants who trained as WRAP facilitators and delivered WRAP training to others. Delivering WRAP training to groups can make a positive contribution to the mental health and well-being of facilitators themselves. This positive impact includes learning more about recovery, developing improved self-awareness, to integrating a WRAP approach into daily life.
- 32 Pratt, Macgregor, Reid, & Given, 2013 (83) (a) Improvement in self-reported recovery and well-being; (b) The role of self-help and mutual support groups in supporting recovery and wellness planning. The participants of WRAP workshops have more positive views in relation to their own sense of recovery and well-being. The WRAP approach used in groups and delivered by trained peer facilitators is very effective and appeared to have a substantial and positive impact.
- 33 Starnino et al., 2010 (84) (a) Hope; (b) Recovery orientation; (c) Level of symptoms. The WRAP workshops participants had a statistically significant improvement in hope and recovery orientation, but not in symptoms.
- 34 Stokoe & Bradbury, 2013 (85) (a) Coping self-efficacy; (b) Confidence to manage mental health difficulties; (c) Anxiety The WRAP programme improves coping self-efficacy and confidence in ability to self-manage and reduces levels of distress and low mood. Improvements in ability to seek support and cope related to improvements in

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5		and Depression symptoms; (d)	all but one of the clinical outcomes: participant's levels of anxiety did not
6		Overall clinical presentation.	significantly change over the WRAP programme.
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8	35	Wilson, Hutson, &	Satisfaction with recovery programs is multi-factorial, and it is strongly
9		Holston, 2013 (86)	correlated to Patient Autonomy, Significant Services, and Length of Program
10		Factors related to patient	Participation.
11		satisfaction with WRAP.	
12			
13		(a) The original reason to use a	
14		PACE/Recovery Program; (b)	
15		Changes in thinking about	
16		recovery from "mental illness";	The most common reasons for using the PACE Program are an interest in
17		(c) Successes implementing	learning more about consumer/survivor perspectives and a desire to learn
18		PACE/Recovery Program	more about recovery. Participants experience increased hope that recovery
19		principles; (d) Helpfulness of	was possible, and they came to realize the importance of believing in the
20		the program's discussion about	person and of self-determination. Most respondents found the discussion of
21	36	the empowerment model as an	the empowerment model a helpful antidote to what they perceived to be an
22		alternative to the	overemphasis on the biological/medical aspects of mental illness. Half of all
23		biological/medical model of	respondents indicated that the program aided them in being more helpful to
24		mental illness; (e) Types of	others in their recovery. Learning more about successful examples of PACE
25		assistance that might be helpful	implementation would be helpful to their own implementation.
26		in further implementing PACE	
27		principles.	
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32		The acceptability, the	The WRAP programme helps Chinese mental health consumers in New
33		applicability, and the	Zealand to have a more positive attitude and understanding of mental health
34	37	effectiveness of the Western	and recovery. Some adaptations are suggested to make WRAP more
35		concept of mental health	acceptable, applicable, and effective to this population: (a) Use simple
36		recovery including in the	language and not too much jargon, (b) Introduce more Chinese-style wellness
37		Wellness Recovery Action	tools, (c) Have longer sessions or more sessions, (d) Give more explanations
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Plan (WRAP) programme in about the content, (d) Use the media to make the programme is more
improving the effectiveness of accessible, (e) Include family members in learning WRAP.
recovery among Chinese
mental health consumers' self-
help organisation in New
Zealand.

For peer review only

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	3
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	4
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	5-7
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	5
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	7
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	9-10
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	8-9
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	8
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	8
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	10
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	10



SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	Click here to enter text.
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	10-11
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	11 and Figure 1
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	11-13, Table 1 and 2
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	Click here to enter text.
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	11-23, Table 3, Supplementary Table 4, Supplementary Table 5
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	Click here to enter text.
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	23-26
Limitations	20	Discuss the limitations of the scoping review process.	26
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	26
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	Click here to enter text.

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable



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3 to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used
4 in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).
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8 *From:* Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews
9 (PRISMA ScR): Checklist and Explanation. *Ann Intern Med.* 2018;169:467–473. doi: [10.7326/M18-0850](https://doi.org/10.7326/M18-0850).
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