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A stakeholders' perspective on the 'Kickstart 2 Recovery' football programme in a community mental health service

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Thesis

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Summary

Background:

Occupational therapists have a role and responsibility to focus on recovery (McCullough, 2014) and activity-focused interventions with social value can combat current challenges for recovery (Lloyd, Waghorn, Williams, 2008). Football is a socially and culturally valued occupation in Ireland (The Irish Examiner, 2018; Moran, 2019) and the 'Kickstart2Recovery' programme is an initiative to combat some of the challenges experienced by those with mental health difficulties, for example social isolation. Furthermore, the link between mental illness and poor physical health and the need for this to be considered in services has been well established and (Stubbs, Vancampfort, De Hert & Mitchell, 2015) (Vancamopfort et al., 2014). A gap in research was identified investigating the perceived influence of the 'Kickstart2Recovery' on the recovery journey of mental health service users involved.

Methodology:

The aims of this study were as follows:

(1) To explore the perceptions of programme stakeholders of whether engagement in football had a positive impact on the recovery outcomes of mental health service users taking part in the 'Kickstart 2 Recovery' programme.

(2) To explore the perceived experiences of and methods used by FAI coaches and healthcare professionals whilst supporting the recovery journey of service users engaged in the 'Kickstart 2 Recovery' programme.

This exploration was guided by the theoretical perspective of the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend & Craik, 2007). A qualitative study using descriptive phenomenological research methods, Finley (2006) outlining the benefits of this approach. Four participant groups were recruited to conduct semi-structured interviews which consisted of three footballers, six healthcare professionals, six occupational therapist facilitators and six Football Association of Ireland coaches. Theoretical thematic analysis was used to produce themes.

Findings:

Upon analysis of data, a number of topics were coded across all four participant groups. These were formed into four themes and are the main findings of this study: (1) Participation over performance, (2) Need for pathways and opportunities, (3) Learning through participation in football and (4) Social inclusion, connection and flexibility. This research found that the stakeholders of K2R do perceive the group as having a positive influence on recovery outcomes, in particular the areas of managing mental health, identity, self-esteem and trust and hope (MacKeith, & Burns, 2008). However when it comes to the outcome of connectedness, this study found that at present the K2R programme is not perceived to be capable of meeting this. Subtle ways of supporting service user learning and development through leisure engagement was a prominent finding. Stakeholders perceived a need for more opportunities within K2R to better meet group outcomes, for example physical health. Finally, stakeholders suggested creating clear exit pathways for service users to move on and progress their engagement in community settings.

Conclusion:

This study successfully met it's aims to explore the perceptions of K2R stakeholders of whether the programme had a positive impact on recovery outcomes and the methods used to try and achieve this. Limitations of the study included low number of footballer participants and no female footballers in the sample. Actions were taken to minimise the impact of these and maintain a recovery focus. A number of research gaps were addressed, however, gaps remain for future research to explore. These include follow up data collection to examine whether changes are sustained and within what environments, to explore programme effectiveness following changes requested by this study's findings and the reasons why low numbers of female players get involved with these interventions. Implications for practice are outlined for each participant group and include improved communication between stakeholder groups, creation of opportunities for co-production and service user choice, for the intervention to be provided on a continuous basis and for additional opportunities to be offered in conjunction with football sessions to better address physical health and social inclusion outcomes

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CHAPTER ONE – INTRODUCTION

1.1. Mental healthcare models and approaches

1.1.1. Development over time

The treatment of those with mental health difficulties has been called into question as early as the 1880s. This came in the form of the American Mad Pride movement and continues to this day (Lewis, 2006). The reliance on medication in an effort to make physiological processes 'normal' grew, while outcomes such as empowerment and connectedness were cast aside.

What constitutes mental illness is not straightforward and remains a controversial debate in both society and services (Thompson, 2007). When care of those with mental health difficulties changed from institutional based living and treatment to community-based services in the late 20th century, the social model of disability argued individuals were still socially oppressed due to the placement of diagnostic labels on them (Barton, 1998). In addition to the negative impact on social circumstances, diagnostic labels are often a barrier to the development of a sense of identity and impairment management methods. Therefore, the placement of those with mental health illness into their local environments did not and does not automatically resolve barriers to recovery (Lewis, 2006).

The medical model remains to be the perspective which underpins most psychiatric services and the social construction of difficulties experienced is still often ignored (Weitz, 2013). Shakespeare (2006) calls on the healthcare providers working with those who are oppressed by their labels to go further. To support individuals to choose how they want their impairments to be viewed and treated, be that through the medical model or other methods. In addition he stresses the need for services to address environmental barriers to the inclusion of those with disabilities and to acknowledge their unique experiences.

1.1.2. Approach of occupational therapy

Since the profession began, occupational therapy has been located within health systems and has had to contend with predominantly medical model methods of care (Townsend & Polatajko, 2007). The World Health Organisation (WHO) is the international body striving to bring good health to it's 194 member states. One of it's central publications, titled the 'International Classification of Functioning, Disability and Health (ICF)', is the measure used to assess health and disability at both individual and population levels (WHO, 2018). The analysis examines how experiences of health disability are influenced by the person's context and the activities they have access to under four main domains. These include body functions, activities and participation and environmental factors (WHO, 2018). This analysis approach bares similarities to models of care used in occupational therapy, for example the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend & Craik, 2007). This model analyses the ability of successful engagement in the self-care, leisure and productive occupations provided to the person to connect them to their various environments. It's vision is that all people will be active, valued members of their society through their engagement in occupation and not be limited based on their ability to perform. This places both the profession of occupational therapy and occupational therapy models of care in a good position to work successfully to improve the health and quality of life of those experiencing ill health or disability (Richards & Vallee, 2020), including those recovering from mental health difficulties.

1.2. Physical activity, mental health and occupational therapy

In 2018, the WHO published a global action plan on physical activity titled 'More active people for a healthier world' (WHO, 2018). It stated that worldwide, 25% of adults did not meet global recommendations for physical activity and that physical inactivity is one of the leading risk factors for death. Within the same year, a survey showed that physical activity was the most commonly cited tool that Irish people used to stay mentally well (Mental health Ireland, 2018). The efficacy of physical activity to address mental health symptoms has mixed results (Schuch et al., 2016) (Pearsall, Smith, Pelosi, & Geddes, 2014) but the relationship between mental health and physical health has been well established as has the link between mental illness and poor physical health for those living with conditions such as schizophrenia, bipolar disorder and depression (Stubbs, Vancampfort, De Hert & Mitchell, 2015) (Vancamopfort et al., 2014) (Holt, de Groot & Golden, 2014) (Dorning, Davies & Blunt, 2015). Those currently living with mental illness in Ireland have a life expectancy of typically fifteen to twenty years less than someone without and often do not receive physical healthcare as in line with international best

practice (Finnerty, 2018). There is a clear need, both in Ireland and worldwide, for initiatives that will encourage those with mental health difficulties in particular to engage in physical activity.

The book by Carless and Douglas (2010) goes beyond the physical health benefits alone to explore how physical activity can contribute to mental health recovery. Research interest into the connections between exercise and mental health improvements increased fourfold between the 1980s and 1990s (Faulkner & Biddle, 2001). This is now well established.

A 2011 systematic review examining over one thousand recovery narratives found the five essential processes needed for recovery to occur were connectedness, hope, identity, meaningful roles and empowerment (Leamy et al., 2011). The scope for engagement in physical activity to go beyond symptom improvement and achieve recovery outcomes, such as improved sense of identity, has been discussed in the literature (Cole, 2014; Carless & Douglas, 2010). Physical activity engagement in group environments has been seen to particularly target recovery processes, especially the need for connection (Curran et al, 2017).

The approach of occupational therapy both considers the physical health needs of the individual in addition to the environmental and activity factors that, when correctly combined, provide choice, control, challenge and mastery (Creek, 2010). The perspective of occupational therapy models, such as CMOP-E, remind us to go beyond the performance of an activity to consider all features of engagement. This allows the mechanisms that influence wellbeing to be activated (Cole, 2014; Townsend & Polatajko, 2007). Physical activity is also considered an occupation for many people, meaning it falls within the domain of concern for the occupational therapy profession (American Occupational Therapy Association, 2014). This places occupational therapy in the position of having the scope to facilitate recovery outcomes through engagement in physical activity.

There is a value placed on engagement in physical activity to stay mentally well by Irish people. In order for the activity to have a positive impact on the recovery journey of Irish people experiencing symptoms of mental ill health, the concepts of hope, identity,

connectedness, roles and empowerment must be addressed. While Ireland has many nationally bred sports, football is one team activity that has social and cultural value.

1.3. Football in Ireland

Football in Ireland originated from Belfast and was largely confined to Ulster and Dublin between the 1880s and 1910s. Conflict arose between the North and South of Ireland clubs during the Easter Rising in 1916 (Football Association of Ireland, 2009). Leinster and Munster based clubs backed the eventual split of the Football Association of Ireland from the Irish Football Association in Belfast. These events caused tension between the Football Association of Ireland and teams from the United Kingdom who refused to play teams from the Republic until 1923. It is thought this history between the UK and Ireland may be what sparked the fan base of over 120,000 people that travelled to the UK for football in 2014 and countless more to watch the sport on television (The Irish Examiner, 2018). In addition the resettling of many Irish people to British cities, including football players who feature on many UK club squads, further solidifies the loyalty and popularity associated with the sport that often leaves national sports like the GAA struggling to compete for fans (Moran, 2019).

Football is a culturally and socially valued sport for Irish people and facilitates a community of both players and fans to share a common interest. The 'Football For All programme' is an initiative that aims to replicate this sense of community for those who are often isolated or excluded from mainstream sport, including those experiencing mental health difficulties (Football Association of Ireland, 2017). It aims to promote inclusion in Irish football and support individuals to participate in a way that's meaningful for them. In addition, it provides opportunities for people with disabilities and ill health to re-engage in their communities through participation in football (Football Association of Ireland, 2017). A programme built specifically to target challenges posed to mental health service users called the 'Kickstart 2 Recovery' programme grew from this initiative in 2011.

1.4. The 'Kickstart 2 Recovery' programme

'Kickstart 2 Recovery' (K2R) is a *'partnership approach to enhancing provision for people with disabilities'* – Oisin Jordan, Football For All National Coordinator. The study by Moloney and Rohde (2017) provides the following description of the programme alongside unpublished material provided by the Football Association of Ireland (FAI).

K2R began with a group of community mental health service users and an occupational therapist looking to fill a service gap with a meaningful activity, football. It aims to promote inclusion in Irish sport by helping service users to re-engage in their communities through participation in football (Football Association of Ireland, 2017). It uses an inclusive philosophy by supporting individuals to engage at the level they are able to and that's meaningful for them. In addition, the FAI is a recognised brand in Irish society as part of a sport with cultural and social value (The Irish Examiner, 2018; Moran, 2019).

It is estimated that approximately sixteen programmes have been run across Ireland with eight to sixteen people engaging per group. The programme is designed to be delivered in six or eight week blocks four to five times per year. This would work out on average, six to eight weeks followed by a three week rest interval and so on. K2R sessions are typically facilitated in local football facilities, both indoors and outdoors, with some sites using sports halls and GAA pitches. K2R sessions include the following activities: introductions, warm-up, skill drills, matches, cool-down and feedback. Some groups facilitate a social session after in a café. The occupational therapist and the coach will meet before, during and after the group to monitor the engagement of the players in order to ensure that the challenges presented in sessions are at the participants' level.

The target population are those involved with mental health services who are at risk of or who already are becoming longstanding receivers of care. Key outcomes of K2R are in areas of personal identity affirmation, social and leisure skill development, overall health promotion and physical health benefits. All being delivered in a sustainable way at the community level. A national survey of the programme found football, as a therapeutic intervention for service users, promoted community integration as the main aim. This was done through familiarisation and access to community leisure resources, awareness of the benefits of leisure, development of social skills and provision of a safe space for service users to experience fun and enjoyment and develop self-esteem and confidence.

To be involved in the group footballers have to be referred by their mental health team. This is followed by an initial assessment by the occupational therapist and general practitioner physical health clearance. Participants then set goals to achieve in the group and their progress is monitored weekly by the occupational therapist. Once the group ends participants are invited to meet the occupational therapist again to reflect on the goals they set and rate their perceived level of engagement.

1.5. Study need

Three Occupational Therapists and the current Football For All National Coordinator approached the Occupational Therapy Department in Trinity College Dublin to request research be carried out on the K2R programme. A phone survey was conducted by one of these occupational therapists with facilitators from around Ireland. The findings suggest that the professionals involved in these programmes were struggling to find specific evidence base for the intervention and evidence of recovery outcomes for mental health participants. The researcher had experienced similar frustration when co-facilitating the group during a clinical placement in 2017.

There is a worldwide need for further research examining the efficacy of different types of interventions in the area of mental health recovery (Vita & Barlati, 2019). This study will therefore explore whether engagement in football can positively influence recovery outcomes and hopes to add to the evidence base for the K2R intervention.

1.6. Aims and objectives

Although it was recommended that the K2R programme be evaluated, this is a health research project and not a clinical audit or service evaluation. The Government of Ireland (2018) describes health research as:

"A qualitative or quantitative study aiming to improve the health of the population as a whole/ part of the population through exploration of the way social, cultural, environmental, occupational and economic factors influence health."

Current research and health guidelines have identified physical ill health as a major challenge for all populations but in particular, those experiencing mental health difficulties (WHO, 2018; Stubbs, Vancampfort, De Hert & Mitchell, 2015; Vancamopfort et al., 2014; Holt, de Groot & Golden, 2014; Dorning, Davies & Blunt, 2015). Physical activity is a method used by Irish people to stay well and football has social and cultural significance (Mental health Ireland, 2018; The Irish Examiner, 2018). Therefore, this study will explore whether engagement in football can positively influence recovery outcomes for Irish mental health service users. It will also examine the methods used by facilitators (Vita & Barlati, 2019). The K2R programme is the national initiative used to deliver this intervention in Ireland so is therefore the group included in this study. The objectives of this study were as follows:

1. To explore the perceptions of programme stakeholders of whether engagement in football had a positive impact on the recovery outcomes of mental health service users taking part in the 'Kickstart 2 Recovery' programme.
2. To explore the perceived experiences of and methods used by FAI coaches and healthcare professionals whilst supporting the recovery journey of service users engaged in the 'Kickstart 2 Recovery' programme.

1.7. Methodology

A qualitative study using descriptive phenomenological research methods was carried out, Finley (2006) outlining the benefits of this approach. Four participant groups consisting of footballers, healthcare professionals, occupational therapist facilitators and FAI coaches were recruited to take part semi-structured interviews. Theoretical thematic analysis predominantly guided by the CMOP-E (Polatajko, Townsend & Craik, 2007) was used to produce themes. Additional guidelines were employed when designing data collection tools to explore topics in more detail with different participant groups.

1.8. Thesis overview

In this thesis, Chapter Two will outline the current literature and rationale for the current study. Chapter Three will outline the theoretical and methodological perspectives used for the research. Chapter Four will discuss the qualitative findings of interviews carried out with stakeholders involved in the K2R programme. Finally Chapter Five will apply the qualitative findings in the context of research reviewed and the objectives of this study. Recommendations, research limitations and conclusions will then be discussed.

1.9. Definition of terms

Service user: A person who is a current or past user of mental health services (Health Service Executive, 2017, pp.32).

Stakeholder: An individual, group, professional or organisation who has an interest or actively participates in promoting recovery at an individual or organisational level (Health Service Executive, 2017, pp.32).

Social inclusion: The participation of individuals in the social, cultural and commercial activities in their local and wider community (Health Service Executive, 2017, pp.32).

Empowerment: Having the information, choices and confidence to make informed decisions on one's own life. (Health Service Executive, 2017, pp.3).

Recovery: Recovery is a deeply personal unique process of changing one's attitudes, values, feelings, goals, skills and/ or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness. Recovery includes the development of new meaning and purpose in life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Physical activity: Physical activity is any bodily movement produced by skeletal muscles which causes energy expenditure greater than at rest and which is health enhancing. (Mental Health Services, 2018).

Occupation: The groups of activities and tasks of everyday life, named, organised, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity). (Townsend & Polatajko, 2007, pp. 17).

Occupational therapy: Occupational Therapy is the art and science of enabling engagement in every-day living, through occupation: of enabling people to perform the occupations that foster health and well-being: and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life (Townsend & Polatajko, 2007, pp.2).

Occupational engagement: To involve oneself or become occupied, participate. (Townsend & Polatajko, 2007, pp.26).

Occupational performance: The actual execution or carrying out of an occupation. (Townsend & Polatajko, 2007, pp.26).

Occupational participation: Involvement in a life situation through occupation. (Townsend & Polatajko, 2007, pp.26).

1.10. List of abbreviations

'Kickstart 2 Recovery' – **K2R**

Canadian Model of Occupational Performance and Engagement – **CMOP-E**

Canadian Model of Client-Centred Enablement - **CMCE**

Health Service Executive – **HSE**

United Kingdom – **UK**

National Health Service - **NHS**

Multidisciplinary team – **MDT**

Healthcare professionals – **HPs**

Occupational therapist facilitators – **OTFs**

General practitioner - **GP**

Football Association of Ireland - **FAI**

Football Association of Ireland coaches – **coaches**

Current study - **CS**

CHAPTER TWO – LITERATURE REVIEW

2.1. Introduction

The positive influence that engagement in physical activity, such as playing football, can have on mental health recovery outcomes has been identified (Carless and Douglas, 2010; Football Association of Ireland, 2017). The role of occupational therapy in supporting engagement in these activities has been mentioned (Polatajko, Townsend & Craik, 2007; American Occupational Therapy Association, 2014). This chapter will explore these concepts further through the literature. The review concludes with a critique of a group of studies examining the use of engagement in football as an intervention in mental health. The literature review was completed prior to data collection to identify gaps in existing research on football interventions. However, as this was a qualitive study the literature review was continuously updated throughout the research process (Morse, 2003).

2.2. Search strategy

2.2.1. Search terms

In the search for literature to critique, the following key words and Boolean terms were used from the working study title:

"A stakeholders' perspective on the 'Kickstart 2 Recovery' Football Programme in a community adult mental health service."

'Football', 'community', 'adult' and 'mental health' were chosen as they identify the population, healthcare area, setting and occupation in question. The programme name was not used in the search due to the limited amount of existing studies on K2R. Terms followed by a *, such as "team*" indicate that they were combined with other terms in that column in various search combinations to maximise result yield. For example, "team" would have been combined to form terms such as "football team", "soccer team", "team sport" and so on. The overall term of "recovery*" was used and combined with other terms in the column. The 'Community' column aims to address connectedness variations to explore literature around this concept further.

Table 1: Search terms used

Football	Community	Adult	Mental health
Football	Community	Service user	Mental health
Soccer	Inclusion*	Client	Mental illness
Team*	Exclusion*	Adult	Mental condition
Sport	Local*		Psychiatr*
Club*	Community-based		Mental wellness
	Integration*		Recovery*
	Social*		

2.2.2. Journals

Databases searched included AMED, CINAHL, ERIC, General Science Full Text, Health Source: Nursing/ Academic Edition, MEDLINE, OmniFile Full Text Mega, PsychARTICLES, PsychINFO, Readers' Guide Full Text Mega and Social Sciences Full Text. Articles were excluded if they did not meet the inclusion and exclusion criteria set, these are outlined in section 2.2.7. The most common reasons for exclusion included studies examining the impact playing professional football has on the mental health of football players, rather than the use of football to improve mental health, in addition to studies that did not involve the active engagement in football by programme participants.

2.2.3. Books

Literature from fields of occupational therapy and mental health recovery were included to provide context and structure to the review where relevant.

2.2.4. Websites

Websites including Time to Change.org, Mental Health Ireland, www.paha.org.uk Physical Activity and Health alliance, NICE.org, OT seeker and Cochrane review were searched. Both research studies and policy documents were sought.

2.2.5. Expert contact

Key authors in the area of achieving recovery outcomes through engagement in football were contacted via Research Gate but no responses were received.

2.2.6. Citation searching

The reference lists of similar studies were evaluated for additional literature. Papers that were consistently referenced across these studies articles were also assessed for further relevant studies. This proved particularly useful to identify remaining resources not found using the above methods (Greenhalgh & Peacock, 2005).

2.2.7. Inclusion and exclusion criteria

McDonagh et. al (2013) discuss the importance of providing clear descriptions and rationale when outlining the inclusion and exclusion criteria for literature searches. The criteria areas are: Population, intervention, comparator, outcome, timeframe, setting and study designs.

Table 2: Inclusion and exclusion criteria adapted from McDonagh et al. (2013)

Domain	Inclusion criteria	Exclusion criteria
Population	Studies involving participants, designers and facilitators of football programmes.	Studies done with child/ adolescent participants.
Intervention	Programmes incorporating participant engagement in physical activity.	Programmes within which participants are not actively engaging in physical activity.
Comparator	Studies that include physical activity engagement in their comparison.	Studies that don't include engagement in physical activity in their comparison.
Outcomes	Perceived positive change in service user recovery outcomes of hope, identity, connectedness, roles and empowerment.	Studies that don't discuss a perceived positive change in at least one of the recovery outcomes of hope, identity, connectedness, roles and empowerment.
Timeframe	None	None
Setting	Programmes that are inclusive of service users from all parts of the community.	Programmes in acute or inpatient settings.
Study design	Studies of varying size, design and quality.	Studies not available in English. Studies published between 2005 and 2020.

2.2.8. Description of studies included

A total of seventeen studies examining football interventions were included in the final review. As mentioned, it was decided that contextual literature would be also included. This was to assist the researcher in determining how football interventions fit within the fields of recovery literature and occupational therapy. This more clearly identified the research gap the current study would address. A summary of these seventeen studies is outlined in Appendix 7.1. Variations were present in design, geographical location, timeframe and population. Twelve out of the seventeen studies used a qualitative approach, two studies were mixed methods and the remaining two used quantitative methodology. Eight of the studies were based on non-clinical populations, one study having a mixture of both clinical and non-clinical participants. Although K2R only consists of footballers who are receiving clinical care from community mental health teams, non-clinical studies were included. This was to provide insight into how football interventions may have an impact on the recovery journey for those who don't meet the current thresholds for community mental health services or who have yet to access them.

The timeframe of the interventions varied in addition to the opportunity for participants to re-engage. For example, three studies involved facilitation of a league or membership of a "club". Both of these interventions were accessible to footballers on a continuous basis (Brawn, Combes & Eilis, 2015; Darongkamas, Scott & Taylor, 2011; McElroy, Evans & Pringle, 2008). In comparison other programmes had a limited number of weeks they were available for with the aim of moving participants on to another sporting outlet. This was the case for most of the studies based on clinical populations (Mason & Holt, 2012; Moloney & Rohde, 2017; Lamon et al., 2017; Hargreaves & Pringle, 2019; Friedrich & Mason, 2018; Friedrich & Mason, 2017). Ten of the studies collected data from the footballer perspective only, the others included staff. No studies split staff participants into separate samples but rather analysed them as one group's perspectives. Three studies were based on Irish populations, the other fourteen being based in the UK. One study examined the K2R programme and was the only study within which the group was classified as an occupational therapy intervention (Moloney & Rohde, 2017). The other two Irish based studies used a combined approach of football engagement and a Cognitive Behavioural Therapy intervention (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffeny, 2012).

2.3. Guidelines and policy influencing recovery in Ireland

2.3.1. Challenges

Smith, Jones, Houghton and Duffell (2016) identify the ongoing confusion in research and policies on the difference between sport, physical activity and exercise and the benefits they bring. Often policies give recommendations for exercise and miss the scope for physical activity, particularly from a leisure perspective, to address areas such as personal identity, social confidence, social support, and a sense of belonging (Corretti, Martini, Greco & Marchetti, 2011). These issues can be seen in national mental health policy.

The history of policy in Ireland reveals individuals are often held responsible for their experiences of social exclusion (Considine & Dukelow, 2009). In addition, there is a lack of opportunity for people to improve their circumstances themselves even if they do manage to access the skills and resources to do so. Policy tends to present short-term solutions which only continue to perpetuate the exclusion of individuals living in disadvantage (Higgins, 2016).

It has been thirteen years since 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (Department of Health and Children, 2006) was published and the issue of exclusion has remained. Although this policy marked the impact the service user movement in the late 1990s had on society, in particular with regards to the de-institutionalisation of those receiving mental health care to community-based services, this transition has not been seamless (McDaid & Higgins, 2014). Re-institutionalisation has occurred in community services and general society through the widespread social exclusion of Irish mental health service users and domination of medical model treatment (McDaid, 2014).

However, the policy did meet some suggestions made by it's predecessors. For example, by recommending mental health services be community-based and adopt a multidisciplinary approach which was welcomed by both staff and service users (Johnston, 2014). This resulted in more community and primary care resources being available (Kelly, 2017) which did create more opportunities for service users to expand their social networks and engage access community-based activities that better met their needs (Mental Health Reform, 2019). Since then, a greater willingness has grown among

the Irish public to access mental health services and service users have become interested in other methods of staying well (McDermott, 2018). One such method being through engagement in physical activity.

2.3.2. Physical activity and football

Guidelines discussing physical activity for the general population show a surge of resources into addressing physical health issues in Ireland. The Government of Ireland (2013) has published the 'Healthy Ireland' framework with the vision being to support the physical and mental health of the population on personal, social and economic levels. This framework accounts for the physical health and mental health challenges facing the Irish population but appears to discuss them as separate issues. In contrast the 'Let's Get Active!' guideline (Mental Health Services, 2018) applies recommendations to both the general population and mental health service users. It discusses physical activity as having both physical and mental health benefits and acknowledges the relationship between the two. In relation to football, the FAI have released the 'Football for all strategy 2017-2020' which strives to replicate the sense of community that is present in mainstream football for those who are often isolated or excluded from sport, including those experiencing mental health difficulties (Football Association of Ireland, 2017). It aims to promote inclusion by helping service users to re-engage in their communities through participation in football at the level they are able to and that's meaningful for them.

The FAI has also published strategies to develop and improve the accessibility of playing football for women (Football Association of Ireland, 2015). The majority of the studies examining football interventions included in this review had no female participants and this inequality and difference in interest patterns between genders exists in Irish society (Fitzmaurice, 2017). It is therefore likely that the male female ratio in Irish based football interventions will be impacted. Although it is outside the scope of this study to explore gender trends within football interventions and football in society as a whole, the impact political and sociocultural powers have on the occupational engagement and inclusion of populations is within the domain of concern of occupational therapy (Hocking & Mace, 2017). The 'Getting Inside Men's Health' policy (Richardson, 2004) has challenges the social construction of gender roles in the area of healthcare (Lee & Owens, 2002) and explores the potency of gender attitudes. It recommends both genders work together to challenge and deconstruct socially assigned roles and the feelings of exclusion that come with them. Research has shown that environments which provide opportunities for

reciprocal connections and choice may reduce the impact of gender norms and their impact on mental wellbeing (Addis & Mahalik, 2003) and increase the changes of both men and women being included in football interventions. Despite these recommendations, gender trends can be seen in football intervention research.

A study by Shanley and Jubb-Shanley (2007) states Irish based programmes require the support of policy and guidelines in order to maintain alignment with recovery principles and access of needed resources. This is turn will empower service users, create the means for them to be involved in the design and delivery of interventions and preserve the interventions that are available (Nesta, 2013). Although policies in recent years have shown a positive shift in the provision of community-based resources and the attitudes of the Irish public as a whole towards mental health, widespread social exclusion and disadvantage remains. There is a confusion in the difference in benefits between engagement in a socially valued form of physical activity as opposed to exercise alone, particularly for people with mental health difficulties. However physical activity has been given more attention in health guidelines and the FAI is one such organisation who has created opportunities specifically for those experiencing mental health difficulties. Long-term, sustainable answers are needed to combat the social exclusion and inequality in Ireland (Higgins, 2016) and programmes such as K2R need the ongoing support of funding and research. This study therefore aims to add to the pool of evidence analysing football interventions which has grown in the last forty years.

2.4. Recovery and football interventions

The use of football as an intervention in the area of mental health care emerged in the UK in the 1980s and showed benefits for both physical and mental health outcomes (Plant, Richardson & Pringle, 2019). Examples given include weight loss, hope for the future and social inclusion. Football interventions have now grown in popularity both in clinical and non-clinical settings with various design variations, for example the incorporation of competition and health education (Hynes, 2008; Parnell & Pringle, 2016). In relation to addressing physical health, a systematic review by Oja et al. (2015) compared different sports and their benefits and concluded that football is particularly suitable to address some of the issues those with mental health difficulties are faced with. Furthermore, a review by Soundy et al. (2015) found that participation in sports is associated with reduced isolation and improvements in social confidence, autonomy and independence.

One of the most commonly mentioned benefits of football interventions is that they allow mental health service users the opportunity to engage in sport that is free from the social exclusion and stigma which they often encounter in community settings (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffney, 2012; Moloney & Rohde, 2017; Mason & Holt, 2012; Brawn, Combes & Eilis, 2015; Darongkamas, Scott & Taylor, 2011; Lamont et al., 2017; Friedrich & Mason, 2018; Friedrich & Mason, 2017; McElroy, Evans & Pringle, 2008).

Physical activity has been shown to improve quality of life for mental health service users as it provides an opportunity for social interaction and purposeful activity (Alexandratos, Barnett & Thomas, 2012). However Hutcheson, Ferguson, Nish, and Gill (2010) maintain that people with mental health difficulties are often at risk of being excluded from community sport. In their study they found that both service users and staff described difficulties with accommodating physical and mental health needs in addition to barriers such as lack of opportunity for meaningful engagement and poor social skills. These studies indicate that football interventions facilitated by mental health services may have the potential to accommodate service users at the performance level they are at, rather than refusing them if they can't meet the standards set by the activity or the environment. Recovery literature provides an insight into how issues of stigma and social exclusion present.

Traditionally social stigma was seen as the principle aspect of stigma to be overcome, however the self-stigmatisation that occurs following experiences of social stigma can be more troublesome for recovery outcomes (Jahn et al., 2019; Corrigan, 2004). When it comes to resisting social stigma or changing self-stigmatising thoughts, individuals need to possess a certain amount of skill and knowledge. Having a sense of identity beyond that placed on them by their diagnosis is central to protecting themselves from internalising social stigma. Firmin et al. (2017) describe creating and maintaining sense of identity as being achieved through engagement in daily life opportunities that reinforce identity and challenge negative beliefs attached to certain diagnoses (Firmin et al., 2017).

Some studies examining football interventions claim that as football is a team sport, it provides an environment within which players are included in a group to achieve a common goal and have opportunities for social interaction as part of the game (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffney, 2012; Moloney & Rohde, 2017;

Brawn, Combes & Eilis, 2015). However recovery literature has shown that it's not quite that simple. The study by Filia et al. (2018) indicates that although engagement in social activities is one of the most highly cited methods to combat social exclusion, the issue is multifaceted and cannot be resolved with one outlet alone. Furthermore, people being in the presence of others does not necessarily mean they are establishing the meaningful connections and social supports that make these activities successful.

A 2012 study (Tew et al., 2012) found that having at least one personal relationship that provides hope and encouragement, as well as achieving a sense of belonging to and acceptance in one's community, was influential in giving an individual a sense of social inclusion. Young and Ensing (1999) maintain that individuals often create these supportive relationships among other service users who have experienced similar difficulties. The positive influence this has on recovery outcomes has similarly been demonstrated through interventions that involve the service user in programme design and provision (Treichler et al., 2015). Repper and Perkins (2003) maintain that a vital characteristic of meaningful and empowering friendships is for individuals to be role models and advice givers for each other

Forty percent of people with mental health difficulties experience difficulties with social engagement (Central Statistics Office, 2016). Interventions that not only bring service users together but make efforts to encourage participants to connect with each other are vital for recovery. In addition, players need to be given the opportunity to challenge any self-stigmatising perspectives they may hold. Therefore, community based sports engagement is to be recommended in tandem with traditional psychological and medical interventions (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffney, 2012; Brawn, Combes & Eilis, 2015; Mason & Holt, 2012).

Despite this recommendation, there appears to be a dearth in research outlining specifically the methods used by those facilitating football interventions to achieve these outcomes. For example, O'Doherty, Stevenson & Higgins (2012) maintain that there is a need for interventions to have clear plans on how they will incorporate outcomes such as service user narratives and the opportunity to establish meaningful connections. Two other studies claim to incorporate these outcomes (McArdle, McGale & Gaffney, 2012; Brawn, Combes & Eilis, 2015) but fail to explain how this is done.

The HSE published a national framework for recovery outlining how service providers should be facilitating recovery-focused care (HSE, 2017). This framework outlines four principles that should be imbedded in service provision, these include: centrality of service user lived experience, co-production of interventions with all stakeholders, an organisational commitment to recovery-orientated care and supporting recovery orientated learning and practice.

A study by Roe, Rudnick and Gill (2007) reveals there is often a misunderstanding about what recovery means and how it is supported amongst service providers. While a personally defined journey, the concept of recovery gives hope to all individuals that a meaningful life is possible no matter the severity of their symptoms (Roe, Rudnick & Gill, 2007). This often requires professionals to look beyond the individual recovery to issues of social justice and social inclusion (Davidson et al., 2006). However, there is a tendency for the removal of social barriers such as stigma and disempowering interactions that are limiting a person's ability to live a meaningful life to be forgotten (Ramon et al., 2007). This can pose a barrier to recovery orientated learning and practice.

Furthermore, the potential for health care providers to hold negative beliefs towards an individual's ability to recover and the service they can provide has been seen to have a negative impact on recovery outcomes (Dell, Vidovic, Vaughn & Sasaki, 2020). Roberts (2000) discusses the more recent movement towards use of service user narratives to empower them in their recovery as a way forward. Moloney and Rohde (2017) in their study of the K2R programme discuss the efforts made to incorporate service user narratives within the group setting. However, they don't appear to outline how wider environmental challenges will be addressed for clients.

The lack of an organisational commitment to recovery-orientated practice equally remains to be an issue. One in five community-based service users have reported issues such as lack of open communication, respect when receiving care, medicalisation of social stressors and an over reliance on medical model treatment options (Cullen, 2019; Dickerson, 2006; Howell & Voronka, 2012). The prioritisation of symptom management over recovery approaches still occurs (Hughes & Parker, 2014). Best practice is outlined as the promotion and expansion of individual skills and resources, as well as addressing the ways in which social exclusion and stigmatisation operate within the client's environment (Fieldhouse & Bannigan, 2014; Garverich, Prener, Guyer & Lincoln, 2020).

Although K2R support service users to engage in a socially valued activity in the local community, it is unclear whether the skills they gain from the programme are transferable to other environments or whether this is an aim of other interventions they receive from their service.

When it comes to centralising the lived experience of service users, research recommends that we must resist our desire to interpret their narratives to fit our preconceptions and hopes for what interventions are achieving (Mathison, 2018). Research analysing community connection and stigma must strive to bring the voices of participants to the forefront which many studies examining football intervention do try do through qualitative methodologies, for example the studies by Mason and Holt (2012) and Friedrich and Mason (2018).

When it comes to co-production, however, there appears to be little evidence that this is achieved. For example, in a study by Robertson, et al. (2013), the importance of there being trust and co-operation between staff and footballers is mentioned but this does not include the opportunity for co-production. Some programmes do involve sports and community partnerships in the programme delivery and mention the value this has added to the programme for the service users (Brawn, Combes & Ellis, 2015; Moloney & Rohde, 2017; Mason & Holt, 2012). Despite this, there appears to be no attempt to provide opportunities for service users themselves to provide input into the programme design or delivery. Fenton et al. (2017) have identified the role community and sports partnerships can have in supporting the recovery of individuals. However, to fully gain the positive impact that co-production has on recovery outcomes, all stakeholders would need to be equally involved (Health Service Executive, 2017).

There appears to be a dearth in the existing literature on a clear focus to achieve recovery outcomes and the methods that are used to achieve these. Current football interventions appear to not be addressing key challenges for service users in recovery, for example stigma and social exclusion, outside of the group environment. Those studies that do claim to be addressing these issues don't explain how they do so. There is a need for research that considers how positive social interactions and learning within the group setting could be extended to community environments. In addition, the specific facilitation methods that are used in the group to fully involve service users and maintain a recovery focus needs to be better explored.

2.5. Football as a leisure occupation

Doroud, Fossey and Fortune (2015) conceptualise mental health recovery as an occupational journey within which engagement in personally and socially valued activity is paramount. The study identifies a need for future research analysing occupations outside the area of productivity. Physical activity has the potential to fall within any of the three occupational areas of self-care, productivity and leisure (Townsend et al., 2007). It is the meaning, value and purpose given to the physical activity by the person engaging in it that decides whether it's a leisure activity or not (Molineaux, 2010). The social and cultural value placed on the activity is equally important to consider and has been mentioned in the studies included (McGale, McArdle, & Gaffney, 2011; Moloney & Rohde, 2017; Mason & Holt. 2012; Hargreaves & Pringle, 2019; Magee, Spaaij & Jeanes, 2015).

Iwasaki et al. (2014) suggest that engagement in experiences that are enjoyable, expressive and meaningful fall predominantly within the leisure category. The leisure enhancement model by Baxter et al. (1995) solidifies this description, stating the purpose of leisure as being: relaxation and refreshment, entertainment and personal and social development. Benefits of leisure as outlined by these authors include the release of emotions, escape from reality and opportunities for personal and social skill development. Iwasaki et al. (2014) apply these benefits to those with serious mental health difficulties and report leisure engagement may strengthen their recovery. When relating physical activity to leisure for this population, Hargreaves, Lucock, and Rodriguez (2017) have examined this relationship and found the distraction from mental health symptoms through the flow experience as crucial for participants to access the benefits of leisure. Csikszentimihalyi (1975) writes about flow experiences and describes it as individuals not being consciously aware of their movements and actions but are concentrating on striving towards a goal and experience a loss of self-consciousness.

There is a high value placed on the flow experience and opportunity to engage in activities for the sole purpose of enjoyment without other pressures for those with mental health illness difficulties living in the community (Craik & Pieris, 2006). Furthermore, leisure activities with a social component have been seen to positively influence issues such as community exclusion and stigma (Repper & Carter, 2011). Programme designers and facilitators must therefore recognise the value of a leisure approach to intervention and consider what aspects of the activity are meaningful for the individual in order to create a flow experience.

In addition, the benefits that can come with the design of football interventions in general has also been shown in research. For example, the study by Chapman, Fraser, Brown and Burton (2016) indicates a tendency for those with mental health difficulties to prefer activities with a social component carried out with professional instruction which is what football interventions consist of. Group sports have been seen to have a positive influence on the subjective recovery experience of mental health service users, particularly in the areas of rebuilding identity and self-esteem (Carless, 2008; Carless & Douglas, 2008). Team sports in particular have been recognised in international research as capable of improving overall health as well as providing a sense of meaning, enjoyment and inclusion (Andersen, Ottesen & Thing, 2018). A study with Irish community-based service users found that meaningful leisure activities that allow choice and goal achievement are key for supporting recovery and recommends that further research is done to explore this (O'Doherty, Stevenson & Higgins, 2012).

Some of the studies included discuss attempting to incorporate the interests of each player into sessions to maximise their enjoyment, which would in turn make a flow experience more likely in addition to the above benefits (McArdle, McGale, & Gaffney, 2012; Brawn, Combes & Ellis, 2015; Moloney & Rohde, 2017). However, studies do not appear to focus upon individual preference but instead upon symptom reduction and physical fitness. The primary focus of many of the studies appears to be a reduction of mental health symptom severity and of physical health improvement rather than on facilitating leisure experiences. Examples include the studies by Lamont et al. (2017), Mason and Holt (2012) and Curran, Richardson and Pringle (2016). The study by McGale, McArdle, and Gaffney (2011) incorporated CBT based discussions during football training and participants reported they disliked having sessions interrupted. Similarly, the study by Benkwitz and Healy (2019) incorporated health promotion education into their football sessions.

Football is well placed to address physical health issues while still having a positive impact on mental wellbeing (Friedrich & Mason, 2018). Equally it is clear that promoting and creating opportunities for those living with mental health difficulties in Ireland to engage in physical activity is crucial and to be highly encouraged (The Government of Ireland, 2013: Mental Health Services, 2018). However existing research appears to focus more on outcomes of addressing symptom severity, physical fitness and health promotion

rather than the enjoyment of the activity itself. This leads to the loss of the benefits that the flow experience brings about which positively impact the recovery journey and overall well-being for those with mental health difficulties (Hargreaves, Lucock & Rodriguez, 2017; Craik & Pieris, 2006). In addition, meaningful engagement brings about similar outcomes by it's nature including improved overall health, physical functioning, and quality of life (Iwasaki, Coyle, & Shank, 2010; Eime, Young, Harvey, Charity, & Payne, 2013). The positive impact exercise and the flow experience have on mental and physiological health is well known (Mikkelsen et al.,2017; Hargreaves, Lucock, & Rodriguez, 2017).

It appears that football interventions are well placed to create an opportunity for flow experiences within a positive social context. Equally it appears that football interventions are often not facilitated from a leisure perspective and that this would be beneficial for both the mental and physical health of service users. This perspective has also been recommended for exploration in research with Irish populations (O'Doherty, Stevenson & Higgins, 2012).

Occupational therapy models of practice, such as the CMOP-E, focus on how the person's skills and environmental supports can be brought together to facilitate successful engagement in self-care, productivity and leisure activities (Polatajko, Townsend & Craik, 2007). Leisure is a key area in the domain of concern for occupational therapy (American Occupational Therapy Association, 2014) and the profession plays a key role in supporting mental health recovery (McCullough, 2014). Therefore the current study being undertaken within the field of occupational therapy from a leisure perspective will address the identified research gap. In addition, studies have identified maximising accessibility of football interventions for service users as vital (McGale, McArdle, & Gaffney, 2011; Mason & Holt. 2012; Curran et al., 2016; Magee, Spaaij & Jeanes, 2015) and finding a balance between the person, the activity and the environment to facilitate meaningful engagement and connection is a primary outcome of occupational therapy (McCullough, 2014; Polatajko, Townsend & Craik, 2007). The next section will critique existing studies examining football as an intervention with this perspective in mind.

2.6. Football as an intervention

2.6.1. Gender trends

As discussed there is a disparity between the engagement of males and females in football interventions. Multiple studies examined the use of football in addressing both mental and physical health for non-clinical populations and in combating gender behaviours that are adverse to health, predominantly with all male samples (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffney, 2012; Curran et al., 2017; Pringle et al., 2013; Lewis, Reeves & Roberts, 2017; Robertson et al., 2013). However the transferability of findings for both genders can be questioned.

The study undertaken by Brawn, Combes and Ellis (2015) aimed to explore the relationship between engagement in competitive football sessions and mental health recovery. While the findings provide valuable information in areas such as improvements in social interaction, community connection and service user empowerment, the majority of the article discusses benefits for all mental health service users despite the study consisting of an all-male sample. As discussed, there are external factors that influence the male/female ratio of individuals who involve themselves in these interventions that the authors will have little influence over. However, there does not appear to be an attempt made to demonstrate efforts to include women in the intervention, explain why no women were present or to acknowledge the impact socially constructed gender roles may have had.

Studies that do not acknowledge the role of female staff who are actively involved in football sessions may pose another limitation. The 'Getting Inside Men's Health' policy (Richardson, 2004) suggests opportunities for reciprocal connections between males and females may reduce the impact of masculinity norms and their impact on mental wellbeing (Addis & Mahalik, 2003). However, none of the studies reviewed reflected on the impact the gender of facilitators may have had on group benefits or even dynamics (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffney, 2012; Curran et al., 2017; Pringle et al., 2013; Lewis, Reeves & Roberts, 2017; Robertson et al., 2013). In the study by Benkwitz and Healy (2019) the authors themselves took part in football sessions as part of their methodology and one of the authors was female. The potential influence she could have had on the group dynamics and benefits was not discussed and again, they apply their findings to both genders despite having only male mental health service users in their group.

There appears to be a gap in existing research analysing the impact female staff engaging in the group may have on the experience of service user participants and the group dynamic as a whole. In addition, Pringle and Pringle (2016) alert us to the need for female mental health service users to be targeted in these types of interventions. They state that while the majority of both men and women in the UK don't meet recommendations for an active lifestyle, women are less likely to meet this. There is therefore a gap for studies that use methods to try recruit female players and to explore whether they are less likely to engage in football interventions.

2.6.2. Recovery and overall health focus

One of the barriers for services in Ireland trying to undertake a recovery-orientated approach is that the concept of recovery is misunderstood (Higgins, 2008). Repper and Perkins (2003) examine the difference between mental health recovery and management of mental health symptoms. They state a recovery orientated focus would look to enable people to use and develop skills and strengths as the primary focus of interventions, rather than symptom removal and assessment as an indicator of recovery progress. However, there is a tendency for current research in the area to take a symptom removal approach as a primary outcome rather than overall recovery. An example is the study by Lamont et al. (2017). Although this study shows promising scope for the ability of football interventions to reduce severity of mental health symptoms experienced, they define their study as recovery-orientated, which it does not appear to be. Similarly, other clinical population studies discuss the shift from symptom reduction to quality of life and recovery focused interventions but go on to describe outcomes such as symptomatic change, weight loss and smoking cessation (Friedrich & Mason, 2018; Mason & Holt, 2012).

A positive aspect of current football intervention research is the combined focus on addressing both physical and mental health in interventions. A need to address physical health for mental health service users was mentioned in Chapter One – Introduction. The study by Friedrich and Mason (2018) states football interventions are well situated to address these physical health issues whilst also having a positive impact on mental health due to the cultural value and popularity of football. Studies examining the effectiveness of football interventions in non-clinical populations in particular, are skilled in making the connection between both areas in programmes (McGale, McArdle & Gaffney, 2011; Robertson et al., 2013; Curran, Richardson & Pringle, 2016). However, research with clinical populations appears to focus on physical health benefits in the context of mental

health symptom reduction or not to give enough focus on the need for players to address physical health outside of the programme.

The study by Darongkamas, Scott and Taylor (2011) includes a clinical population and aims to come from a recovery perspective in their research, focusing on issues like social inclusion and physical activity for those with mental health difficulties. However, researchers speak about physical activity in the context of the mental health benefits it brings about. They appear to treat physical health and mental health as separate entities. Studies that do address physical health mention benefits such as smoking cessation and weight loss but they don't appear to discuss whether physical activity has become part of footballers' routine. Nor do they appear to show follow up that confirms changes observed were sustained (Mason & Holt, 2012; Moloney & Rohde, 2017; Lamont et al., 2017).

There is a gap in existing research for football interventions that follow through with recovery-orientated aims, methods and outcomes. In addition, there is a gap in research with clinical populations for programmes that identify the need for players to work on their physical health outside of the group. Whether the addition of physical activity has become part of footballers' routine and whether change observed and reported within the group setting is sustained and transferable to external environments is another gap that the current study hopes to address.

2.6.3. Socially included or community based?

Repper and Perkins (2003) describe social inclusion as access to roles, responsibilities, activities and resources needed for recovery in order to maintain or discover new ways to access these areas. However current research appears to describe community-based activities as being the same as, or supporting, social inclusion. For example, Moloney and Rohde (2017) stress the importance of the group providing opportunities for footballers to socialise after sessions through a cup of tea and chat. Although findings show footballers to be more connected to players in the group, the authors claim their social inclusion was fostered as a result. However, there does not appear to be any data that showed clients had improved access to roles, responsibilities and activities needed for recovery in environments outside of the group as a result of their engagement in football. Similarly, the study by Lamont et al. (2017) examines how a walking football programme supports the recovery of individuals but does not appear to discuss the role of social inclusion in recovery.

Other studies suggest that the establishment of sports partnerships and the setting up of sessions in local sports centres had improved social inclusion for people with mental health problems (Hargreaves & Pringle, 2019; Benkwitz & Healy, 2019; Friedrich & Mason, 2018). There appears to be a potential misunderstanding in the existing literature about the differences between community-based activity and the facilitation of social inclusion. They are not the same. The study by Magee, Spaaij & Jeanes (2015) states that football programmes tend to promote social interaction within the group but don't appear to facilitate carryover into the community setting or with other individuals outside of the group. They call for the incorporation of exit pathways into football programmes for clinical groups in order to better bridge the gap between individuals and their communities.

In relation to studies with non-clinical populations, engagement in football to positively influence the social inclusion of players appears to be a success. This is the case whether or not there are additional educational opportunities of how to stay well and how to stay connected within the community (Robertson et al., 2013, Lewis, Reeves & Roberts, 2017; Pringle at al., 2013). For clinical populations, social connections and interactions made within football sessions have been shown to have a positive influence on self-esteem, hope and the authors are confident that individuals will re-integrate in their communities (Brawn, Combes & Eilis, 2015; McElroy, Evans & Pringle, 2008). The gap in existing studies examining football interventions therefore appears to be with clinical populations and whether social skills and connections made within the group setting can be brought to the community environment. However, can engagement in football interventions positively influence experiences of social inclusion for service users? In addition, what methods and exit pathways would best bridge this gap for service users?

2.6.4. Ethical dilemmas and limitations

Ethical dilemmas and limitations seemed to be present within existing studies, particularly in the areas of recruitment, design and programme description. For example, Mason and Holt (2012) maintain that their interview schedules were based on literature and extensive piloting. However they don't go into detail on what guidance was used nor provide a copy of the interview questions. In relation to programme description, Friedrich and Mason (2018) didn't explain if their intervention was delivered in one block or continuously. In addition they did not state if staff members were involved in the football sessions or how many times a week the group was run. Studies tended to lack description of football session content, inclusion and exclusion criteria and didn't often discuss barriers to

engagement. This can be seen in the study by Moloney and Rohde (2017). In addition, the tendency for researchers to be either programme facilitators themselves or to have taken part in football sessions leading up to research, poses a potential ethical dilemma. It calls upon the issue of consent and whether participants felt coerced into taking part, particularly for the service user group. For example, in the study by Benkwitz and Healy (2019) researchers engaged in sessions and selected service user participants whom they felt would give further insight into the programme thereby introducing bias. The researchers may have selected those players who had positive feedback on the programme or that players felt obliged to take part.

This issue can also be seen in the study by Darongkamas, Scott & Taylor (2011). The programme was being evaluated by staff who were involved in it's facilitation to determine if outcomes were being met. However, the purpose of the evaluation was to discover if the club was meeting it's outcomes. This implies footballers who would have come forward to get involved may have been keen to speak positively about the group. Similarly, in studies by Moloney and Rhode (2017) and Mason & Holt (2012), the interview schedules appears to ask no negatively worded questions about participants' experience of the group. This would require players to bring up barriers of their own volition and discuss them with the staff member who facilitated the group they were involved with. Studies with non-clinical populations tended to provide more detailed description of the intervention and recruitment was often done on a voluntary basis rather than through referral or service recruitment (McArdle, McGale & Gaffney, 2012; Pringle et al., 2013; Robertson et al., 2013). The studies that do examine positives and negatives of programmes tend not to ask participants for solutions as to how they could be solved which may result in individuals missing the chance to be involved in programme re-design (Hargreaves & Pringle, 2019; Benkwitz & Healy, 2019).

A gap in exists in the clear description of a data collection tool used within these studies, along with the piloting and the inclusion of questions that encourage study participants to reflect on both the potential positives and negatives of their experiences. A clear description of how the intervention is facilitated at the outset is also needed. Equally there appears to be a lack of independent research carried out on these programmes. It is hoped the current study will explore both the positive and negatives of stakeholder experiences with the programme. In addition, all participants will be prompted to give

suggestions on how to improve the intervention which is an important component of recovery-orientated services and research (Health Service Executive, 2017).

2.6.5. Methodology

As mentioned, twelve of the studies included used a qualitative research design, two studies used mixed methods and the remaining two used quantitative methodology. With regard to quantitative methodology, the use of valid and reliable instruments to measure recovery-based outcomes is vital to building an evidence base for these kinds of interventions (Lusczakoski et al., 2014). However, because recovery is an individualised journey, direct measurement of this process can be challenging (Anthony, 2000). Furthermore, a study by Bibb and McFerran (2017) found that self-report measures, which are often used in quantitative research measuring recovery-orientated outcomes, are often cognitively challenging for participants, the language is often not culturally appropriate and the empowering changes that take place during a person's recovery journey are diminished.

Qualitative methodologies are vital in empowering service users to tell their stories within research (Doroud, Fossey & Fortune, 2015). It allows the important shift from questions of "what changes occurred" to "how and why did these changes occur" that need to be answered in research examining mental health recovery (Hopper, 2012). Hasson-Ohayon, Roe, Yanos and Lysaker (2016) therefore recommend that mixed methods methodology is the most appropriate approach for tracing progress in recovery as it captures the picture of process and the outcome. Although this methodology was considered, in order for it to be correctly carried out and provide worthwhile data the researcher would need to have skills in conducting both qualitative and quantitative research (Hissong, Lape & Bailey, 2015). The researcher had completed a previous study using a qualitative approach and felt more confident using this methodology.

Five of the studies included used qualitative methodology and included footballers in addition to other stakeholders (Benkwitz & Healy, 2019; Magee, Spaaij & Jeanes, 2015; Friedrich & Mason, 2018; Robertson, et al., 2013; Mason & Holt, 2012). Two of these studies were with clinical populations only (Friedrich & Mason, 2018; Mason & Holt, 2012) and the third was with both clinical and non-clinical participants (Magee, Spaaij & Jeanes, 2015). Although the two studies using clinical populations did explore both the perspectives of footballers and staff, the sample size for the staff group was small.

In addition, no studies split staff participants into separate samples but rather analysed them as one group. The level of exposure to people with mental health difficulties and professional responsibility of the football coaches and the healthcare professionals would be different and therefore their perspectives on recovery and their roles in supporting players in the programmes would be different. Therefore, a gap in research analysing insights of these groups separately exists.

2.7. Summary of gaps in the literature and research aims

- There appears to be a gap in existing research analysing the impact female staff engaging in the group may have on the experience of service user participants and the group dynamic as a whole. In addition, there is a gap for studies that use methods to try recruit female players and to explore whether they are less likely to engage in football interventions This will be further explored in the current study.
- There is a gap in research with clinical populations for programmes that identify the need for players to work on their physical health outside of the group. Whether the addition of physical activity has become part of footballers' routine and whether change observed and reported within the group setting is sustained and transferable to external environments is another gap that the current study hopes to address.
- With regards to research examining social inclusion, there is a gap in existing studies with clinical populations investigating whether social skills and connections made within the group setting can be brought to the community environment. Can engagement in football interventions positively influence experiences of social inclusion for service users? In addition, what methods and exit pathways would best bridge this gap for service users is a gap.
- With regards to methodology, although there are existing studies with clinical populations that explore both the perspectives of footballers and staff, the sample size for the staff group was small. In addition, no studies split staff participants into separate samples but rather analysed them together as one group. Therefore, a gap in research analysing insights of these groups separately exists.
- Only one study was found that examines the K2R programme and this was the only study within which the group was classified as an occupational therapy intervention (Moloney & Rohde, 2017). There is a need for further research to explore the benefits of football for people with mental health difficulties and for the effectiveness of the K2R programme.
- There appears to be a dearth in the literature of a clear focus on the achievement of recovery outcomes and the methods that are used to achieve these. There is a need

for research that considers how positive social interactions and learning within the group setting could be extended to community environments. In addition, the specific facilitation methods that are used in the group to fully involve service users and maintain a recovery focus needs to be better explored.

- Football interventions are often not facilitated from a leisure approach and this has been recommended for exploration in research with Irish populations (O'Doherty, Stevenson & Higgins, 2012). Therefore, the current study being undertaken within the field of occupational therapy from a leisure perspective will address the identified research gap.
- Policies in recent years have shown a positive shift in the provision of community-based resources and the attitudes of the Irish public as a whole towards mental health. This study therefore aims to add to the pool of evidence analysing football interventions and to help identify the challenges programmes are faced with, for example the unequal engagement of genders.

2.7.1. Research aims

The below research aims have been created to address the gaps outlined above;

1. To explore the perceptions of programme stakeholders of whether engagement in football had a positive impact on the recovery outcomes of mental health service users taking part in the 'Kickstart 2 Recovery' programme.
2. To explore the perceived experiences of and methods used by FAI coaches and healthcare professionals whilst supporting the recovery journey of service users engaged in the 'Kickstart 2 Recovery' programme.

This chapter has discussed search strategies used to identify current research in the area of recovery through football. The relationship between the recovery model and K2R was discussed alongside the value of sport and leisure to mental health service users, governmental publications and guidelines that influence the provision of football interventions in the Irish context. Finally, critique of current football intervention research was carried out to identify a research gap. The next chapter will describe methodology used to address research gaps identified.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

A gap in research was identified regarding the influence participation in football has on the recovery of service users in adult community mental health services in Ireland. In addition, a gap was identified in existing qualitative research in the area of recovery through football that lacked detailed explanation of methods used to ensure transparency. The methodology outlined in this chapter will therefore investigate whether engagement in football can positively influence recovery outcomes for Irish mental health service users using clear descriptions of methods and theoretical guidance. This exploration was done using the theoretical perspective of the Canadian Model of Occupational Performance and Engagement (CMOP-E)(Polatajko, Townsend & Craik, 2007) which includes the Canadian Model of Client-Centred Enablement (CMCE)(Townsend, Polatajko, Craik & Davis, 2007).

3.2. Research aims

3.2.1. Outline of aims

The below aims target the gap outlined in existing research on the use of football interventions in mental health:

1. To explore the perceptions of programme stakeholders of whether engagement in football had a positive impact on the recovery outcomes of mental health service users taking part in the 'Kickstart 2 Recovery' programme.
2. To explore the perceived experiences of and methods used by FAI coaches and healthcare professionals whilst supporting the recovery journey of service users engaged in the 'Kickstart 2 Recovery' programme.

This research was designed to explore the opinions and experiences of each participant group within the K2R programme, the groups being players and facilitators.

3.3. Philosophical perspective

3.3.1. Justification for philosophical worldview – social constructivism

When choosing a worldview, both constructivism and advocacy perspectives brought positives and negative aspects to the research (Creswell, 2009). The profession of occupational therapy is concerned with the subjective experiences of functional difficulties and how policy either enables people to overcome them or adds to the barriers (Hinojosa, Kramer, Royeen & Luebben, 2003), making both perspectives applicable. However, it was decided that an advocacy perspective may be beyond the scope of this research project. There is currently only one other study examining the K2R project in Ireland (Moloney & Rohde, 2017) and it was felt there would need to be more research undertaken before a change in policy could take place. An approach from a constructivism perspective would allow the experiences of all stakeholders involved in K2R to be explored and would lay a foundation for future research. In addition it has been a highly influential perspective in the challenging and deconstruction of medical model based attitudes in the area of psychiatry and facilitates a recovery model approach to care (Kriegler, 2015).

Social constructivism was therefore the worldview taken for this project. It allowed the researcher gain a deeper understanding of how football is experienced as an approach to supporting recovery from the perspectives of the four participant groups:

1) Service users (footballers)
2) Football Association of Ireland coaches (coaches)
3) Referring healthcare professionals (HPs)
4) Occupational therapists who co-facilitate the programme (OTFs).

3.4. Research design

3.4.1. Qualitative research

Pope and Mays (2006) outline the domain of concern for qualitative methods in health research as being the collection of meanings people attach to their experiences of the social world using multiple sources and to make sense of a social phenomenon. This study aims to take a descriptive phenomenological approach to inquiry in line with theoretical guidance being employed. However, Sandelowski (2000) cautions researchers when undertaking qualitative research against labelling their methodology as based in phenomenology, when it only possesses undertones of the concept. Although this study cannot take the identity of a phenomenological design, it bares more resemblance to descriptive phenomenology than a qualitative descriptive approach.

3.4.2. Descriptive phenomenology

Descriptive phenomenology is a method widely used to explore and describe the lived experience of a phenomenon (Christensen, Welch & Barr, 2017). The CMOP-E model takes a similar approach to exploration of human experience as descriptive phenomenology by moving beyond the who, what and where of occupational engagement, towards the how and why (Polatajko et al, 2007). Data collection methods reflect these ideals and address concepts discussed in Chapter Two. For example, the relationship between sport engagement and mental health recovery. Adams and Anders van Manen (2017) discuss the need for researchers to 'bracket' their own experiences of a phenomenon during the research process, to recognise the benefit of having an existing understanding to aid deeper questioning, exploration and interpretation at a descriptive phenomenological level. Undergraduate student placement experiences, participating in the K2R programme and evaluating it on a superficial level, sparked the desire to explore it's impact on mental health recovery on a deeper level. The combination of 'bracketing', researcher experience and theoretical guidance will assist in the consideration of descriptive phenomenological methods to inform the research process.

Applebaum (2012) defends the ability of qualitative studies using descriptive phenomenology in psychological research, to move past superficial presentation of themes and participant quotations, to present true answers around human experience. The author states to strive for objectivity in human science would be to objectify human beings and that transparency in methods and striving for discovery, rather than verification of a phenomenon, will produce real findings.

The use of mentioned frameworks informed this research and ensured focus remained on the research question at hand. However Hansen (2006) mentions the both complimentary and conflicting relationship between descriptive phenomenology and social constructivism. These differences are also mentioned by Applebaum (2012) and Finley (2006) who identify a need to manage this conflict if combining these perspectives in research.

3.4.3. Managing conflict between phenomenology and social constructivism

Hinojosa, Kramer, Royeen and Luebben (2003) discuss occupations as being a combination of an individual assigning meaning to an activity based on personal and subjective experience, whilst also recognising the influence of socially constructed values, culture, socioeconomic background and locality, to name a few. This relationship between the person and their environment through doing, is reflected in the CMOP-E model (Townsend & Polatajko, 2007). There is an ongoing debate in the profession, on whether interventions on an individual or a societal level are the best use of skills possessed, particularly in the area of psychiatry (Schwartz, 2003).

This clash between environmental and personal influences on experience is mirrored in research using a descriptive phenomenological approach to inquiry whilst holding a social constructivist worldview. Finley (2006) discusses this struggle in their own research. They state the combination of a social constructivist approach using descriptive phenomenological methods offered advantages and disadvantages but that a more important concern is matching methodology approaches with the skillset, interests and values of and opportunities available to, the researcher. As this is a study being undertaken in the field of occupational therapy it seems appropriate to embark on implementing methodology that respects areas addressed by the profession, being both the person and their environment. Furthermore, the design of the programme being studied involves an occupational therapist as co-facilitator. This means study findings could have particular relevance to the practice of those professionals, enabling them to challenge and refine current practice.

3.5. Theoretical perspectives

3.5.1. Justification for choice

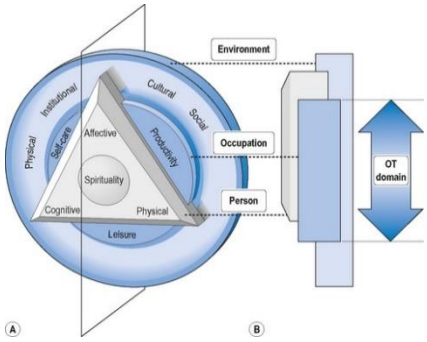


Figure 1: The CMOP-E model (Townsend & Polatajko, 2007)

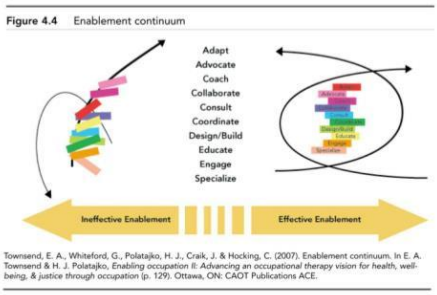


Figure 2: The CMCE model (Townsend et al., 2007)

As argued, CMOP-E as the theoretical perspective to guide to study process, will ensure beliefs from both social constructivism and descriptive phenomenology are respected. This was due to the model's holistic perspective on both the 'how' and 'why' of individual experience, alongside the way in which their social, cultural, institutional and physical worlds will influence this. However, this model also includes supplementary frameworks providing guidance to those supporting the successful engagement of individuals. Turpin and Iwama (2011) state as part of the analysis used by the CMOP-E, implementation of The Canadian Practice Process Framework (CPPF) and The Canadian Model of Client-Centred Enablement (CMCE) are required to sufficiently explore experiences of an individual's engagement. It is therefore clear that in order for experiences of service users in the K2R programme to be fully considered, the perspectives of those supporting their engagement must also be explored.

Townsend et. al (2007) outlines guidance provided by the CMCE in relation to making professionals aware of typical issues with enablement in healthcare settings, alongside core skills to support engagement. In comparison the CPPF provides occupational therapists with a pathway to use at an individual or societal level, within which, the guidance of the CMCE and analysis using CMOP-E come into play (Craik, Davis and Polatajko, 2007). The CPPF framework was not utilised in this study due to the varying professions and roles of facilitators involved, this being explained in more detail below in 'participants'.

It was therefore decided that the CMCE and the main model of CMOP-E, illustrated above, would form the basis of analysis and methods used to explore the experiences of the facilitator and service user groups engaging in the K2R programme.

3.5.2. Additional theories to guide qualitative design

As discussed, the CMOP-E as the overriding theoretical perspective would have the scope to combined research approaches of social constructivism and descriptive phenomenology (Finley, 2006). It would assist in examining if football as an occupation, facilitated through enablement skills, would be capable of connecting service users to their communities by supporting engagement despite symptoms rather than reducing symptoms to better performance (Polatajko et al., 2007). However, as identified in Chapter Two, similar studies had failed to adequately explore concepts of recovery outcomes and to demonstrate guidance used for data collection methods. While the CMOP-E and CMCE were identified as appropriate models to guide this research, neither model is specifically designed to be used in the field of mental health recovery. In addition both models were designed to examine and enable an individual's ability to engage in the three occupational areas of self-care, productivity and leisure rather than leisure alone. It was decided that additional frameworks would implemented to create data collection tools and ensure topics of recovery and leisure engagement would be clearly targeted in them.

The Mental Health Recovery Star (Recovery Star)(MacKeith & Burns, 2008) and the model of leisure enhancement through occupational therapy (leisure model)(Baxter, Friel, McAtamney, White & Williamson, 1995) were added to guide data collection methods for the service user group. It was hoped the leisure model would bring additional focus to the leisure section of occupation within the CMOP-E and that the recovery star would bring the person, occupation and environment relationship into the context of mental health recovery. The purpose of the recovery star is to combine service user feedback and narrative with the support of front-line staff to facilitate recovery and social inclusion in ten key areas (Dickens, Weleminsky, Onifade & Sugarman, 2012) making it capable of addressing both the topics and relationships involved in this study.

For the facilitator groups, *A National Framework for Recovery in Mental Health: A national framework for the mental health service providers to support the delivery of a quality, person-centred service 2018-2020* (HSE recovery framework)(Health Service Executive, 2017) was added. It provided context within which facilitators running interventions aiming

to improve recovery outcomes are striving to work within. This framework acknowledges the move of mental services to community provision, the drive to offer a wider range of mental health interventions and the importance of the lived experiences of service users to the recovery process (Health Service Executive, 2017). Again, this makes the document a fitting informant to analyse both the topics of concern and the relationships involved in the K2R programme.

When considering methods of inquiry each of the named frameworks were examined as to what methods they used. A summary of this is shown in Figure 3.

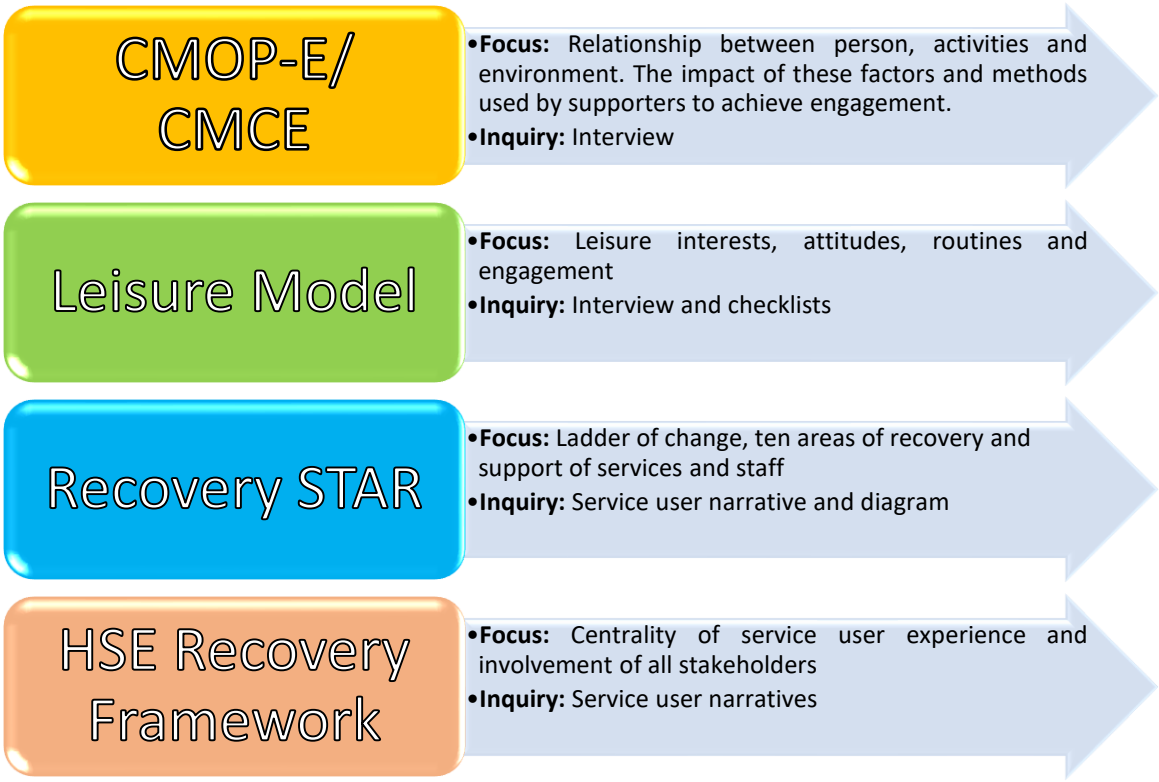


Figure 3: Theoretical frameworks - strategies of inquiry

As illustrated, the strategy of inquiry used by each framework is a qualitative interview or analysis of a narrative. Individuals are facilitated to explore and describe their lives and experiences and make decisions on what actions they would like to be taken. Descriptive phenomenology uses this strategy of inquiry as it requires information to be accessed and understood through the people experiencing it (Ellis, 2016). A similar approach to inquiry will therefore be used in this study with the target population.

3.6. Participants

3.6.1. Target population

A gap in research was identified investigating the impact participation in football has on the recovery of service users in adult community mental health settings in Ireland from a service user and staff perspective. With respect to the methodology mentioned, it was necessary to explore the perspectives of those subjectively experiencing the phenomenon in conjunction with those involved in service provision and facilitation of engagement. Therefore, both individuals engaging in the K2R programme and those facilitating this engagement, were included in the target population. These groups were named as footballers, coaches, OTFs and HPs.

Although the CPPF is also informed by these two frameworks, it was decided that use of a theory specific to the occupational therapy process may exclude those in other facilitator roles such as coaches. Despite this research project being in the field of occupational therapy and having a participant group of OTFs, it was equally important that findings were relevant to the other groups and their involvement with the programme. Therefore, for the majority of this chapter OTFs will be discussed as part of the healthcare professional group. In addition, it was originally thought K2R programme designers from the FAI and sports centre staff could be included. However, none of these groups came forward and it was decided that a higher level of exposure to the facilitation of the group was desired in the study population. Social constructivism and descriptive phenomenology combined will explore the phenomenon in question from the perspective of facilitator and service user groups whilst acknowledging the wider social and cultural influences on these experiences. Figure 4 explores the groups that fit these criteria using the framework by Miles and Huberman (1994) which explores researcher assumptions on potential characteristics of the target population. This is done under the four headings of setting, actors, events and process. This will subsequently be used to inform suitable sampling methods, inclusion and exclusion criteria and recruitment pathways in combination with discussed methodologies.

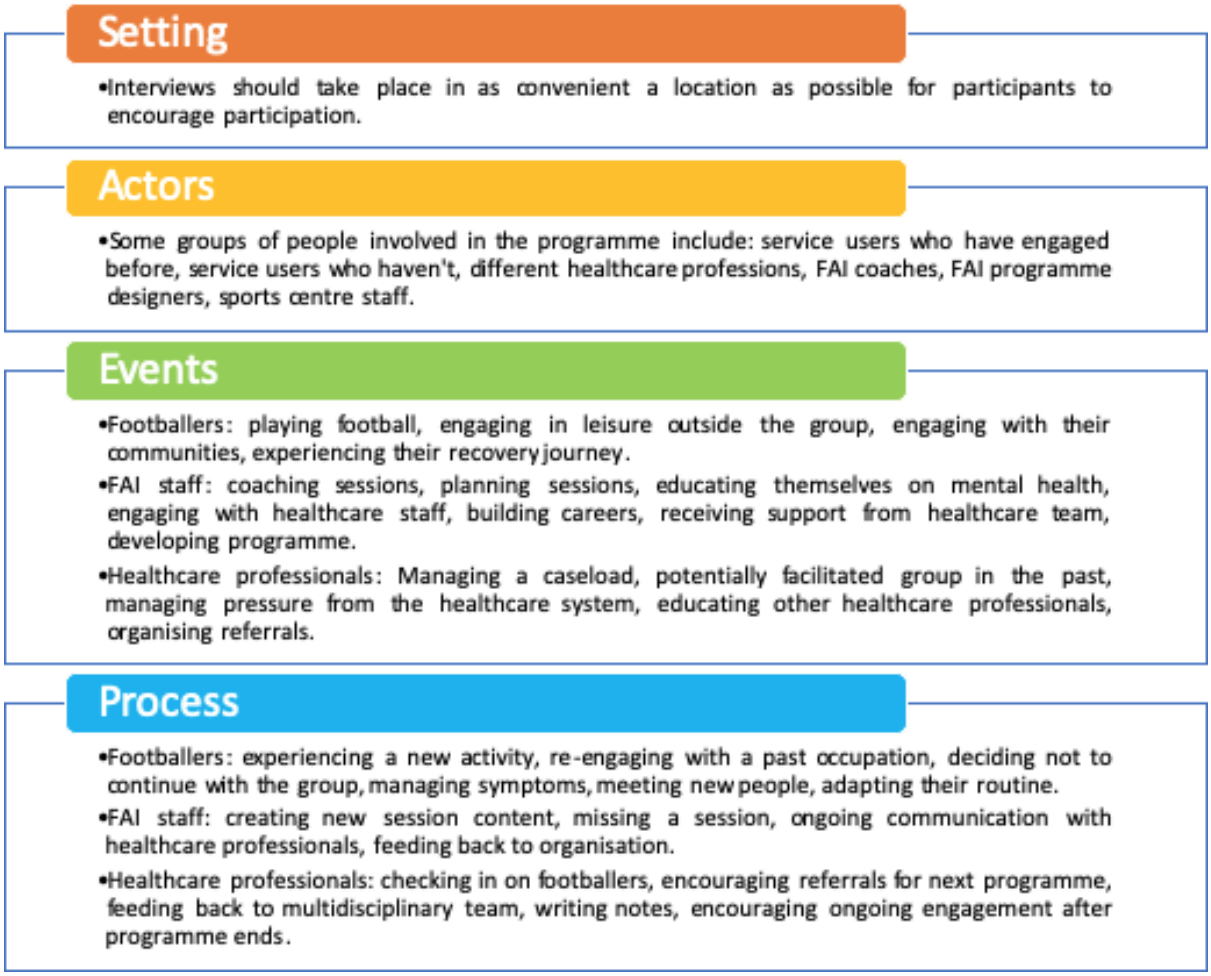


Figure 4: Analysis of target population

Hissong, Lape and Bailey (2015) state that purposeful sampling for participant selection in qualitative research is most appropriate, to ensure participants with the most detailed and relevant exposure to a phenomenon are studied. They equally stress the importance of data collection being done in the participants own environments. The groups involved in the direct provision and experience of the programme are service users, healthcare professional facilitators and FAI coaches. As the programme is delivered as part of the multi-disciplinary team design of Irish mental health services and through collaboration with the FAI, healthcare professionals working with footballers during their engagement and FAI staff who support coaches are impacted by the phenomenon. On a wider scale the programme is influenced by HSE provision of funding, service policies and procedures, government documents guiding interventions and treatment of those with mental health difficulties.

The question being investigated was the impact participation in football has on the recovery of service users in adult community mental health services. Discussed methodological approaches would place most value on data from footballers as this group's narrative is what the phenomenon is asking. However, in addition to the value the CMOP-E places on inclusion of facilitator perspectives, those working in the Irish mental health services are often faced with societal negativity (The Irish Times, 2018) (Cullen, 2019). The perceptions and experiences of facilitators will therefore likely have an influence on the delivery of the service. Professionals supporting engagement of service users, in addition to referring healthcare professionals and FAI staff involved in programme design, were therefore included in data collection and phenomenon exploration.

3.6.2. Sampling methods and size

As mentioned above, a purposive sampling method was used with this study and homogenous selection within each participant group was employed. DePoy and Gilson (2007) describe homogeneous selection as discovering the diversity within a group of people who are initially selected for their similar characteristics. For example, level of exposure to the phenomenon being studied, level of interest in the phenomenon and geographical area. DePoy and Gitlin (2011) describe the focus of sampling using a phenomenological approach, as being placed on the level of exposure and experience each individual had with the phenomenon being studied, rather than a higher number of participants. They continue to mention that researchers using homogeneous selection in sampling are working to minimise variation, therefore a group of five to ten individuals is sufficient to provide a picture of the phenomenon that is representative of the wider population. A target sample of five participants in each of the four groups, twenty total, was set. Inclusion and exclusion criteria for each group are outlined in Tables 3, 4 and 5 followed by recruitment efforts. Mentioned characteristics such as exposure to the phenomenon and any variances in type of exposure were considered.

Table 3: Inclusion and exclusion criteria - footballers

Inclusion criteria	Exclusion criteria	Justification
Service Users who are engaged in the 'Kickstart to Recovery Programme within the Louth Meath Mental Health Services.	Those not involved in the 'Kickstart to Recovery Programme'.	-This service site reported to be following the 'Kickstart to Recovery' model in their programme.
Those who have completed a PAR-Q activity readiness questionnaire	Those who are physically not ready as identified by the PAR-Q.	-To ensure potential participants possessed skills at time of interview that would allow them to participate safely in the programme.
GP Clearance signature	Those who are suicidal or actively abusing substances.	-To avoid attempting to recruit people experiencing additional vulnerabilities at time of data collection.

Table 4: Inclusion and exclusion - healthcare professionals

Inclusion criteria	Exclusion criteria	Justification
Those whose caseload includes clients who have completed at least six out of eight sessions of the programme in the last five years.	Those who have not had service users involved with the programme on their own caseload.	-To ensure potential participants had personal experiences of the phenomenon being studied. -To be inclusive of those engaging with the phenomenon since its beginning at this site.
	Those who have worked with service users who have completed less than six sessions of the programme.	-To prevent findings from being an unfair reflection of what a community service is capable of achieving.

Table 5: Inclusion and exclusion criteria - FAI coaches

Inclusion criteria	Exclusion criteria	Justification
Those who have coached service users involved in the programme in the last five years.	Those who have not been involved in the design or coaching of the programme.	-To ensure potential participants had personal experiences of the phenomenon being studied.
Those involved in programme design in the last five years.		-To recognise those involved in programme design may not have had personal contact with a group.

3.7. Role of gatekeepers

Two occupational therapists at each site acted as gatekeepers for all participants in this study. Their role was to disseminate the PIL to the group members. The risk of bias when professionals involved in programme facilitation act as gatekeepers was discussed in Chapter 2. Other potential pathways were considered but it was decided the Occupational Therapists were best placed to fill this role. They were integrated in each site and had a pre-existing relationship with these groups, making the recruitment process easier. In addition, the relationship the therapists had with group members and staff proved to be invaluable to the recruitment process as they were able to reduce concerns expressed by some of the group members in relation to the pre and post interviews. As discussed, this meant the researcher could facilitate their request and change data collection methods. Furthermore, the positive influence good therapeutic relationships between staff and service users within community mental health settings has on recovery outcomes is supported in literature (Farrelly & Lester, 2014; Priebe, Richardson, Cooney & Adedegi, 2011).

The Occupational Therapists recruited service users, healthcare professionals and coaches to the study by distributing the PILs and answering any questions raised. The recruitment of OTFs, was done through the Association of Occupational Therapists of Ireland acting as gatekeeper.

3.8. Recruitment pathways

Table 6: Footballer recruitment pathway

Time	*Action taken place*	*Action purpose*	*Action response*	*Additional action*
3 weeks before group. (Week of 21/01/2019)	Phone call from Occupational Therapist to arrange pre-group appointment. Occupational Therapist mentions research on the programme is taking place and would the individual like more information via the post to read.	Gain permission to provide information from participant and use their address for research purposes.	If the participant agrees, the Occupational Therapist posts the information and tells participant they can ask any questions at the pre-group review. This information invites footballers to question session.	Occupational Therapist to answer questions at appointment. Should the participant not bring up the study the Occupational Therapist will not discuss it.
2 weeks before group. (Week of 28/01/2019)	Researcher question sessions at both sites (place and time detailed in study information pack posted).	To give interested participants opportunity to ask questions and meet researchers.	Researcher arranged a room with Occupational Therapist on research team and was present for time slot.	_____
Group begins and pre-group reviews take place. (Week of 04/02/2019)	A participant asks about the research project during pre-group review. Occupational Therapist answers questions asked.	Allow the participant opportunity to ask questions with someone they know and trust.	Occupational Therapist states if participant would like to take part, they should contact the researcher.	Provide researcher contact details again.
Week 5 of group. (Week of 04/03/2019)	Occupational Therapist mentions to group that researcher would like to visit and explain study in person to those not present at question session/ who have more questions.	Allow participants interested in research to meet team.	Should service users agree, the researcher team will visit in second last week of group.	Occupational Therapist to contact researcher and state if the visit is to go ahead or not and provide space for those not interested during talk.
Week 6 of group. (Week of 11/03/2019)	Researcher meets with interested footballers with research supervisor and explains study process.	Allow interested participants to meet and ask questions of research team.	If participants approach, explain research process and GDPR rights using accessible language.	Ensure any participants wishing to do a phone interview sign a consent form during this meeting. Book appointments for face to face interviews.

Time	*Action taken place*	*Action purpose*	*Action response*	*Additional action*
Weeks 7-8 of group. (18/03 -29/03 2019)	Researcher meets participants/ calls them, explains study and GDPR rights again and consent form is signed if participant is happy to do so	To provide participants another opportunity to hear study process, ask questions and choose not to take part.	Conduct interview if consent is given or thank footballer and cancel meeting should they not want to take part.	Research team Occupational Therapists outline risk management plan for when meeting it taking place should participant become distressed.

Table 7: Occupational Therapist Facilitator recruitment pathway

Time	Action taken place	Action purpose	Action response	Additional action
13/03/2019	Email sent to AOTI to request circulation of recruitment email of Kickstart facilitators, both Occupational Therapy and non-Occupational Therapy.	Effort to recruit healthcare professional facilitators due to completed interview findings.	A second email was sent to follow up with request. Apology email received for delay.	Researcher changed deadline in application for participant responses to accommodate delay.
16/04/2019	Study circulated to members.	Allow members express interest in participating in the study.	Check emails and phone calls.	_____
16/04 – 23/04 2019	Time period for participants to respond to recruitment appeal.	To both address time pressures for data collection and allow staff working in busy environments time to respond	Should a professional get in contact, researcher would explain study details over the phone again.	Book time for phone or face to face interview should participant want to take part.

Table 8: Healthcare professional recruitment pathway

Time	Action taken place	Action purpose	Action response	Additional action
Week of 21/01/2019	Research team Occupational Therapists explained study during a multidisciplinary team meeting.	Make team aware of study and question answering session being done by researchers at both sites.	Occupational Therapist provided information packs to those interested and encouraged them to attend question session with researchers.	_____
28/01 – 01/03 2019	Interested professionals contacted researcher. Research team Occupational Therapist reminded professionals of time remaining to get involved at weekly team meetings	To both address time pressures for data collection and allow staff working in busy environments time to respond	Should a professional get in contact, researcher would explain study details over the phone again.	Book time for phone or face to face interview should participant want to take part.

Table 9: FAI staff recruitment pathway

Time	Action taken place	Action purpose	Action response	Additional action
Week of 21/01/2019	Research team Occupational Therapists mentioned study to the coach at their site. Study information was shared through an email sent by the researcher to the FAI office on the National Sports Campus to circulate to coaches and programme designers.	To provide staff with information on the study. To make people aware of the study particularly coaches at study sites due to exposure to phenomenon and footballers in target population.	The information pack and email encouraged staff to contact the researcher to ask questions.	_____
28/01 – 01/03 2019	Time period for interested staff to contact the researcher to ask questions and express an interest in participating.	To both address time pressures for data collection and allow staff working in busy environments time to respond.	Should a staff member get in contact, the researcher would explain study details over the phone.	Book time for phone or face to face interview should participant want to take part.

As discussed, it was thought that each participant group would provide a different perspective on the phenomenon being studied. A participant information pack including a Participant Information Leaflet (PIL), interview schedule and consent form was prepared and approved for use through ethics applications. There were three packs, one for coaches, one for footballers and one for healthcare professionals. Both HP and OTF groups received the same information pack, as the aim was to explore their differing perspectives on the same questions, in line with homogenous sampling methods (DePoy & Gitlin, 2011). In addition, information packs were provided via email to coaches and OTFs and included an information sheet about GDPR. Other groups had this information given over the phone pre-interview and sent in a written format post interview.

3.9. Semi-structured interview

3.9.1. Semi-structured interview justification

Hansen (2006) writes that, although an in-depth unstructured interviewing technique is typically associated with a phenomenological approach, a semi-structured interview design allows the researcher to both remember topics they wish to include and facilitate interview flexibility. Interview guides are developed through the data collection process depending on issues raised by participants. Researchers are encouraged to add topics and questions that arise to the interview schedule. Interview guides for each participant group were created using areas of concern, as outlined by the CMOP-E, the HSE framework for recovery, the recovery star and the leisure model.

The CMCE alongside the HSE framework for recovery were deemed to be capable of addressing areas for facilitators, such as most effective methods to support the engagement of service users in a recovery orientated intervention. The CMOP-E, leisure model and recovery star aim to explore areas such as participant assignment of meaning in the area of leisure and how this engagement could potentially connect them to their environment.

3.9.2. Interview schedule creation

As discussed, additional theoretical guides of the recovery star (MacKeith & Burns, 2008), the HSE recovery framework (Health Service Executive, 2017) and the leisure model (Baxter et al., 1995) were added alongside the CMOP-E and CMCE models to help guide data collection methods. Table 10 provides examples of how a question asked with each group addresses theoretical principles and research aims. The process for piloting interview schedules suggested by Majid, Othman, Mohamad, Lim and Yosof (2017) was employed and said to be necessary to ensure the researcher, the primary instrument in data collection, possesses the skills to explore the phenomenon and that questions are capable of supporting this role. This process involves: determining clear questions, having initial questions reviewed by experts, selecting participants, piloting the interviews and then reporting on modifications made.

Table 10: Interview schedules sample

Group	Question	CMOP-E/ CMCE	Leisure Model	Recovery Star	HSE Recovery Framework	Research aim
Footballers	Are you using community resources now? How much social interaction do you have with others now? If so. can you tell me more about that?	Potential change in connection between person and environment through engagement in occupation.	If successful leisure performance took place, confidence in other areas may have increased. Exploration of interests.	Potential change in social networks, relationships and living skills. Connections outside of services.		To explore whether engagement in football had a positive impact on the recovery outcomes of mental health service users taking part in the 'Kickstart 2 Recovery' programme.
Healthcare professionals	Do you think there are barriers/ challenges for service users to engage in the group? If so can you tell me more?	Occupation is the link between people and their environment.			Connectedness supports recovery. Interventions should facilitate people to create social links.	To explore whether engagement in football had a positive impact on the recovery outcomes of mental health service users taking part in the 'Kickstart 2 Recovery' programme.
FAI staff	What do you think the benefits of playing football are compared to another sport/ type of exercise?	Potential difference between team sport and individual activity engagement. Facilitations of connections. Potential engagement support methods used by coach to encourage this.			Connectedness supports recovery. Interventions should facilitate people to create social links.	To explore the experiences of and methods used by FAI coaches and healthcare professionals whilst supporting the recovery journey of service users engaged in the 'Kickstart 2 Recovery' programme.

3.9.3. Pilot interviews

Pilot interviews were required for this study to give the researcher feedback, ensure designed questions were answering the research question and add in any relevant areas participants felt should be addressed. In order to achieve this a feedback form was created for participants to give comments in each area. This form can be found in Appendix 9 with a sample shown in Table 11. An email was then circulated to the research support team to discuss who would be suitable to pilot the questions with. The Occupational Therapy Manager identified two Occupational Therapists working within the same catchment area who were experienced in facilitating the programme.

Two pilot interviews of the healthcare professional interview schedule were carried out. Two Occupational Therapists working in a community mental health service, one at Senior level and one at Staff Grade level, were interviewed. They were asked to do the pilots as their group was running in close proximity geographically to the target population groups meaning some environmental factors may be similar. The Senior Occupational Therapist had been facilitating the group for three years and the Staff Grade Occupational Therapist for one year, meaning their answers would likely reflect other healthcare professionals with varied exposure to the programme and experience in their services. Finally, they were within the same service area so were using the same framework as the target population. This meant their experiences of the existing programme design would likely be similar to the target population. It was hoped the combination of these factors meant changes made to interview schedules would be a good fit for the target population of healthcare professionals.

When arranging pilot interviews for the footballers, it was decided that piloting questions would not be appropriate for a number of reasons. Firstly, as reaching the required sample size for the overall study was an ongoing concern, it would have been unwise to risk carrying out a poor interview with a participant. Secondly, researchers wanted to ensure questions asked were as low a risk as possible to cause any confusion or distress for a vulnerable population. Piloting coach interviews raised some similar concerns. However, feedback was given by the Occupational Therapists on how to better structure the questions for footballer and coach groups and to improve researcher interview techniques. Interview practice and feedback was also provided by the research supervisor. Table 11 provides a sample of feedback provided.

Table 11: Sample of pilot interview feedback

Question	***OT 1 (Senior) Feedback***	***OT 2 (Staff grade) feedback***	***Reflection + Supervision***	***Amendment***
What does football mean to you now having completed this programme? How important was this group to you? On a scale of 1-10 how good do you think you are at football? How fit are you?	- How good do you think you are is a leading question. Should be changed to 'how would you rate your performance, fitness etc. 1 meaning not fit and 10 being very fit".	- Start this question by asking what the best thing about the group was for them.	Supervisor: Consider leisure interest vs. meaning in occupation. Don't need to have a leisure interest for an activity to be an occupation. Look at Baxter model plus meaning literature to properly ask this question. When does meaning in occupation begin? Reflection: Important to compare referral reasons of professionals and factors that make the group an occupation for service users	*Question:* *What was the best thing about the group for you and why? What does football mean to you now having completed the programme on a scale of 1-10, 1 being not very important and 10 being very important? How would you rate your performance and fitness now?* *Prompts:* *What made you go back to the group every week? Is there anything you would have liked the group to have that it didn't?*

3.10. Ethical considerations

3.10.1. Ethics applications

Ethical approval for this study was sought and granted by the Faculty of Health Sciences in Trinity College Dublin and the Health Service Executive ethics board for health-related non-clinical trial-based research projects. Approval and insurance letters are included in Appendix 7.2. The Health Service Executive ethics board covered the two sites where the study was to take place. Twenty service users were estimated to be taking part in the programme over the two sites. Therefore, it was thought that a second application to access another area wasn't necessary as five to ten service users in total were needed. Similarly, twenty healthcare professionals were working across the two sites with the aim of recruiting five to ten people in total. The AOTI pathway was added as an amendment to increase the study sample size and to target the experiences of those professionals involved in the direct facilitation of the programme. The FAI pathway remained the same throughout amendments with the same five to ten sample size set.

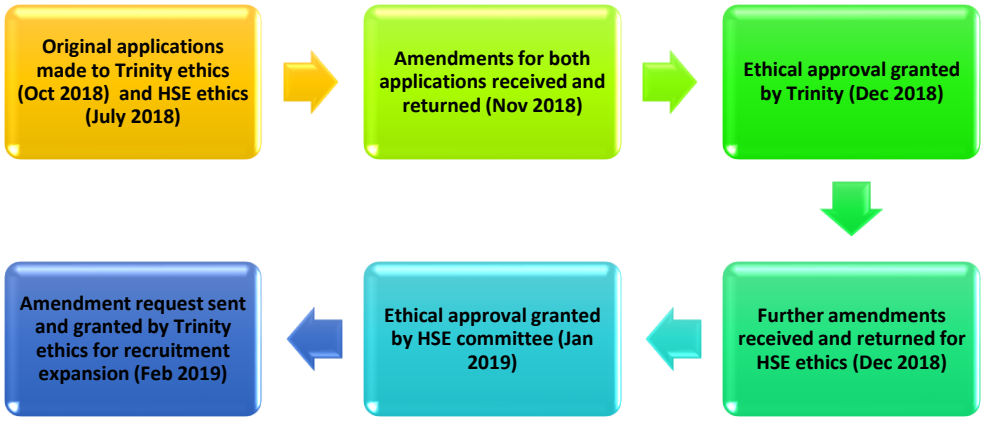


Figure 5: Summary of ethics applications

3.10.2. A six-step process

This study underwent developments on a number of occasions to reflect the flexibility of qualitative research, respect the requests of participants and increase the chances of reaching the goal sample size of twenty participants, a minimum of five in each group. It was thought necessary to use an ethical decision making process to maximise quality of methodology and ensure participant data safety. The six-step process of ethical decision making by Doherty and Purtilo (2016), in relation to informed consent and treatment in clinical research, was used to pre-empt and take action against issues that arose with this study and is summarised in Figure 6.

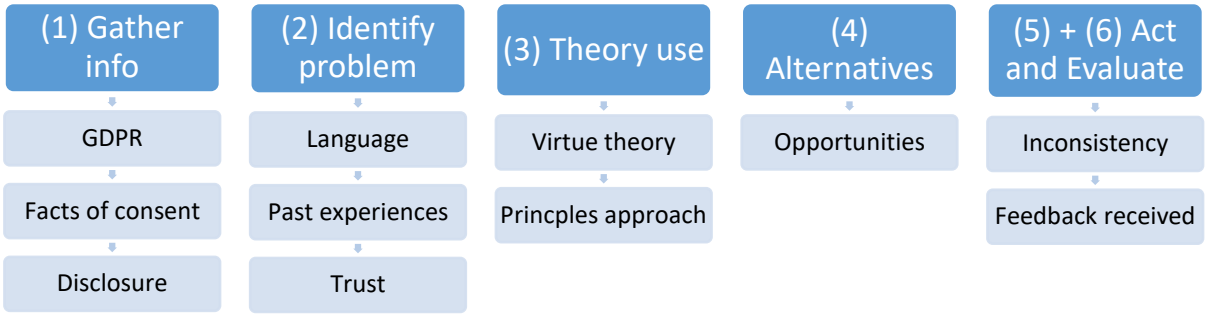


Figure 6: Six step process for Informed Consent Situations

Information gathering

A workshop on Tier 1 of GDPR and Health Research Regulations was attended in February 2019. Significant changes impacting this study were in the areas of consent, transparency, awareness of data type, pseudo anonymisation as a requirement, accountability, enhanced participant rights and collection of as minimal information as is needed. The facts of consent and agreement to research process had to be clear and unambiguous and data use had to be clearly disclosed.

Identify problem

It was found that language used in participant information leaflets was difficult to understand and lengthy to read. In addition, the research team Occupational Therapists stated some participants of the programme were nervous when they heard about the study. They stated footballers expressed lack of trust in someone they had never met and feared their data would be misused or given to others. Equally there were service users who appeared to agree to take part and requested a consent form to sign without reading the information first. Similarly, for the healthcare professional and FAI staff, lack of time to read study information and trust placed in the research team Occupational Therapists was a concern. It was thought they may agree to take part without being fully informed.

Theory use

Virtue theory encourages researchers to emulate characteristics such as honesty, kindness, sympathy and patience whilst interacting with individuals. The approach calls on researchers to respect participant autonomy and to follow the basic foundations of beneficence and nonmaleficence. Pressure was experienced in the recruitment process of the research but these theories ensured participant rights did not become second priority.

Practical alternatives

In relation to data protection, A Data Protection Impact Assessment was completed and submitted to Trinity College Dublin to assess and address data protection risk within the study and feedback was received and implemented. Feedback was subsequently given and addressed by the researcher. In addition security measures such as use of encrypted emails to send participant codes and use of passwords to protect documents such as the participant key, were used. A separate research SIM card was used to store contact numbers under a pseudo name on a fingerprint protected smart phone, only one computer stored participant transcripts and anti-virus software was up to date throughout the study. Recordings were removed from the Dictaphone and saved in a password protected folder on the college computer the day interviews were conducted. Footballer consent forms were stored at the clinic site they were linked to, facilitator consent forms being stored in a locked drawer in the college office which is locked every evening. Following the GDPR training, an information sheet summarising the study's compliance with GDPR was made and explained to participants before their interview and was also provided in written format with their codes. Furthermore, the demographics form for the footballer group was discarded and it was explained that footballers could provide as much personal details, for example their age and diagnosis, as they were comfortable with. All data protection actions were noted in the audit trail, a sample is provided in Appendix 7.8.

In relation to participant recruitment, a question session was arranged to allow individuals who were finding the written information hard to understand, ask questions in person. Participants who contacted the researcher before seven days of receiving the information were encouraged to take the time to consider their involvement. If they had had the information for seven days, a summary was given by the researcher when contact was made and the participant was encouraged to ask questions. Before interviews took place, the study process was again explained before the participant was asked to sign the consent form and a copy of all information was provided.

Evaluate the process

On reflection, training on GDPR requirements and processes should have been carried out before PILs for the footballer and healthcare professional groups were provided. Despite GDPR information being explained and provided in written form at a later date, and original PILs addressing areas of concern, it was an inconsistency with information provision. However, participants commented that they appreciated the transparency of the research process which is what was being strived for.

As discussed in Chapter 1, GDPR was influential when deciding aims and subsequent methodology for this study. A primary concern was preserving its purpose as a health research project examining the role engagement in football can play in positively influencing recovery outcomes. It is not a clinical audit or service evaluation of how the K2R programme is run within services in Ireland. The Health Research Regulations (Government of Ireland, 2018) describe health research as:

'A qualitative or quantitative study aiming to improve the health of the population as a whole/ part of the population through exploration of the way social, cultural, environmental, occupational and economic factors influence health.'

The considerations made and actions taken to ensure the purpose of this study was preserved is summarised in Table 12.

Table 12: Examination of aims as health research project

Study aim	Example of service evaluation aim	Example of clinical audit aim	Methodology requirements to address similarity
To explore the ability of the 'Kickstart to Recovery' model to connect mental health service users to their community environment through engagement in football.	To determine if the 'Kickstart to Recovery' model is meeting goals of the services within which is it run.	To review if facilitators of the 'Kickstart to Recovery' programme are effectively supporting community-based care.	To analyse current environmental supports and barriers to community connection experienced by people living with mental health difficulties.
To explore the ability of the 'Kickstart to Recovery' model to impact the mental health recovery journey of mental health service users through leisure engagement.	To compare the outcomes of two service areas facilitating the 'Kickstart to Recovery' programme.	To assess if the participants currently involved in the 'Kickstart to Recovery' programme are best suited to its aims.	Methods that explore the individual recovery journey experience and if this service interaction impacted that.
To explore the experiences of healthcare professionals and methods used by FAI coaches and staff whilst supporting the recovery journey of service users engaged in the 'Kickstart to Recovery' programme.	To ensure staff supporting the 'Kickstart to Recovery' programme are working under current service standards and best practice guidelines.	To examine if staff involved with the 'Kickstart to Recovery' programme are taking and acting on participant feedback.	To delve in to how an occupational intervention fits within current mental health service structures and the experiences of staff working alongside it in these services.

3.11. Role of the researcher

3.11.1. Influence of phenomenon experience

Finley (2006) states qualitative research aims to investigate and understand the social world and often involves the researcher reflecting on their own circumstances and bias'. If it is not clear how data analysis was done or what assumptions informed the analysis, it is difficult to evaluate the rigour of the results presented and can negatively impact the ability of other researchers to carry out projects in the field in the future (Attride-Stirling, 2001). Dickie (2003) writes of the importance of disclosing experiences with a phenomenon alongside thought processes throughout the research process in equal measures. The author recommends that readers of qualitative research should be brought through ways in which the researcher reflected on and made sense of qualitative data and how their own perceptions and values impacted this. Being a proud member of the occupational therapy community, values associated with the profession and the effectiveness of its interventions have the potential to influence perceptions of programme effectiveness in this study. Equally a strong feminist perspective further strengthened the belief that many aspects of human experience occur due to socially determined circumstances, expectations and roles.

Furthermore, experiences as an undergraduate student participating and evaluating the programme are necessary to acknowledge. On this occasion the programme had a positive impact on the community connection and recovery of participants. Service users stated healthcare professionals and the FAI coach were influential in supporting the changes they made. This makes the experience fall within all aims of this study and very nearly depicts an answer to the research question before it has begun. However, having had the pleasure to learn from individuals with attitudes and opinions very different to mine, a determination to remain open-minded in both personal and professional interactions had become a permanent value and skill. Equally, a frustration at the lack of research that either supported or disproved the phenomenon of recovery through football engagement in the Irish context, ensured an openness despite potential assumptions.

3.11.2. Interview considerations – researcher as the main tool

In partnership with actions taken to increase awareness and 'bracketing' of researcher bias, development of the researcher as a data collection tool was required. This was done through regular supervision with an experienced supervisor and using Morse and Field's (1995) description of common features of poor qualitative interviews.

They state awareness of these potential occurrences and appropriate actions taken to prevent them can improve interview quality.

Presenting one's own perspective. Due to the conversational nature of semi-structured interviews, there was a risk that the researcher would respond to issues raised by participants with personal views. This could prevent or skew what a participant says. The purpose outlined by the sampling method outlined above was to discover the diversities in participant groups. In addition, as discussed above, researchers using semi-structured interviews are encouraged to develop and add to the original interview guide as topics arise. Therefore, **the researcher took care to not respond with their opinion of what participants were discussing but to rather encourage them to explore their perspectives further, in particular if the perspective was one not heard in previous interviews.** This would prevent the researcher influencing what participants were saying and reduced the risk of codes being wrongly interpreted.

Jumping from one subject to another. Due to the presence of an interview guide there was a risk that the researcher would miss points made by participants that answer later questions or be reluctant to follow new topics. **In response pilot interviews took place to both ensure questions were relevant to participant groups and that the researcher was flexible in interview approach. Pilot interviews were recorded with permission from the individuals being interviewed and supervision was given by an experienced senior.**

Receiving secret information. Due to the nature of the area of study there was a risk that participants, particularly service users, may become distressed during interview and make a disclosure requiring action, to the researcher. For example, expression of suicidal thoughts. **In response all interviews took place in a public location and service user interviews took place in the mental health clinic they were attending. This ensured the researcher could request support from another individual if required. For the service user interviews, the researcher was given a copy of their risk management plan whilst within the services and a bleep during interview. One of the Occupational Therapists from the research team was also always present in a room next door should any issue arise. In addition, lone researcher guidelines adapted from the school of speech and language therapy were implemented during this study.**

3.12. Data analysis

3.12.1. Initial questions

Thematic analysis has been seen to be appropriate to use in studies taking a phenomenological approach (Cassol et al., 2018) and in the field of health research (Churchill, 2018). Braun and Clarke (2006) state a recurrent issue with researchers using thematic analysis is not following the steps as explained which results in lack of transparency in qualitative research. This section aims to shed light on steps taken and rationale for these during the analysis process.

(1) Question: The first question was in relation to theme size. Researchers must judge theme size and level of importance in relation to the research questions, the number of times it arises and areas of interest of theoretical perspectives used.
Answer: The prevalence of every code was documented alongside it's theoretical and question relevance. This information can be found in Appendix 7.5. A sample is provided in Table 13.

Table 13: Analysis of code prevalence and relevance

Group	Code	Prevalence	Theoretical relevance	Question relevance
Footballers	Suggestions of what to do if numbers are low.	15	Low	Medium
FAI coaches	Other options and opportunities should be combined with Kickstart.	7	Medium	High
HCPs	Kickstart has spin off for positive change in other areas of footballers' lives.	29	High	High
OTFs	Barriers in general community environments.	3	High	Medium

(2) Question: Will an overview of the whole data set be given or will a certain aspect be focused on.

Answer: It was decided this study would focus on the areas of findings that best answered the research questions and that an additional section of prevalent findings would be provided for each participant group.

(3) Question: Inductive or theoretical analysis.

Answer: Theoretical analysis was chosen as this research is being conducted through theoretical perspectives of the CMOP-E (Polatajko, Townsend & Craik, 2007) and CMCE (Townsend, Polatajko, Craik & Davis, 2007), the recovery star (MacKeith & Burns, 2008), the HSE recovery framework (Health Service Executive, 2017) and the leisure model (Baxter et al., 1995). However initial stages of coding were done inductively and later reduced or prioritised by examining the level of relevance codes had to the research questions and the theoretical perspectives. This was done to ensure unexpected pieces of information or details that were deemed important by participants weren't missed. Table 17 Shows coding analysis methods used in the initial stages and Appendix 7.7 illustrates a sample transcript page.

(4) Question: Semantic or latent themes?

Answer: Latent themes were chosen to make up the majority of the findings chapter. As this study was taking a descriptive phenomenological perspective there was a need to go beyond description to interpretation to discover what environmental structures and social meanings existed in the data set (Braun & Clarke, 2006). Latent themes are also in line with the constructivist paradigm (Burr, 1995) which was employed in this study. However in addition, as inductive analysis methods were taken in the preliminary stages of data analysis, one additional theme for each group was written to account for data deemed important by participants.

Finally, questions five and six were for researchers to clearly choose worldview and state research questions, both of which this study has done.

3.12.2. Analysis steps

Figure 7 provides a summary of steps taken in the analysis process.

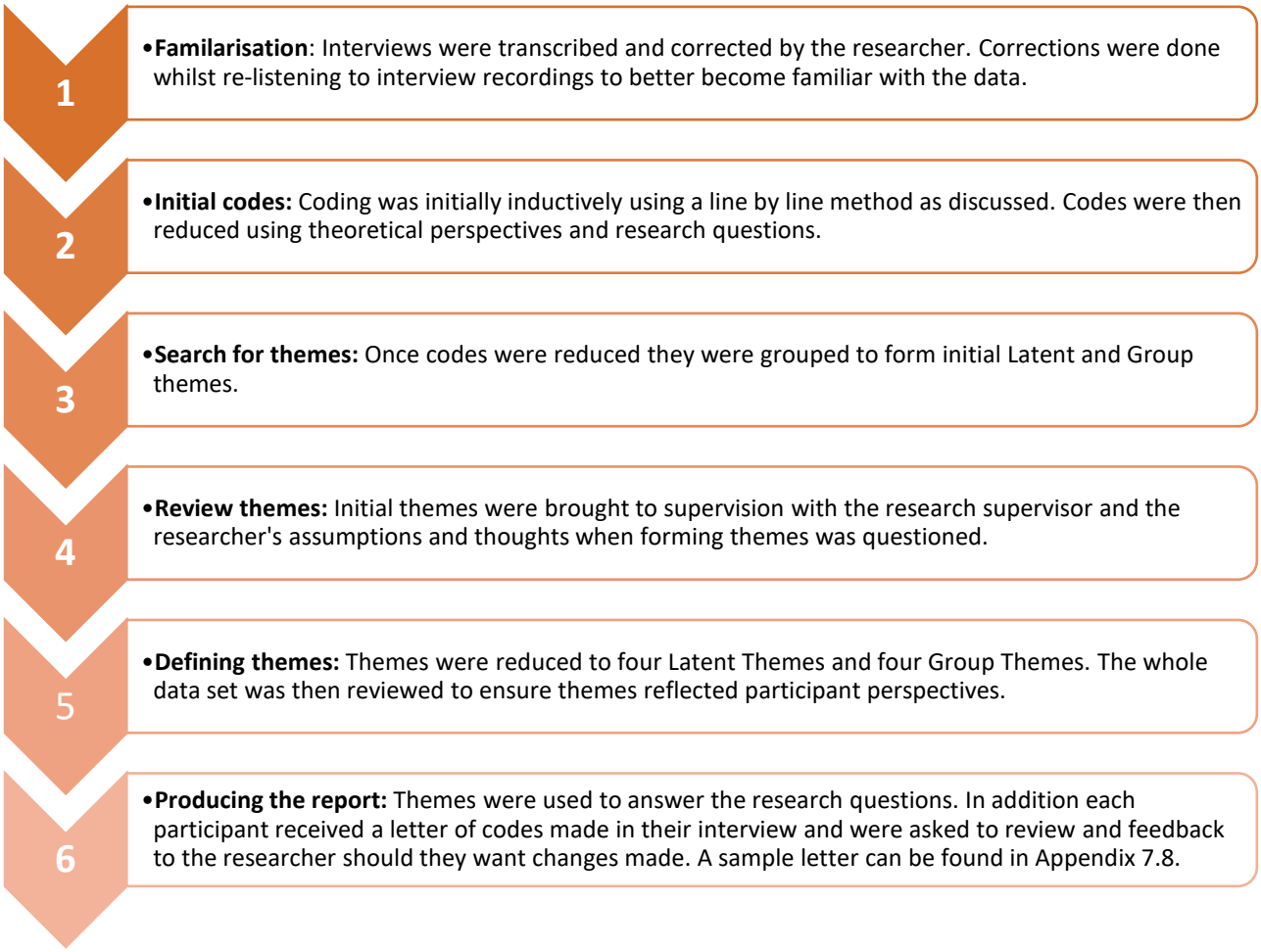


Figure 7: Six steps for thematic analysis

This study used theoretical thematic analysis concepts as outlined by Braun and Clarke (2006). As discussed, the theory that guided this analysis and the formation of themes to answer research questions was the CMOP-E (Polatajko, Townsend & Craik, 2007) which includes the CMCE (Townsend, Polatajko, Craik & Davis, 2007). The additional frameworks were added for the purpose of guiding study methodology and interview question formation and were therefore not employed for the analysis. The CMOP-E as the overriding theory in this study combined research approaches of social constructivism and descriptive phenomenology (Finley, 2006). It examined if football as an occupation was capable of connecting service users to their communities by supporting engagement despite symptoms, rather than reducing symptoms to better performance (Polatajko et al., 2007).

Coding was done primarily in a deductive fashion using Braun and Clarke's (2006) coding guide to code the transcripts line by line. The initial stages of coding were done inductively and later reduced or prioritised by examining the level of relevance codes had to the research questions and the CMOP-E model. Appendix 7.6 shows a sample of a transcript page at initial stages of coding and how information was coded. All codes made for each group and the number of times they were coded compared to the researcher's perspective of their relevance can be seen in Appendix 7.5. Codes were then reduced to form the themes.

3.12.3. Reflection during analysis

Husserl and Dahlstrom (2014) recommend researchers taking a phenomenological approach carry out 'bracketing' prior to data collection and throughout analysis. This process was used to facilitate exploration of bias that may have arisen during analysis and involves the following stages:

- Identify phenomenon
- Analyse recent experience of phenomenon
- Analyse/ develop variations experienced and remove them
- Repeat until essential features of phenomenon are found

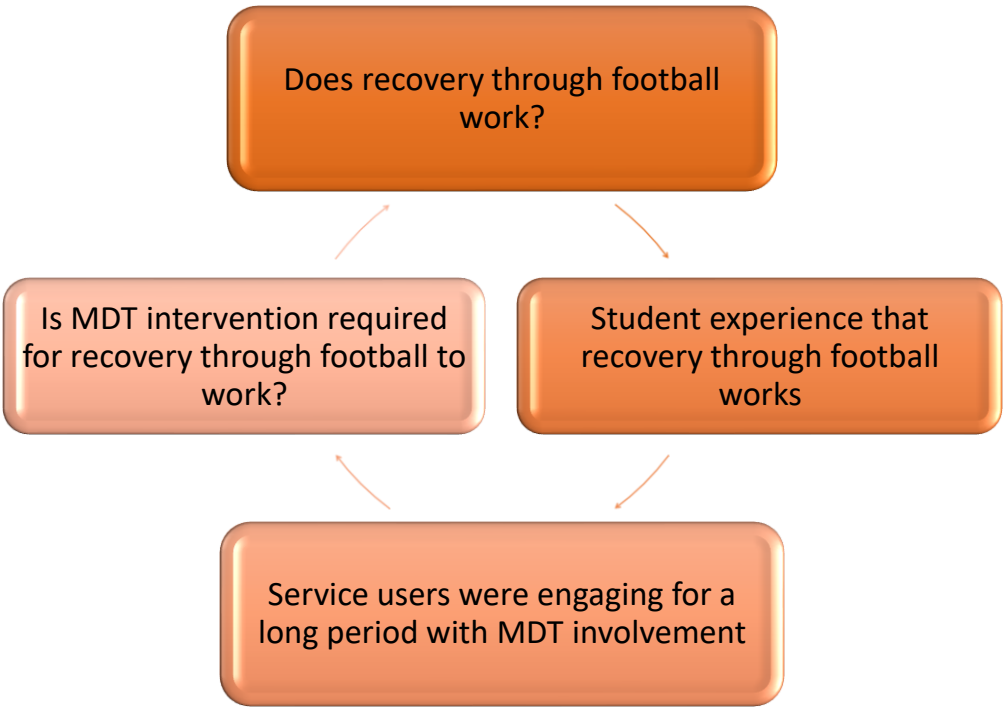


Figure 8: Representation of 'bracketing' process

3.13. Conclusion

This chapter has aimed to outline the methodological choices and actions taken to answer research objectives as transparently and in as much detail as possible. A gap in research was identified investigating the impact participation in football has on the recovery of service users in adult community mental health services in Ireland. Limitations and trustworthiness of the study will be discussed in Chapter Five – Discussion. The next chapter will outline study findings.

CHAPTER FOUR – FINDINGS

4.1. Introduction

This chapter presents the findings of this study. Twenty participants took part in total across four different participant groups. These groups consisted of; programme participants (footballers), Football Association of Ireland coaches (FAI coaches), occupational therapist facilitators (OTFs) and healthcare professionals (HPs). Interviews ranged from twenty-five minutes to one hour in length and theoretical thematic analysis was carried out on the transcripts to create themes (Braun & Clarke, 2006).

4.2. Demographics - Footballers

There were three footballers interviewed as part of this study. This number was less than the number of footballers the researcher was aiming to recruit which was between five and ten. This was due to low numbers attending each of the programmes. The limitation this poses for study results is discussed in Chapter 5 - Discussion.

Footballers were recruited from two sites within the same service catchment area. Both locations were coached by the same FAI coach who is also a participant in this study. As footballers were not asked to fill out a demographics form following GDPR recommendations for data minimisation, the genders of the footballers are not listed. However, facilitators and health professionals working at the sites discussed in their interviews that no females had completed this round of the programme at either site. This implies all footballers included in this study are male. There were two female footballers across the two sites that the researcher hoped would take part in the study. However, they dropped out of the programme before completing it and the limitation this poses to study results is discussed in Chapter 5. Table 14 provides further details of the three footballers who took part.

Table 14: Description of footballer group

Name	Age	History with football	Mental health and reason for group engagement	Community interests
F1	Fifty-five	Street footballer. Coached children's football but never received coaching. Stopped playing due to physical injury. Follows televised football.	Wanted to engage in a community group. Experiences of group work in psychiatric hospital and community settings in the past.	Member of two community organisations
F2	Not mentioned	Big interest in football, particularly tactics. Enjoys learning new skills. Follows televised football.	Desire to practice engaging socially with others.	Involved in a community football group, plays twice weekly in same venue as group.
F3	Thirty-six	Played some football but prefers GAA. Played GAA at a high level in the past.	Managing a schizophrenia diagnosis and the side effects of medication.	Attends the gym regularly and cinema occasionally.

4.3. Demographics – Healthcare Professionals

Six healthcare professionals took part in total, the target sample size of five-ten participants being achieved. They were recruited from two different sites within the same service catchment area as the footballers. This group consisted of professionals who had made referrals to the K2R programme but were not actively involved in the facilitation of it. Each professional had a different level of exposure to the group, see Table 15. The group consisted of two occupational therapists, one consultant psychiatrist, two nurses and one cognitive behavioural therapist. The role that corresponds with each participant will not be indicated as they were encouraged to discuss their perceptions of the programme free from the values and obligations of their roles.

Table 15: Description of health professional group

Name	Exposure to programme	Location
HP1	Has not observed sessions	North and North-East Leinster
HP2	Has observed sessions	North-East Leinster
HP3	Has not observed sessions	North Leinster
HP4	Facilitated the programme in the past at another site	North Leinster
HP5	Facilitated the programme in the past at one of the study sites	North Leinster
HP6	Has not observed sessions	North Leinster

4.4. Demographics – FAI coaches

Six FAI coaches in total took part in the interviews, meaning the desired sample was achieved which included the coach from the programmes targeted for this study. Coaches had varying levels of experience facilitating the group and were from various geographical areas. Whether the group was based in a rural or urban area is indicated as this was an important factor in determining the engagement of footballers with the programme.

Table 16: Description of FAI coach group

Name	Time coaching programme	Other experience/ training	Urban/ rural	Location
FAIC1	Four years	Not currently coaching.	Urban and rural	East Leinster
FAIC2	Not mentioned	Experience working with people with mental health difficulties.	Urban	East Leinster
FAIC4	Five years	Not currently coaching. Experience coaching adult and children's disability teams.	Urban	East Leinster
FAIC5	Three years	Business degree in psychology and management. Experience coaching children's teams.	Urban	East Leinster
FAIC6	Two years	Experience coaching children and accommodating people with disabilities and various needs.	Urban	East Leinster
FAIC7	Five years	Coaches three groups in three different locations. No mental health training. Experience coaching children's disability teams.	Urban and rural	East and north-east Leinster

4.5. Demographics – Occupational Therapist Facilitators

Six occupational therapists who facilitate the K2R programmes took part in the study, the target sample size of five-ten participants being achieved. Due to the level of difficulty in the recruitment of footballers it was decided to try and recruit more occupational therapists who facilitate the groups. The rationale for the recruitment of more occupational therapists was to explore in more detail how this type of activity could be used to facilitate recovery and to explore their perceptions of the programme in greater detail. It was found that the programme design for each site varied slightly which was often determined by access to resources, funding and what participants wanted the group to include. In addition, there were varying levels of facilitation experience.

Table 17: Description of occupational therapist facilitators group

Name	Length of facilitation	Group design	Location
OTF1	Three years	Eight week blocks. Typically four week gap between blocks. Informal health discussions during sessions. Players re-engage in group.	North-east Leinster
OTF2	Two years	Four blocks of eight weeks per year. Typically a four week break. Would continuously if funding was available. Players re-engaged in group for up to two years.	West Connacht
OTF3	One year	Two or three six week blocks a year at the start, now weekly with occasional breaks of one to two weeks. Players remain involved. Social element added to final week before break.	South Connacht
OTF4	Two years	Six or eight week blocks, gaps vary from a few weeks to four months due to difficulty securing a coach. Would like less of a gap. Involved in the blitzes. Players re-engage.	South Munster
OTF5	Facilitated once	Eight week block. States groups needs to be offered continuously. Players re-engaged from previous group with another facilitator.	South Ulster

4.6. Themes

Upon analysis of data, it was interpreted that a number of topics were coded across all four groups. The topics that held the most relevance for research aims and came up most often were analysed through the lens of the CMOP-E model using the guide to theoretical thematic analysis (Braun & Clarke, 2006). These themes are interpreted as the principle findings of this study and are shown in Figure 9.

Figure 9: Section one themes

In addition, there were codes that came up frequently across each group individually. Four additional themes were therefore created, one theme per participant group, as it was decided they were important due to the relevance they held for the overall research question and the frequency in which they arose. These themes are presented in Figure 10. An outline of how the data analysis process was done can be found in Chapter Three.

Figure 10: Section two themes

SECTION ONE THEMES

4.7. Theme one:

The performance of activity, while an important consideration, is only a segment of human occupation. The broader term of 'occupational engagement' encompasses other modes of occupational interactions such as capacity, competence, development, history, mastery and satisfaction. 'Having' occupations is not the same as 'performing' them and it is the opportunity for engagement and the level of importance and satisfaction the activity brings to the individual that matters most. Therefore, the CMOP-E model encourages professionals to move beyond performance and enable meaningful participation (Polatajko et al., 2007).

Each stakeholder group spoke of the K2R programme as being an opportunity for players of all abilities to get involved. While mainstream football groups contain standards of performance that must be achieved for players to take part, individuals who had mental health symptoms were presented with challenges and tasks that met them at the level they were at. Although the healthcare professionals and occupational therapist facilitators outlined certain barriers that are difficult to overcome, the importance placed by each group on accommodating the performance levels of players to allow participation was interpreted as a prominent theme.

4.7.1. Footballers

All footballers spoke about the ability of the coach to accommodate the current skill level, interests and physical ability of players during the session. This ensured that despite the different levels of ability, the engagement in the group was encouraged, achieved and nurtured.

> There was a big difference in terms of skill levels and fitness levels and that didn't make any big difference to the way the sessions were run. – F1
>
> I was expecting I probably wouldn't be fit to do it! To be honest with you yeah. So quite happy that I was able to do it. – F3

Footballers attributed this accessibility to the coach's awareness of treating players equally, the demands of football itself as a sport compared to others such as GAA and being able to take part in and benefit from sessions no matter how they were feeling.

> Well he does it very well. You know feel, like he's treating everybody the same you know? – F2
>
> I would probably find it easier than GAA. If you were to say to me now which would you wanna get back into GAA or soccer I'd probably say soccer. I'd probably find it easier than playing GAA. GAA would be too hard for me now to get back in to probably you know? – F3
>
> I would have been at those sessions sometimes feeling okay but sometimes feeling not so okay you know what I mean? But I still got up and went and benefited from it you know? Whatever way you're feeling you can arrive, get involved, and participate and at the end of it you'll be feeling that bit better. – F1

However, two footballers mentioned potential barriers that they would have to consider before engaging in community groups or K2R again. These included medication side effects and physical health.

> Well I'm on medication…diet, you name it. You know? – F3
>
> I have problems with my knees…its taking about a week for me to recover before the next session. So I don't think I'd be able to unfortunately compete in a full game…it's just not practical. – F1

4.7.2. Coaches

When discussing their priorities when facilitating the programme, coaches described a flexible approach and the importance of accommodating the various abilities and interests of each player in the group as the way to enable engagement.

> As coaches…we can take the intensity down…Sessions based on the ability of the individual you're working with…we like to say nobody would get left behind from the session you do. - FAIC1
>
> You might have someone who's playing who's never really played and quite shy and timid. And then you've got some other person who is tearing around the place and kicking the ball as hard as they can and stuff like that.– FAIC2
>
> Like what I try to do is, might do different games, things like that. - FAIC6

Coaches mentioned barriers to their ability to be flexible and adaptable in sessions. The most common barrier mentioned was the eight-week structure of the group and the time limit this poses to footballers making progress.

> I don’t like the eight week block…you're only getting going, and getting them into a routine, and then it stops. – FAIC5

The majority of coaches suggested that a continuous structure would better support the engagement of players over the eight week structure.

> I’ve seen the group operate in different ways…in general it’s an eight week block…I’ve seen it work where…the eight weeks just continuously rolls over…goes eight weeks again. And that’s been good for the group for continuity. – FAIC7

4.7.3. Healthcare professionals

When speaking about the engagement of footballers in K2R, healthcare professionals discussed enablers present in the group setting that encouraged service users to get involved. The most frequently mentioned enabler was that there was not an importance placed on the performance ability of the player but rather, the focus was on having fun and being comfortable. This was said to have a positive influence on service user feelings of normality and capability.

> There's a whole sense of…standard of performance is not important. It's just doing it and participating in it and enjoying it. - HP1

> Let loose and not be too self-conscious…really get involved…it's the opportunity for involvement in a very safe comfortable way…providing that experience for people to see that they can do actually a lot despite these symptoms they can live well. – HP2

> We had people feeling normal for a while…I wouldn’t have ever seen them feel normal before…they'd be laughing, and they mightn’t have laughed together with people for a while…somebody will be able to stand over 'yeah I went playing football today'. They don't have to say 'yeah I went to the clinic today'. – HP3

Despite the supports present in the group setting, healthcare professionals also discussed barriers that some service users faced when they tried to get involve with the programme. Examples of barriers given were both intrinsic and extrinsic in nature. Intrinsic barriers discussed included physical health limitations, severity of mental health symptoms and general ambivalence to engaging in activity recommended by staff.

> Some people have started and while they're doing it…they've realised that there's something physical going on.– HP6

> It’s really their mental health as well…I don't think it works too well…when they're feeling acutely unwell, their concentration levels. You know they didn't feel comfortable. Doesn't mean they have to be symptom free…I really do think in terms of this group that best referrals are those who are…on the recovery. - HP5

> The ones that never went will never go. You know no matter how many times they say yes to you they just don't go. – HP3
>
> So yeah so their own internal barriers I think and that ambivalence about participation that can often be there with mental health.– HP2

Extrinsic barriers discussed included limitations with public transport in the area, the timing of the group for people in employment and the importance of healthcare professionals only referring service users who are interested in the activity being provided.

> Getting like from (place name) to here is a challenge, two buses really and stuff like that. So, transport would be the thing. – HP5
>
> It's very accessible unless obviously people are at work and sometimes people can be involved in the kickstart programme and during that time they can get a job that they just can't finish it. – HP6
>
> I've learned that from so many groups. They have to have an interest in what the activity is. If they're unsure…I just don't know what that'll tell them about their identity. – HP2

Healthcare professionals discussed methods they used with their clients to help overcome these barriers. The majority of methods discussed were to do with overcoming the extrinsic barriers rather than the intrinsic ones mentioned. Suggestions included changing the logistics of the group and problem-solving barriers with the individual.

> We've tried to accommodate any of those needs…moving location…a lot of work in the background going on to get it to the people who need it. – HP5
>
> That subtlety of tuning into those people and supporting them… try and problem solve around it. – HP2
>
> Initially I would have walked down with him to the pitch…you have to try and make it as easy as possible. – HP4

4.7.4. Occupational Therapist Facilitators (OTFs)

OTFs discussed their value of supporting participation over performance for footballers involved in the programme. The scope of football as an occupation to be graded by therapists and the awareness of players in the group to allow those with lesser ability to participate were mentioned.

> The beauty of the kickstart is that it caters for all levels because if you don't have the skill level of somebody else you can just hang back…It's really adaptable that way. I initially wouldn't have thought you could adapt or grade a general soccer game. You absolutely can. – OTF2
>
> He had the common sense enough not to be too good and it was very selfless and he often passed the ball. He wouldn't tackle people who were low level. - OTF2

Therapists discussed additional enablers that helped support participation. The support footballers had from their own environments and, similar to the healthcare professional group, their own motivation and interest levels were discussed.

> A bit of interest a bit of motivation and you know somebody who thinks that they might benefit from it…most of the people have probably had some participation in the past. And they're probably more likely to kind of continue on with it than people that have never had any sort of involvement with soccer.OTF3
>
> I think peoples' support from home, you know really their social networks and social supports…Even it could be other health professionals or family members. - OTF4

In relation to barriers, therapists spoke of both intrinsic and extrinsic factors footballers were facing that interfered with their engagement. Some examples of intrinsic barriers were again similar to the healthcare professional group and included low motivation, physical fitness, confidence and self-esteem.

> I suppose anxiety, confidence levels just to actually be involved in a group…motivation levels I suppose to actually you know attend every week…I suppose some clients were afraid to look and focus on their actual fitness levels…fear that they were too unfit, maybe too overweight or you know so. Just their own unhappiness with that. – OTF1
>
> Themselves you know intrinsically their own confidence, self-esteem and motivation. Their fitness levels definitely will be a barrier some people would see that they're not fit enough. - OTF4
>
> There would be clientele there that blank outright refuse to engage in anything they have no interest. Year on year it would be offered nothing kind of taken up. – OTF5

The main extrinsic barrier mentioned was to do with transport to the group. Other examples included access to equipment and the social environment within the group not meeting the individual's demographic.

> Transport a lot of people suffering from chronic and enduring mental illness don't drive or they're more isolated. – OTF2
>
> They're quite young…it's probably not really going to work because the profile of the soccer team…you'd have like fifty five down to you know thirties kind of thing…that would probably be an off putting factor for some. – OTF5
>
> A couple of participants they haven't had runners or a tracksuit…they don't have the money to go off and buy those kind of things…they're lucky if they get something in a charity shop or if they can save

> up…having you know access to suitable equipment like you know I suppose clothing. – OTF4

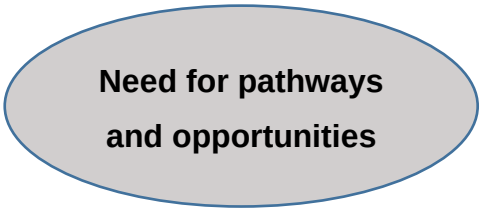
Methods used by facilitators to overcome these barriers were carried out both in removing barriers for people to access the group and to support their engagement when they're playing. Examples of methods included renting buses, providing reassurance and grading roles and tasks to support participation abilities.

> Borrowed a bus from our local day centre for the group and we pick up a certain amount of people and bring them across to the next town. – OTF4

> Put them at ease…give them information, reassure them I suppose. - OTF1

> If we saw someone really struggling we'd say, you know…trying to grade it so people were able to continue with the group during the hour. – OTF2

4.8. Theme two:



There is an endless list of occupations that human beings can engage in. Our ability to trial engagement in different activities to discover those that best fit with our identity and to access them regularly is what allows humans to feel connected to the world and develop a sense of self. The environment is not merely the context for activity but is what determines the options we have to choose from and what we build our lifestyles within. It is a common occurrence for people with disabilities to have the experience of not being able to access environments for a multitude of reasons. This in turn means they cannot engage in the full range of activities on offer to build their sense of self. This not only prevents the individual from building their sense of identity but excludes them from activities that are socially valued and the social circles that come with them. (Polatajko et al., 2007).

All stakeholder groups described the K2R programme as an opportunity for individuals with mental health difficulties to engage in a culturally valued sport. Some of the healthcare professionals discussed players who were excluded from community groups and that K2R was one of the few opportunities they had to engage in an activity that met their needs. All stakeholder groups gave suggestions on how improvements could be made to the programme. This was interpreted as a prominent theme. Running the group on a continuous basis and adding activities to better meet group outcomes was mentioned often in addition to the challenges facilitators faced in supporting players to avail of the group.

4.8.1. Footballers

Footballers discussed pathways and opportunities that their engagement in the group opened up for them. Methods used by the coach were discussed most often. Footballers mentioned having one on one time with the coach to explain game concepts and push skill development as being beneficial. In addition, this created a link to professional football and gave footballers an insight into how the game works on that level.

> Because you can always come in here…have that one on one thing you know? – F2
>
> There was things that (coach name) coached during the sessions…when I was watching, I could see what the players were doing. So it actually made it more enjoyable…to see some of the skills

> that he had been showing us, to see them being done by professionals was interesting. – F1

One footballer with experience volunteering with community groups spoke about the pathways for improved understanding of mental health illness in the local community as a result of initiatives like K2R.

> I know that the clinic as well are doing a lot of work in terms of initiatives with the local community. Working with the local groups and that and that in itself is fantastic because that really breathes healthier interactions and understanding.– F1

When asked for suggestions of how to improve the group and the opportunities it provides, all footballers stated running the programme on a continuous basis would be beneficial.

> More of it…throughout the year. More constant. Maybe with the football season or with the schools or something like that. – F2
>
> Just more, more, more of it. Like more than once a week. Aw every day. Yeah. I probably would do it as much as I could. – F3

One footballer suggested additional opportunities to help players settle into sessions would be helpful due to the nature of the difficulties in a group of service users.

> What I would do…at the start of every session, is just get everybody arrived into a circle and get them passing the ball to one another. I would just recommend that…it can be awkward, you know? – F1

4.8.2. Coaches

Similar to the footballer group, coaches discussed the need for the group to be offered on a continuous basis as opposed to the eight-week structure. This was to allow footballers build the group into their routine and to achieve the benefits of the group longer term.

> People like routine and they like to know what they're doing for the week…When that routine breaks potentially could set somebody back and they're not involved. - FAIC2
>
> You'll see…maybe dramatic weight loss for someone who is seriously overweight maybe over the period of a year or two. – FAIC7

When asked about suggestions to improve the group, coaches stated the group content should remain the same and that additional activities should be added. For example, the addition of a social activity after session, supporting involvement in the local sports club

and building the sessions into a wider exercise regime to properly address physical health.

> To physically get somebody fit in the hour a week doesn't come close. It would need to be incorporated into a much bigger programme to start to have an effect. If people rely on it alone to get them fit, you're wasting your time. – FAIC5
>
> You'd try get them involved in…a local football club…to go to a game and meet up as a group again…the club, they might have a role for somebody. - FAIC6
>
> You could potentially do…some sort of social aspect after? Cup of tea, biscuit…it just straightaway…finishes everyone sort of goes their own way. - FAIC2

Coaches discussed the issue of low participant numbers and the limitations this poses to the opportunities they can offer during sessions. The lack of control coaches had over recruiting new footballers and the pros and cons of involving those outside of the mental health services to make up the numbers were discussed.

> The most challenging times for me as a coach has been the times when I haven't had enough participants at the session. – FAIC7
>
> You're at the mercy of your OT knowing that the programme is on and available. And they are trying to improve that to make sure that everybody knows that this is an option. - FAIC5
>
> You don't want to isolate the guys that really really need it. It would be great to have new people in but you don't want to make it about something else and then lose the guys the programme is fundamentally aimed at. – FAIC5

Additional environmental barriers for participants trying to get involved were mentioned. This included transport, facility availability, medical clearance and equipment.

> Clearances from doctors. Transport would be another…Basic ones would be having the right footwear having the clothing…all these are huge to the individual who doesn't have them. – FAIC1
>
> In the evening time you're gonna struggle for facilities cause thats when football clubs use their facilities more. I'm probably guessing here but out of the three programmes I'm currently working on I'd say there's no full-time workers attending. – FAIC7

4.8.3. Healthcare professionals

Healthcare professionals spoke of the opportunities that K2R provides in addition to the sessions themselves for the service users involved. The focus on enjoyment during

sessions and the subsequent change engagement in the group brought about within the routines and desire to examine other occupational areas for service users was mentioned.

> The whole ethos of Kickstart is about fun…that's really important…might not even have been about the game…but it was everything else…the actual doing piece, engaging in that occupation and the supportive setting, definitely kickstarted him to…look at other aspects of his life. – HP4
>
> Opportunity for that whole balance of routine and how they feel afterwards when they're tired and how they manage that. – HP2

The opportunities presented within the group for players to make choices and decide what level they would like to engage at was also discussed. The impact this had on the recovery progress of individuals was outlined by one professional.

> They're also given…choice I suppose in terms of what they do for the group…the coaches there were saying…'what do yous want to do?'…they kind of feel like they have a bit of ownership…They take it at their own pace. HP5
>
> Another thing they do…people who don't want to play…can just come down and watch. So there's also a possibility to support. - HP1
>
> It is about them finding their voice…people talk about the system…the reality is that a lot of teams like ours it's very open. But the person hasn't found their voice…it's very hard to treat someone who won't contribute to that conversation…it's about giving them a voice and some control. - HP2

Similar to the footballer and coach group, when asked about suggestions to improve the group, professionals mentioned pathways that could be added to K2R. Examples given included access to therapeutic interventions and support to bridge the gap to community groups. In addition, the issues with including players from outside the service were discussed.

> They could do with some one to one therapy for a while first before they do it…a bit of an understanding of their situation…what getting better might look like for them. – HP1
>
> It's not that they will just finish kickstart they loved it and they just go…there will be people who will be able but the majority of people…we know that from our previous groups they'll need someone to bridge that gap with them. There's all sorts of therapies to help people reach those goals. – HP2
>
> It'd be great to open up everything to everybody but then are you going to get the people that really need it…if someone says the wrong comments…it's gonna really hinder someone else's recovery. - HP5

4.8.4. Occupational Therapist Facilitators (OTFs)

All OTFs highlighted the opportunities engagement in the K2R programme provides to footballers that they often are not able to access in everyday life. Areas most discussed were opportunities for socialisation, to engage in physical activity and to add to their sense of identity.

> A big thing for me was to encourage social interaction. Many of these clients would have very few friends, weren't socialising outside the home environment, outside the family circle. - OTF1
>
> An opportunity to increase their fitness in a supportive environment. Some people wouldn't have been able to…do stretches bend down, the mobility and flexibility and things like that would have been very very poor. – OTF4
>
> The Kickstart programme has really really helped people identify again with themselves as somebody who's more capable than they would have deemed themselves before. - OTF2

Similar to the coach group, all OTFs discussed the challenges that come with facilitating K2R. Those most discussed included maintaining professional boundaries and accessing facilities and transport.

> Your professional stance when you do engage…it is sometimes hard to kind of go back into the role of…the OT and doing your formal assessments. – OTF5
>
> It's a huge commitment it's probably an hour transport either side of the group…the other thing funding…we've rented our pitches. The FAI provide a coach but we provide the pitch…organisations or facilities within the community…they wouldn't be overly willing to discount the pitch, we've been paying full rate. - OTF4

OTFs went on to stress the value of having the FAI involved to share the facilitation workload and how K2R was an invaluable addition to the MDT care of service users.

> The value that definitely our participants put in having a coach associated with the FAI... you couldn't even describe it. We've had to run the group a few times when they haven't been available… it's extremely difficult. OTF4
>
> One person in particular that would have worked with another therapist…never really has made huge progress…whilst he was doing the Kickstart programme…his feedback in the meetings was like much better than it ever had been. - OTF1

Suggestions made by OTFs to improve the programme included additional activities that could be added to K2R to improve outcomes. Examples of these included incorporation of a social activity, inviting family and friends and educational discussions around health into the group.

> We went out…for something to eat and drink afterwards…You know to kind of make it…something you would do if you're playing with a club team…to wind up the season you know. – OTF3

> Like 'look if you if you do think of someone you know kind of bring it to me'…it worked well…I wouldn't have any objection to do it again and I think it normalises the experience. - OTF5

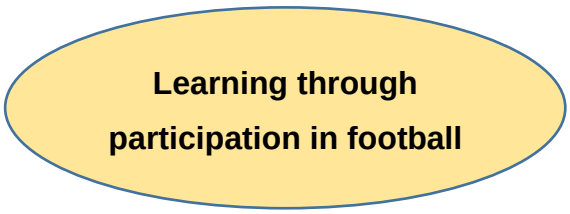
> Have a discussion at the start of the group…more detail with people on a one to one basis…looking at their lifestyle in general. It did come back on the evaluation forms…it's an area people would like to learn more about…in the future…I think it would be a good idea…sort of an addition to the Kickstart. - OTF1

Finally, Occupational Therapists debated the suitability of the eight-week structure of the group, most questioning the scope of the design to achieve the outcomes of the programme.

> A downside to every single kind of group…people saying 'oh I've already missed a week, is there any point'…eight weeks, it's not good enough…it should be an ongoing feature…for the majority I'd say this was the highlight of their week…then that's their highlight gone…I have the evidence…they have been shunned in other community groups. – OTF5

> Pretty much weekly because we run…if you have a bit of continuity you know…it's a little bit easier to kind of keep people, build the momentum. - OTF3

4.9. Theme three:



The occupational therapy profession holds the assumption that occupation in itself holds potential therapeutic value which is strongest when the person can exercise control and gain a sense of accomplishment while doing. Engagement in occupation is required for health, well-being and to bring meaning and structure to life and it's therapeutic use should go beyond the restoration of function and seek to help individuals grow and develop, not merely exist. (Polatajko et al., 2007).

Whether the football sessions alone could bring about therapeutic change was a point of discussion. Some participants felt additional health education sessions could be beneficial while the footballer group strongly disagreed with this suggestion. However, all groups discussed similar areas of development that spontaneously took place during sessions. The skills that footballers learned through their engagement and the transferability of these skills to environments outside of the group setting was also mentioned by all stakeholders. Changes to footballers' habits and the power of a sense of achievement during sessions was discussed and this theme was interpreted as an important finding.

4.9.1. Footballers

All footballers spoke of why they liked the group and the benefits they received. However, due to the idiosyncratic nature of occupation (Polatajko et al., 2007), they all gave different reasons for how this happened for them.

> It's a bit of a see saw…you'll have the moments…"that's great" and then you miss something…It's like life in an hour, you can go through so much, so many emotions. It's a workout for your brain as well as your body. – F2

> When you're participating…the benefits come naturally…You can't form them you know. – F1

> It gets rid of all the negative…feelings in me body…Takes my mind off my problems…you're interacting with people and you're doing something physical. – F3

Footballers also spoke about the habitual changes that engagement in the group encouraged. For example, with their diet and hygiene habits.

> Was just having a banana and water before the session rather than having a lunch or having a feed and then going off and trying to do it…I changed my eating habits on the day alright. – F1

> Just to get up a bit earlier I suppose em, and just, have a bit of food prior to it. – F2
>
> Its more so getting out of the flat and having a shower. – F3

When discussing whether more structured learning opportunities would be beneficial, all footballers felt playing football in itself supported development and that more focused education should be kept separate.

> I don't think the two should mix…you're there for…the physical and the mental benefits of a football session…there's a time and place for it. – F1
>
> I don't know about the discussions…For me just football. – F3

One footballer went on to explain how a more focused approach to bringing about development in the group would only serve as a reminder to the fact the group is a mental health intervention. For them being fully absorbed in the group was the benefit.

> Its focusing on just the positive and sometimes with mental health difficulties you focus too much on the negative…it's too about the labels…that's a mentality in a way in itself…"throw yourself into it…you're not thinking about that…that's a bonus overall. – F2

Finally, when it came to setting therapeutic goals, footballers again felt it wasn't needed for them to gain benefits.

> We did goals in here…I didn't know what to expect for the group…I didn't know how to…gauge really what I might want to get out of it. – F2
>
> I wouldn't be sitting here with a pen with me diary making goals…I have a plan in me head what to do that day. – F3

4.9.2. Coaches

When discussing the development that they encourage while facilitating the group, coaches spoke most of those habits that are needed to engage in everyday life and how the group creates a reason and context for them to be learned. Examples of skills included organisation, responsibility, self-care and communication.

> We try and educate all the individuals…more conscious…runners and you know maybe a pair of shorts or tracksuit bottoms…we give them the information afterwards…about showering and stuff. - FAIC1
>
> A high percentage of my group smoke. They really struggle physically. Now we've agreed as a group no smoking during the session…I still always try to get somewhere five minutes early… good habits and

> discipline. Different things sport has given me that you try…incorporate into your groups. – FAIC5
>
> Football as a tool to interact and get people talking. You get so much from sport…you learn how to communicate, you learn how not to annoy somebody or to annoy somebody…much that you can learn. - FAIC2

All coaches stressed the importance of creating opportunities in sessions for players to achieve and feel confident above all else. Some coaches discussed meeting players outside of the group setting and the skills the player learned being transferred.

> If we start asking the participants to do…two volleys and an overhead kick, they're not gonna be able…you might be making them feel bad about themselves. That sense of achievement that we all get from being able to complete a task…They're delighted with themselves. – FAIC2
>
> They all come away with something, they can have a sense of achievement from that. I've seen it time and time again…people who couldn't look me in the eye when the group started…year or two down the road…meeting people shaking hands looking them in the eye and being completely different. – FAIC7
>
> They feel a lot more comfortable and a lot more confident to talk to people in an open environment. - FAIC1

4.9.3. Healthcare professionals

Similar to the coaches, healthcare professionals discussed the development they observed with footballers that was encouraged by their engagement experiences in the group and that extended beyond the group setting alone.

> They might not have been doing as much and because they're doing this group have gotten into it. - HP6
>
> Feedback from the lads…you bring your water. Fizzy drinks or anything are not encouraged…getting fluids in that they wouldn't do…a lot of them smoke a lot less. - HP5
>
> I've often seen…if they're doing the hour of exercise in the kickstart…doing a little bit more then in the evenings themselves…it all adds up. – HP4

The main skill area of development discussed was in the area of social skills.

> Socialisation…massive in mental health and can affect not avoiding social situations…what we have to do to be independent. - HP4
>
> An awful lot of the problems with…social skills is the lack of practice and the lack of topics to talk to other people about. Even having that to talk about with other people. – HP2

> Enjoyed being out…meeting all the different people…had an interest in it as well…definitely brought them on. – HP6

4.9.4. Occupational Therapist Facilitators (OTFs)

Similar to the other groups, OTFs discussed the knock-on behavioural change and development they observed with footballers that was encouraged though their engagement in the group. Habitual changes, particularly in relation to self-care, were discussed most.

> A lot of people wouldn't ordinarily come into town. Their typical day would be to wait at home, having gotten up really late, and done nothing for the day. - OTF5

> They would be sort of preparing themselves earlier in the day…one or two…would have said it does help them sleep better at night…there's a couple people who it would say trigger them to have a shower afterwards and that may not be something they do on a regular basis. – OTF3

In addition, OTFs discussed how they thought development happened. One participant recalled players comparing themselves to others and experiencing the consequences of their health choices.

> It would have shocked most participants just how unfit they were…we would have had a good few of the clients saying like 'oh god I can't believe how unfit and breathless I am', you know because of smoking…when they saw that maybe other people weren't as breathless…was nearly a motivator to work to make…at one stage like a client nearly fainted…after the incident like he would have said he didn't have breakfast. It was nearly a catalyst…to learn more. - OTF1

Finally, OTFs like the other groups discussed the transferable skills that footballers developed in the group. Social and cognitive skills being most mentioned.

> Loads of transferable skills you know…socialisation skills… ability to plan and execute a task…read the pitch…predict you know situations. – OTF4

> Most of all I saw the ability to focus. How long they could maintain focus on what they were doing within the group increase and improve. – OTF2

4.10. Theme four:

When examining the difference between participation in an activity and participation in life, the value placed on the occupation by society and the social role that comes with it is a key distinguishing factor. The social environment is complex and influences what activities we want to take part in, when we do them and how we do them. In addition, it is present on various levels from our immediate social circles to how we are being represented in policy. Our ability to meet the expectations of the social environment will largely determine what occupations we have access to and when and in turn, our identity. Therefore, social connections and acceptance of people into social groups is crucial and required for social justice (Polatajko et al., 2007).

As discussed in Chapter 2, the issue of social exclusion and stigma is a prominent theme in studies examining recovery for mental health service users. Within this study, the positivity influence that the social environment in the K2R programme had on footballers involved was discussed by all groups and was interpreted as an important finding of this study. Differing perspectives were given about whether friendships were formed in the group in addition to whether K2R is capable of being a steppingstone for players wanting to get involved in community sport. The need for flexibility in facilitation approach was another important finding.

4.10.1. Footballers

All footballers discussed the empathy, understanding and sense of connection between service users that they experienced in the K2R group environment.

> There's other people…the same as me…I can relate to them…you fit in better…you feel they're the same as you. It's nice to know I'm not the only one. F3
>
> There's a natural empathy there…I've always seen that, my life experience of meeting people…with mental health difficulties, they tend to have a natural empathy…it came out on the football pitch. – F1
>
> You get to talk to other people…you might not have to even say a word but you just feel kind of more connected with the world because there's like, thirteen other people there in the same room. – F2

The subtle gestures of social support were also mentioned.

> One of the good things…a couple of the guys…were finding the skills difficult…physically it was tough for them. And everybody just stayed back and gave them space, which I thought was brilliant. – F1

The opportunity to make choices and suggestions created by facilitators was another important factor and made the football group feel like a safe space for players

> The way that the coaches do the training…you can make your own mind up whether or not you want to try things. – F2
>
> It is a good healthy situation…you can say it, 'what about a water break'.– F1

When questioned further about connections made in the group, players differentiated between connections and friendships. They stated although the environment was accepting and supportive, they were not forming friendships. Reasons given for this included personal preference and low participant numbers.

> I don't think people were getting that close to be honest. The only person I got to know a little bit is (client name), that's it…There's not that many people turning up to make a team to be honest with you. It's a downer when you walk in and only three people have turned up. – F1
>
> Just to have a laugh like with one or two of them…if I do that more…I feel better…I don't think I'm that sort of person who makes a lot of friends. – F2

External to the group, footballers described their social interactions and initiative to try new things in other environments as being positively influenced by their engagement in K2R. Two footballers attributed this change to the confidence players gain in the group.

> Certainly it helps your other social interactions, outside of the group. – F1
>
> I did a kind of a, side step thing…one guy…a really good player…came up and shook my hand and said great feet. So that's a really nice thing to come from someone that's a good footballer…that was because of, what we did with (coach name)…I wouldn't have the confidence to do certain things…when I was in the group, learning the different skills…it gave me the confidence…to try those things…make me realise well "oh I can do other new stuff". – F2

Finally, footballers discussed barriers and negative experiences they continue to have with regards to social exclusion. They mentioned barriers in community sport and activities in general.

> I don't spend time with people that drink anymore cause I don't drink. I haven't really got…I used to meet up with people and that for coffees and stuff…I don't really do that anymore no…I fell out with one of them. – F3
>
> I was never a talented footballer…I never got involved in a formal, playing for a club. – F1
>
> I don't know if I'm fit for doing that. – F3

Two footballers discussed the potential risk of service users in the group experiencing exclusion if players external to the service were to be involved.

> Keep it within…if you open it up to…people who aren't trained…they might not know what to be doing you know…in your face.– F2
>
> It wouldn't be fair like, it would be cruel!...they'd be so much better than the other people. That's the whole point of it isn't it? If I was there…everybody else…wasn't on medication…no mental health issues, I would probably feel a little bit, 'oh god', left out. – F3

However, one footballer described general societal stigma around mental health as improving.

> I do feel that it's being accepted more…some people, when they hear mental health difficulties, get very nervous…you just want them to be natural…I do find there's a lot more support out there…understanding. – F1

4.10.2. Coaches

Coaches described positives observed and methods used to support sense of inclusion within K2R. Similar to the footballer group, examples of positives observed included social support between players and increased engagement in community activities for some players.

> The group…are probably more welcoming and open than some other groups…one or two lads who would struggle and the other guys are great with them. They've a great time…they reach out if someone is struggling…if we're teaming them up, and they end up with someone of lesser ability that they will allow them to do it…It's less of the ego based stuff. I would see a lot less than I would in any other session. – FAIC5
>
> He sits…up there on his own, sitting and watching the games. And I'm like, that's amazing. - FAIC4
>
> There was a handful…of guys who are starting to go to games now, you know on a Friday night…from the group. – FAIC7

Methods used to promote a positive social environment primarily revolved around the focus coaches place on treating participants like footballers. They try to not focus on mental health difficulties in sessions but rather on connecting players to each other and their communities.

> One of the big takeaways…it's very important that the players are treated as footballers by the coach…they're mental health patients and that's what the OT is there for but the coach…they should be treated as participants in a football programme. – FAIC7
>
> There is this kind of cloud over some of the participants who might feel that they…are frowned upon…for maybe having some sort of disability…not really focusing on the fact that they're involved in mental health…focus more on the fact that they're footballers. - FAIC1
>
> There is mental health difficulties, that doesn't really come into play because we all enjoy mixing as a group. We all enjoy scoring goals. – FAIC5

Other methods discussed were in relation to flexibility and willingness to adapt the session to include all players on the day. Coaches viewed it as their responsibility to adapt what they're doing rather than the footballers.

> Can go from the best to the worst yet your content is the same, it's just coaching, it's the variable…you're the one that adapts. – FAIC5
>
> You have to be sort of flexible, you have to be relaxed. You have to be willing to put a plan together but the plan may be ripped up after a couple of minutes…all sorts of challenges as a coach…you have to be prepared to do anything. – FAIC2

Finally, coaches spoke of challenges to the inclusion of footballers in community sport and ways in which they are trying to facilitate this.

> If you're coming along as somebody that has them issues, straight away they're gonna be on that even though you don't know what they're like. - FAIC6
>
> It's a tricky one for us and how we would incorporate them in…from ability terms they wouldn't be able to play…we just haven't quite figured out what ourselves, the OT and the club how we would do that. – FAIC5
>
> If we can do more of this type of stuff…it gives that little bit of hope…some of the guys have probably always struggled and have always been on the periphery of their areas' groups. - FAIC5

4.10.3. Healthcare professionals

Healthcare professionals stressed the importance of addressing the issue of social exclusion and discussed the role groups like K2R and professionals themselves can play in combating this. Some participants stated a group like K2R is enough to start the process of bridging this gap.

> Seeing that other people struggle with the same difficulties. And at the same time they can still connect…A route back to more mainstream activities. You know, 'I can try this that's one step I've done. Maybe I could get back to the things that I used to do or get involved in other clubs'. - HP1
>
> You'd feel more involved in the community and that it's not something that's just run from the day hospital that they have to go to. – HP6
>
> That kind of graded transition for a lot of clients…they just don't feel ready to join a local football group, but something that's a little bit more supported that's kind of in an environment that allows them to participate. - HP4

Other professionals stated more support would be needed to ensure connection is continued.

> Kickstart is giving them an experience, a very safe way, with peers that they feel comfortable with…then it's about trying to bridge that gap for them you know afterwards…it's not that they will just finish…and they just go now to, there will be people who will be able but the majority of people…they'll need someone to bridge that gap with them. – HP2

Similar to the footballer group, some professionals distinguished social connections from friendships being made in the group.

> I don't think it's really about making friends. It's just about making connection of some sort…maybe bumping into that other person on the street…you have something in common to talk about rather than the clinic. - HP2
>
> Within mental health it's not something that we would have really encouraged…this was the first group we've seen…people might actually make friends and that probably sounds silly but we don't really encourage everybody to…get involved in other people's problems…we try and let them…have their own kind of circle of friends, community. – HP5

Others stated friendships were made in the group and supported further community involvement

> One particular guy because he made two friends…he sees them outside of here…his kind social circle grew…they go for walks. So that's something brand new. - HP6
>
> Would take each other's phone numbers. They text each other…you know having that chat, someone saying a friendly word…'how are you'. Someone might not have asked you that all week. And you get to the pitch and it can just change your whole outlook. - HP5

Finally, professionals described the additional barriers present in community sport compared to K2R and the benefits of having a group of solely service users.

> There's definitely more barriers…this is very much like, tailored to the needs of the clients…using the expertise of the coach and the occupational therapist and their core skills as a supportive role. - HP4
>
> Its bigger and there's no one to coach them…there's no one to paint the picture for them of what it will be like. – HP2
>
> If you have it maybe that people aren't in the service it could become competitive…like your normal realm of the different sports that are ran…where people do get wound up and then they can be nasty…it's just very safe…it'd be better kept within the group. - HP6

4.10.4. Occupational Therapist Facilitators (OTFs)

Factors that are enablers and barriers to social inclusion and connection were discussed in two areas: the K2R group itself and the wider community. With regards to the group itself, facilitators stated the social connections made between players and the environment of normalcy created a sense of inclusion for footballers and resulted in increased community engagement for some.

> When you're part of a group for over two years, individuals become…a family because they start understanding each other…they gave him the space…to enjoy the group which was just an amazing experience overall. – OTF2
>
> The encouragement that participants give each other or how people would say 'we're doing something' and somebody else might join along…of the lads attended a gym group outside of our group. You'd often hear them you know let others know that they could come. - OTF4
>
> When you are there you don't feel like you're at…a mental health activity. I mean I think we just enjoy it…everybody's just a football player…you kind of lose a bit of the labels…people are brought together that way. – OTF3

Some OTFs, whose groups use the eight-week design, stressed the importance of being flexible with both block length and gap length to meet the needs and interest levels of players. Flexibility was also needed to ensure numbers weren't low.

> We actually…extended the group to ten weeks…but we found then client…they like the structure of just the eight weeks and then having the break. – OTF1
>
> It depends on I guess…momentum so it depends on how long you take a break for and when you take the break because…if somebody say comes out…week five or something…sometimes they can slip away. - OTF3
>
> You know…because of the very low numbers I participated with them as well. - OTF5

Finally, with regards to social inclusion and engagement outside of the group, OT facilitators discussed their efforts and success stories of people engaging in the community after K2R.

> Giving people the opportunity to increase their confidence, maybe exploring what's available in the area…they're more aware of what's out in their community to potentially move onto…one or two people have managed to do that. - OTF4

However, all Occupational Therapists discussed the persistent barriers still present for footballers trying to get involved in community groups.

> I don't think it would transfer that easily yet to kind of like 'oh I want to join the club in town now'…some of them would have had quite negative experiences of when they have tried to break off into you know joining a group in town…you might expect there would be more open attitudes and everything but there's not. – OTF5
>
> There's definitely a sense…whether or not they'd be accepted or included…be able to meet a standard…of community organisations. – OTF3

SECTION TWO THEMES

4.1. Footballers

4.1.1. Theme: "I wanna play more!" – F2

Footballers discussed the aspects of the group that made them want to engage again. The factors most mentioned included the staff involved and the mental and physical benefits they experienced.

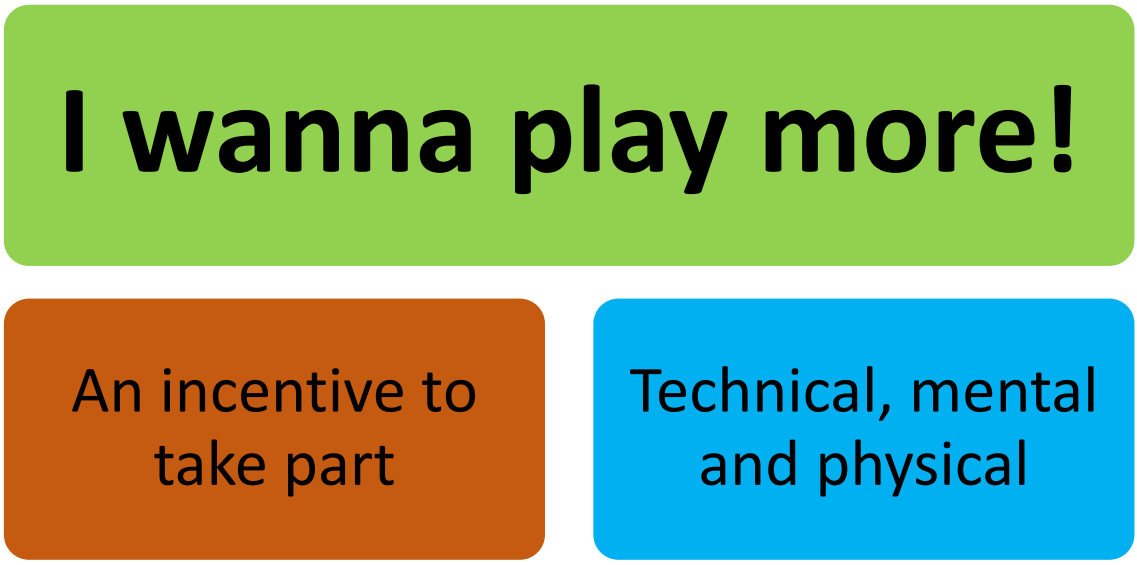


Figure 11: Footballer theme and subthemes

4.1.1.1. Subtheme one: "Technical, mental and physical" – F2

Footballers mentioned the endorphin release and relationship between physical health benefits and mental wellbeing.

> First of all just physically, you feel that bit better, and you know your physical health, your physical health helps your mental health you know? – F1
>
> It's a, a bit of adrenaline, eh, I think it's your endorphins and stuff like that? – F2

In addition, mental health benefits were mentioned. Examples included improved mood, confidence and to keep themselves going.

> Definitely the mood was better after the football…It builds confidence levels…when you're feeling very down it can be very difficult to go out and meet people. – F1

> To keep myself going like. I just do it, ah I just feel better. – F3

4.1.1.2. Subtheme two: "An incentive to take part" – F1

When reflecting on characteristics of the group that made footballers want to take part, two aspects mentioned were the involvement of the FAI coach and the active role the Occupational Therapist took in the group.

> The coaches are professionals. So, whatever they teach us is gonna be top notch like so. It's definitely like, you know, a huge bonus like so. – F2

> She's trying to put everybody at ease and chat to everybody. And that's great to have that, that is so important, I should have emphasised that earlier…her manner…her welcome and all that and then the finish off at the end. – F1

One footballer went on to discuss the benefits of other staff members getting involved and his perspective of the group being accessible for females.

> I think it's because…they think it's a lad sport and they just, then when they play they second guess themselves…I'm not saying the girls don't know how to play football but in general, there wouldn't be that many. And they had a great time, so. - F2

4.2. FAI coaches

4.2.1. Theme: "More to it than the football" – FAIC1

Coaches spoke about the benefits of playing team sport and the support footballers in a team provide to one another. They stated football skills are only a small part of what K2R provides compared to the social and mental positives it brings players.

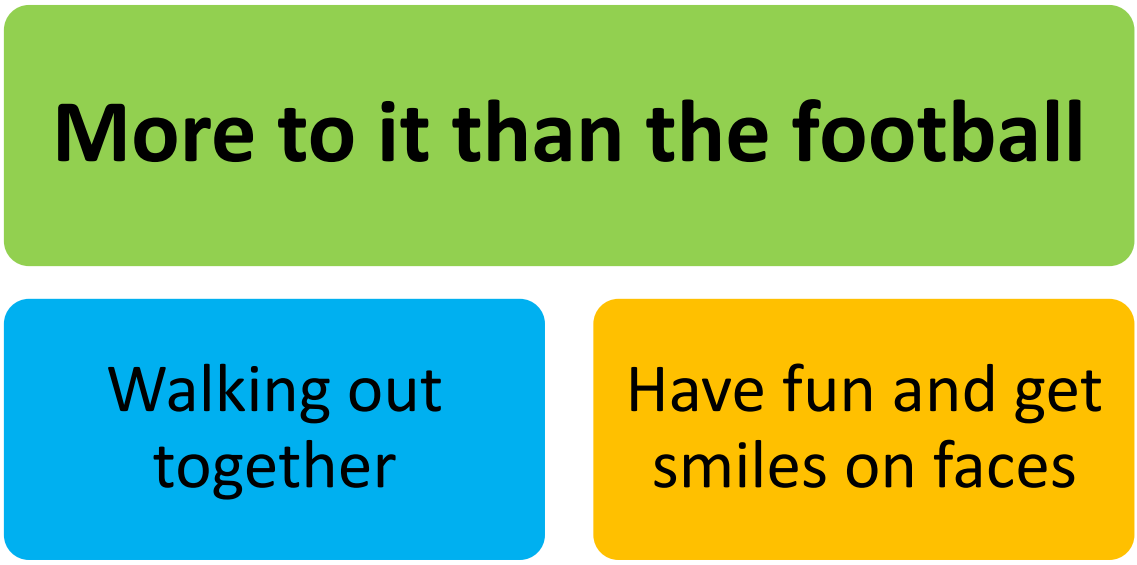


Figure 12: FAI coach theme and subthemes

4.2.1.1. Subtheme one: "Walking out together" – FAIC4

Some coaches spoke about the lessons and dynamics that comes with football as a team sport and the skills this requires of participants.

> This is your team. So forget about what goes on. So the first thing was that they were there and they had the respect and they were working as a team. - FAIC4

In addition, coaches spoke of players becoming more comfortable working with each other and wanting to spend more unstructured time interacting.

> It's common for me to have to drag the participants back to play football because they're all chat. Whether that's with the OT or with each other but certainly for me the most powerful time in the hour is the water breaks…that they're all full of chat now. It was very different when I first began taking the sessions. – FAIC7

4.2.1.2. Subtheme two: "Have fun and get smiles on faces" – FAIC5

When speaking about their priorities when coaching sessions, all participants spoke of facilitating activities that were fun and made footballers want to come back, as crucial.

> Making it as fun as possible is probably the best thing you can do because you're always then, there's always that onus is on the individual themselves that they enjoy it that much they come back. - FAIC1

On the other hand, coaches spoke of treating footballers like footballers and not making exceptions based on difficulties. They stated footballers valued this aspect and had more respect for the group as a result.

> He can get frustrated with me because I'm not letting him do what he wants. But at the same time, he comes back because he knows he won't get away with it. - FAIC6

4.3. Healthcare professionals

4.3.1. Theme: "A real team thing." – HP4

Healthcare professionals stressed the value that K2R holds for footballers and also the benefits it has for their own work with their clients. They attribute the contribution of the FAI as a huge enabler and strength of the programme.

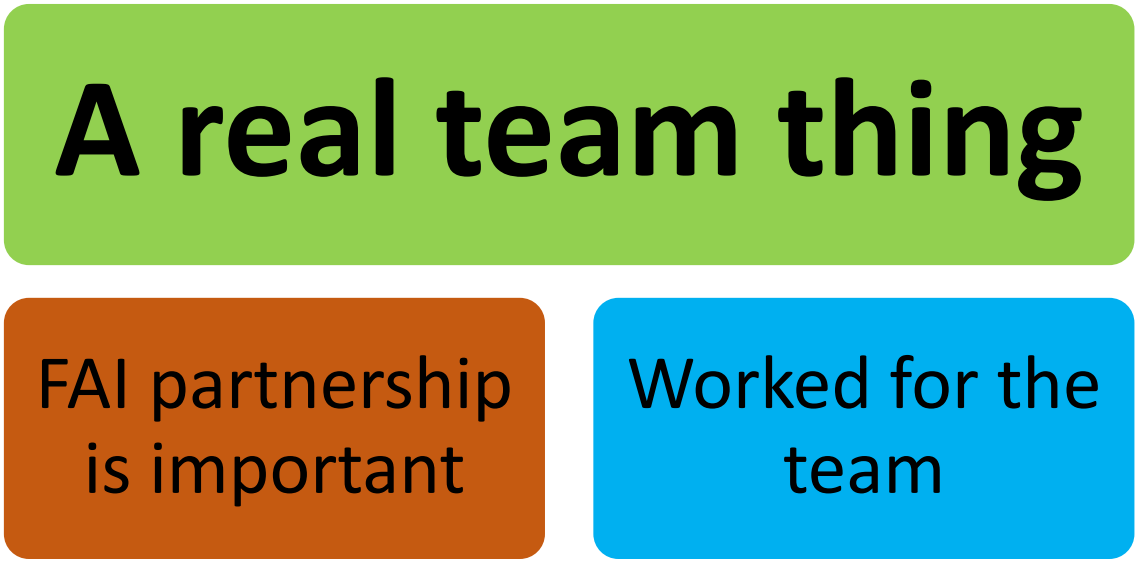


Figure 13: Healthcare professional theme and subthemes

4.3.1.1. Subtheme one: "Partnership with the FAI is important" – HP4

Professionals discussed the value their clients placed on the status of the FAI and how this is an incentive to be involved.

> Someone's here from the FAI…It's held in esteem for people who are football fans so. Yes I think that really helps people value it. - HP2

In addition, the involvement of coaches was connected to their relationships with good playing facilities and this further added to the footballers' sense of value.

> You walk in it's bright it's open. Like you kind of feel nearly part of the club, the lady kind of welcomes you in and you're not going into a dark dreary old hall. It's just so professionally run, you kind of think 'yeah I could do this'. – HP1

4.3.1.2. Subtheme two: "It worked for the team." – HP3

Most healthcare professionals spoke about the fact that, having their client engaged in the programme, facilitated their own work with the person and the team's work towards supporting recovery.

> The OTs reported back that he was very athletic and he had very good skills. That's been useful for me to know about him…I've been able to encourage him to look at other things. – HP1
>
> It will help. Because they're engaging, they're taking part…they are motivated to be doing stuff…it helps full circle really. They're motivated you're encouraging them. You're offering the support and you just know that things can move forward. - HP6

Staff also spoke of the occasional benefits of when a client can't engage as it encourages them to look at their health and get support from the team.

> But most of the medications, one in particular that clients are on here, they would have a lot of kind of cardiac investigations and stuff so we'd make sure they've seen their GP or they've had different tests done so. Make sure that they're physically well enough to do it. - HP5
>
> Which is good then because it highlights something that they weren't aware of. So that can be investigated and they can be properly started on either medication or whatever properly. - HP6

4.4. Occupational therapist facilitators (OTFs)

4.4.1. Theme: "Their only opportunity." – OTF5

OTFs stated K2R was a group that was able to meet the needs of people experiencing varying mental health symptom severity and that playing or being actively involved was a key aspect in supporting footballers.

Figure 14: OT facilitator theme and subtheme

4.4.1.1. Subtheme one: "People with interests." – OTF4

Facilitators stated the group was able to meet both the physical and mental health needs of clients in the service.

> Gave people a chance to engage in that so. That's why I suppose we had an interest in trying it. It met our expectations of what we wanted to offer clients and we just felt it fitted well with our client group. - OTF1

All OTFs also stressed how important the presence of the group was for those involved.

> It was absolutely meaningful, obviously from observations but also the continuity, the amount of attendance that certain people attended year in year out for a whole two years. – OTF2

4.4.1.2. Subtheme two: "You have to play." – OTF2

Facilitators stated there were a number of reasons and benefits to them being participants alongside footballers. One example being breaking down barriers.

> You're trying to break down the barriers between therapist and service users. If you can do that successfully you build up a trust and a bond. - OTF2

Another example was being able to gain better observations and support the group more closely.

> I think as well, you can kind of grade a little bit more if you're involved. You can't tell somebody you can encourage people to pass but like if there's somebody really struggling and you know they're really on the periphery of the group you know you have a bit more control over the group. – OTF4

4.5. Conclusion

This chapter presented themes that represented the findings for this study. The next chapter, Discussion, will aim to analyse themes in the context of existing research and the chosen theoretical perspective of CMOP-E (Polatajko, Townsend & Craik, 2007). The recovery star (MacKeith & Burns, 2008), the HSE recovery framework (Health Service Executive, 2017) and the leisure model (Baxter et al., 1995) will be included in the analysis where relevant.

CHAPTER FIVE – DISCUSSION

5.1. Introduction

This chapter discusses the findings of the study within the context of current research and research aims set. The themes that were coded across the four stakeholder groups will be predominantly used to answer research aims, these themes were as follows: (1) Participation over performance, (2) Need for pathways and opportunities, (3) Learning through participation in football and (4) Flexibility, social inclusion and connection. The group themes will be incorporated where relevant. Study limitations and recommendations for further research and practice will then be given.

The purpose of this study was to answer research aims through a combined social constructivist and phenomenological perspective, achieved through the use of the CMOP-E model (Polatajko et al., 2007). CMOP-E provided a basis for analysis for findings in this research. The additional frameworks incorporated into Chapter Three Methodology enable the exploration of participant group perspectives will be discussed where relevant. Table 18 summarises the aims of this research and shows what themes will be used to discuss findings under each aim. The abbreviations of ‘coaches’ for FAI coaches, ‘HPs’ for healthcare professionals, ‘OTFs’ for OT facilitators, ‘K2R’ for ‘Kickstart 2 Recovery’ programme and ‘CS’ for current study will be used throughout this chapter.

Table 18: Research aims and answering themes

Research aim	Theme
To explore the perceptions of programme stakeholders of whether engagement in football had a positive impact on the recovery outcomes of mental health service users taking part in the 'Kickstart 2 Recovery' programme.	**Theme one:** Participation over performance **Theme four:** Flexibility, social inclusion and connection
To explore the perceived experiences of and methods used by FAI coaches and healthcare professionals whilst supporting the recovery journey of service users engaged in the 'Kickstart 2 Recovery' programme.	**Theme two:** Need for pathways and opportunities **Theme three:** Learning through participation in football

To explore the perceptions of programme stakeholders of whether engagement in football had a positive impact on the recovery outcomes of mental health service users taking part in the 'Kickstart 2 Recovery' programme.

5.2. Theme one: Participation over performance

This research found that the stakeholders of K2R do perceive the group as having a positive influence on recovery outcomes, particularly in the areas of managing mental health, identity, self-esteem and trust and hope (MacKeith, & Burns, 2008). This theme demonstrates that engagement was valued above performance by professionals which created an environment of acceptance for footballers to engage at the level that brought them meaning and subsequent benefits (Polatajko et al., 2007). However, conflict arose in the OTF and HP groups as to whether intrinsic barriers to recovery, such as mental health symptom severity, could or should be overcome in order to enable the participation of service users in the programme. Occupation is deemed to be the bridge that connects the person to their environment and to not offer an activity because of perceptions of intrinsic barriers means engagement will not be achieved (Polatajko et al., 2007). All groups agreed on the need to overcome extrinsic barriers, such as transport, to allow people

engage in and benefit from the group. Although the removal of environmental barriers is vital to supporting participation, the person is at the centre of the enablement model (Townsend, Whiteford, Polatajko, Craik, & Hocking, 2007).

Findings demonstrated that service users were able to engage in the leisure activity. The K2R group was able to support the engagement abilities of footballers involved and within a safe, non-taxing group environment. People were challenged by tasks in sessions and experienced a temporary escape from their difficulties. These benefits mirror findings from existing research examining engagement in leisure activities (Iwasaki et al., 2014; Hargreaves, Lucock & Rodriguez, 2017). The footballers described how positive it was for them to be able to join the group at their current ability levels, despite perceived mental and physical barriers. By taking a strengths based approach coaches were able to create an accepting group environment and to ensure football was seen as an accessible sport. Football has been shown to be a particularly suitable sport to address challenges faced by those with mental health difficulties (Oja et al., 2015) and having an opportunity to be successful in a supportive environment has been seen to challenge stigma narratives and build an identity beyond diagnosis (Firmin et al., 2017). Therefore, the approach of the coaches appears to be in line with recovery literature and guidelines that support this approach, of moving past treatment of symptoms to rebuilding personal identities (Estroff, 1989; Health Service Executive, 2017). In addition, as discussed, the opportunity for footballers to engage in a task within an environment adapted to meet their needs does reflect the main message of the CMOP-E. That is the creation of an interaction between the person, the environment and the occupation, to facilitate engagement over a performance standard to, in turn, positively influence health and well-being (Polatajko et al., 2007).

However, the perceptions of HPs and OTFs differed from those of footballers and coaches. Although both groups acknowledge that the programme accommodates people of different abilities and interests, they discussed examples of performance barriers such as bad eyesight and severity of mental health symptoms that may prevent people from engaging in the programme. It appears these groups have had both successful and unsuccessful experiences of referring players to the group which has an impact on their referral criteria and enthusiasm. For example, the opinion that a high prevalence of symptoms means the person is not at a stage of being discharged from services and therefore shouldn't be included in the group is shows a malalignment within these groups

with what recovery means. There appears to be somewhat of a remaining focus on symptom severity in some circumstances, rather than on quality of life and learning to live and participate in daily activities despite symptoms (Roe, Rudnick & Gill, 2007). The barrier that healthcare providers own stigma and beliefs about an individual's ability to recover has been shown to have a negative impact on recovery (Dell, Vidovic, Vaughn & Sasaki, 2020). Facilitation of clients to overcome all barriers, both intrinsic and extrinsic, therefore needs to be given more focus than symptom severity in K2R (Fieldhouse & Bannigan, 2014). There appears to still be a need for the group to be adapted to meet the needs of its participants, rather than participants being excluded due to not meeting the expectations for the group. In addition, the criteria of physical capability and recovery journey timing as impacting the inclusion of players in football interventions is a new finding of the current study which has not been found in other football intervention research with clinical populations. (Mason & Holt, 2012; Moloney & Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healy, 2019; Magee, Spaaij & Jeanes, 2015; Friedrich & Mason, 2018).

Differing perceptions between groups also arose in other areas. All groups acknowledged the leisure interests of footballers were accommodated within the group. However, the perceptions of HPs and OTFs again appeared to clash with their desire to support engagement. For example, in relation to interest levels needed to engage in the group, all coaches stressed that interest in football was not required for people to gain benefits like social interaction and increased confidence. These ideals are in line with a rebuilding of identity during mental health recovery (Repper & Perkins, 2003) and the concept of leisure exploration outlined by Baxter et al. (1995). The functions of leisure are outlined as being: relaxation and refreshment, entertainment and personal and social development (Baxter et al., 1995). Benefits of leisure outlined by this model and found in this study included the release of emotions, escape from reality and opportunities for personal and social skill development.

However, this study found that HPs were concerned about what encouraging those who were unclear about their interest or desire to engage in the activity would tell them about their identity. Coaches stated they were able to take the skills, interests and past experiences of each player with football and focus on working with them to support experiences of enjoyment, success and sense of achievement rather than performance. Although interest in the activity is a principal way of bringing meaning to engagement,

importance and satisfaction can come about for various reasons and the subsequent impact on building identity can still occur (Polatajko et al., 2007). For example, a study by Craik and Pieris (2006) shows there is a high value placed on the flow experience and opportunity to engage in activities for the sole purpose of enjoyment for those with mental health illness difficulties living in the community. A study by Chapman, Fraser, Brown and Burton (2016) indicates a tendency for those with mental health difficulties to prefer activities with a social component and team sports in particular have been recognised as being capable of providing a sense of meaning and enjoyment (Andersen, Ottesen & Thing, 2018). Therefore, it is important for K2R stakeholders to remember that interest and meaning can be found from a variety of factors and to provide the opportunity to footballers to explore this. Leisure exploration of new activities is said to be done successfully by matching the client's performance abilities, their attitudes and purpose for leisure with occupations that are socially meaningful (Baxter et al., 1995). This study found that coaches are capable of meeting the abilities and attitudes of players with suitable challenges and group roles. In addition, football is a socially meaningful sport in Ireland. Therefore, successful leisure exploration appears to be possible in K2R and was a similar finding to those made by Hargreaves and Pringle (2019).

HPs talked about their experiences in supporting footballers to problem-solve engagement barriers and the level of importance they placed on this. However, they also described occasions where they had to encourage service users who were experiencing ambivalence to engage in the programme. Furthermore, encouragement was given in situations when they perceived service users would never attend the programme despite the support they gave. HPs appeared to experience conflict between, how much encouragement was required to support engagement in the programme, and how much would disempower the footballer. This provides a potential answer to the question posed by existing research in the area as to why footballers may or may not get involved in football interventions (Mason & Holt, 2012; Moloney & Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healy, 2019; Magee, Spaaij & Jeanes, 2015; Friedrich & Mason, 2018).

Despite these concerns, footballers did perceive a positive change in some recovery outcomes, such as identity, self-esteem, trust and hope. Changes in these areas reflects findings from existing studies examining the enablement of mental health service users to engage in football (Mason & Holt, 2012; Hargreaves & Pringle, 2019; Magee, Spaaij &

Jeanes, 2015). Similarly, HPs perceived K2R as being a first step for people to make positive changes with regards to not only managing their mental health but also their physical health. Examples included managing tiredness, facilitating change in routine and committing to the intervention and these lifestyle changes have been found in existing studies with both clinical and non-clinical populations (Mason & Holt, 2012; Friedrich & Mason, 2018; McGale, McArdle & Gaffney, 2011; Friedrich & Mason, 2017). Although intrinsic barriers were a topic of debate, both HPs and OTFs were keen and confident to work on overcoming extrinsic barriers. Actions such as changing group time, location and content to accommodate people were mentioned. Transport was found to be the biggest extrinsic factor that was seen as a barrier. The socio-economic status of group participants was found to be influential as there was a tendency for them not to have disposable income to spend on things like equipment or to have their own transport. Enablement of clients to access and engage in meaningful activity is not only done on the individual level but on a social change level as change in communities influences individual engagement. The efforts of facilitators to recognise these factors is positive and will make successful enablement more likely (Townsend et al., 2007).

The impact extrinsic barriers had on the ability of players to participate in the group is a new finding of the current study and again, answers questions posed by existing research as to why footballers don't engage in football interventions. The study by Benkwitz and Healy (2019) was one in particular that questioned why participants may not engage or may disengage from football intervention programmes. The authors criticised the ability of community mental health services to filter principles of recovery into their work in supporting individuals. There is conflict between this claim and findings in the current study. Although there is evidence of facilitators having trouble in deciding what action would be best in line with enabling recovery, all groups were reflecting on what the best action would be and gave examples of overcoming extrinsic barriers.

When it comes to addressing intrinsic barriers to engagement, the OTF group did make suggestions. Provision of suitable roles in the group, for example various playing positions alongside reassurance and grading by both the Occupational Therapist and the coach, were described as sufficient to overcome barriers in most cases. The study by Darongkamas, Scott and Taylor (2011) confirms the ability of roles to support meaningful engagement for both chronic mental health service users and those more newly linked with services. The importance of occupational roles is recognised in CMOP-E, among

other models, as they provide not only routine and structure but social and cultural identity and sense of purpose (Polatajko et al., 2007). In addition, the study by Moloney and Rohde (2017) shows the scope of football as a sport to be adapted to meet the challenges for people experiencing symptoms of psychosis. This appears to show that the concerns of HPs have the potential to be addressed in K2R. The adaptation of activities to meet the needs of the individual is a key skill used in occupational therapy, showing the role for occupational therapists to remain involved in the facilitation of football interventions such as K2R (Townsend at al., 2007). The OTF group in this study discussed the importance for this to be done, particularly for individuals who would be at a high risk of exclusion in community settings. It was found that for some players, K2R was the only environment they had in which their physical and social skill levels could be accommodated to allow meaningful engagement. The need for this opportunity to be available to them was considered vital and reflects the value placed on “having’ activity by CMOP-E (Polatajko et al., 2007).

5.3. Theme four: Flexibility, social inclusion and connection

As discussed, this research found that the stakeholders of K2R do perceive the group as having a positive influence on recovery outcomes, particularly in the areas of managing mental health, identity, self-esteem and trust and hope (MacKeith, & Burns, 2008). However, a gap was identified in existing studies with clinical populations investigating whether the engagement of service users in a football intervention, such as K2R, would be capable of having a positive impact specifically on their inclusion in community environments and if so, how does this come about. Existing research often claimed social inclusion to be an outcome of their studies and the likelihood of this occurring was questioned (Moloney and Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healt, 2019; Friedrich & Mason, 2018; Magee, Spaaij & Jeanes, 2015; Brawn, Combes & Eilis, 2015; McElroy, Evans & Pringle, 2008). This study found that at present, the K2R programme design is not capable of connecting service users to their community environments.

Findings showed service users did perceive to be included in the group setting and their perceptions of whether it would be possible for them to engage in a community group was more positive after their experiences of success in K2R. These changes in perception did result in some players making more health-conscious choices and becoming motivated to connect outside of the group. However, this did not guarantee that footballers would go on to engage in the community, nor did it guarantee they would be successful should they attempt to do so. Therefore, although footballers were engaging in a community based environment, this study has found that it is not enough for all participants to become more socially included.

This is an important finding as it contradicts conclusions from existing studies (Moloney and Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healt, 2019; Friedrich & Mason, 2018; Magee, Spaaij & Jeanes, 2015; Brawn, Combes & Eilis, 2015; McElroy, Evans & Pringle, 2008). In addition, social connection and inclusion is considered essential for recovery (Health Service Executive, 2017) yet is a longstanding challenge for people with mental health difficulties (Hutcheson, Ferguson, Nish, & Gill, 2010). Engagement in social activities, such as a football group, is one of the most highly cited methods to combat social exclusion (Filia et al., 2018). However, the issue is complex and spans across all environments, from close social circles to institutional and political contexts, and therefore requires a multifaceted approach to improve (Filia et al.,

2018; Polatajko et al., 2007). All stakeholder groups in this study identified barriers and enablers within K2R and beyond to the successful connection of players to their communities. Suggestions were made as to how the issue of social inclusion in mental health care could be better addressed. The success of connections made within the group was attributed to the treatment of footballers as people and not service users, the flexibility of facilitators, the physical environment being valued by the community, staff taking part in the group and the level of understanding between service users.

With regards to treating service users like normal football players, all stakeholder groups identified this as important. It was the ability of the coach in particular to treat footballers in this way that was found to allow individuals an escape from their difficulties and condition labels. Footballers respected the status that coaches held being part of the FAI and this status was perceived to be extended to include group members. This provided a value to the football sessions and created an identity as FAI trainees for footballers. Having access to activity that is valued by cultural and social environments has the ability to positively influence wellbeing (Polatajko et al., 2007) and has been seen to challenge stigma and negative self-image associated with mental health diagnoses (Firmin et al., 2017). This adds to findings by existing studies that discuss the value involvement of community partnerships holds for the service users involved (Brawn, Combes & Ellis, 2015; Moloney & Rohde, 2017; Mason & Holt, 2012).

Running the sessions themselves like regular football sessions was another important method identified by the coach group. They claimed the symptoms players had that presented in the group didn't interfere with their engagement and so didn't need to be focused on. These findings add to those made by Hargreaves and Pringle (2019) who discussed footballers' experiences of escape during football sessions. Their study had also incorporated coaching from a professional football club, indicating the status of the coach is an important contributor to benefits outlined. Equally it suggests that remaining focused on the football itself, rather than on the symptoms that arise, doesn't pose a barrier to engagement but rather contributes to footballers' belief in their ability and desire to engage as theorised by CMOP-E (Townsend et al., 2007).

Flexibility was another factor described as key by coaches when creating an inclusive environment in sessions. Willingness to change session plans on the day and belief that coaches are the ones who need to adapt to allow successful engagement, rather than the

footballers needing to change, was mentioned. This bares resemblance to the conceptualisation of the client-professional relationship by the CMCE model (Townsend, Whiteford, Polatajko, Craik, & Hocking, 2007). Professionals are responsible for sharing power with the client and to be a facilitator of client driven change, rather than controlling it. It appears here coaches were willing to be flexible in order to allow footballers engage successfully. Flexibility was also discussed in relation to the length of intervention blocks and the break length between blocks.

Although all groups described a continuous design as being the ideal set-up, it was found that block and gap length should change depending on the level of interest in the group, the momentum that had been developed, whether new players had joined and the time of year. This would not be considered an example of co-production but it is evidence of a united desire of facilitators to accommodate the needs and wants of clients in programme design which is vital for achieving recovery outcomes (Health Service Executive, 2017). In addition, the importance of patterns to the formation of occupational identity is discussed by CMOP-E (Polatajko et al., 2007) and was reflected in the perceptions of participants in this study that the group should be provided on a continuous basis. The study by Darongkamas, Scott and Taylor (2011) was the only other study that provided the opportunity for service users to engage in their football group on a continuous basis. This suggests that this is a relatively new finding.

The social value that the physical environment held in the community was found to positively influence the perception of inclusion for participants in the group. Footballers commented on the high standard facilities as providing a sense of importance, a point echoed in other studies (Hargreaves & Pringle, 2019; Magee, Spaaij & Jeanes, 2015). In addition, it provided a safe and accessible physical space for players away from the mental health clinic which was perceived to further distance them from their service user identities, as important process within the recovery journey (Jahn et al., 2019). This impact of the physical environment has been seen in studies using football as a metaphor for psychological interventions (Spandler, McKeown, Roy & Hurley, 2013). In addition, CMOP-E describes the physical environment and the social and cultural value placed on it as having an influence on the experience of those participating in it (Polatajko et al., 2007). This study found that service users were more comfortable in a non-clinical environment as the stigma of mental health is removed. The current study adds to existing

findings by suggesting the additional benefit of the use of non-clinical environments to challenge stigma and in turn, build identity beyond diagnosis.

The involvement of staff as players in sessions was equally found to positively contribute to the inclusive environment in the group. This study found that playing with staff made footballers keener to engage as they perceived the group as truly inclusive for everyone, no matter what their role, gender or ability. In addition, they felt more comfortable when attending appointments as they perceived themselves as equals to staff in the group. This adds to the findings by Lamont et al. (2017) and Magee, Spaaij and Jeanes (2015) who claim healthcare professionals who engage with service users are better able to share their experiences and challenge power imbalances. OTFs who had participated in their group supported this claim and also stated they were better able to grade the tasks in sessions and break down power imbalances when participating, a finding mirrored in another study (Moloney & Rohde, 2017). The same study maintained that the K2R is inclusive of all genders which the current study also seems to suggest. Furthermore, this gives an insight into the influence female staff can have on the dynamics of an all-male football group which none of the existing studies reviewed reflected upon (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffney, 2012; Curran et al., 2017; Pringle et al., 2013; Lewis, Reeves & Roberts, 2017; Robertson et al., 2013). The current study found that female staff playing alongside male service users created positive perceptions of group accessibility and contributed to power sharing. Both of these processes are theorised as vital to successful engagement by the CMOP-E model (Townsend, Whiteford, Polatajko, Craik, & Hocking, 2007) and is a new finding for the body of literature examining football interventions.

In relation to the social environment, all participants placed value on the fact that having a group designed for service users supported group inclusion due to the level of understanding between players. Footballers themselves described shared experiences, the ability to understand each other and the natural empathy and comradery, as enablers to engagement. Being in the same room as people with similar issues was found to make players feel more connected regardless of the amount of conversation they had. These findings are similar to those in existing studies (Mason & Holt, 2012; Hargreaves & Pringle, 2019; Benkwitz & Healt, 2019; Friedrich & Mason, 2018; Brawn, Combes & Eilis, 2015).

However, the current study yielded a new finding in relation to how these perceptions come about. It was found that there are subtle and organic behaviours in the group that provide this sense of understanding, one common example being players supporting the performance of less skilled players. For example, the OTF, coach and footballer groups all reported observing skilled or experienced players stepping back and giving space and opportunities to those with less experience to try and score a goal or to dribble for a few metres instead of tackling them instantly. Acts like this were found to have a huge impact on the accessibility of the group for less skilled players and for all participants as a whole. Those players with less skills were able to participate and those players with more skills had the opportunity to support another person. Both dynamics are valuable in supporting recovery outcomes as individuals with mental health difficulties are often the receivers of support from professionals or those without mental health difficulties (Repper & Perkins, 2003).

Service users having the opportunity to be the one giving advice and support to another and to receive support from someone they perceive to be on their level is vital for empowering connection. This therefore may provide an insight into how these perceptions come about. It also further indicates the need for K2R to be provided on a continuous basis so that these opportunities for connection are available. All stakeholder groups reported these types of interactions are rare occurrences in community sport settings, suggesting the ongoing issue of social exclusion in community sport for people with mental health difficulties may be present in the communities of these service users (Hutcheson, Ferguson, Nish & Gill, 2010).

All stakeholder groups confirmed that it was these positive experiences of connection in K2R that made players more willing to seek out new means of social connection in the community, reconnect with outlets from their past or alter how they're engaging in their existing outlets. One example of this included a player utilising new skills he had learned in the group in his other community-based football group and receiving positive feedback from his peers as a result. Another example given was of a footballer wanting to look for a community-based football team to play with on a continuous basis when K2R was complete. These examples appear to reflect the perspective of CMOP-E in that although the individual themselves will determine the purpose of an occupation for them, successful occupational engagement will always positively influence wellbeing in some way (Polatajko et al., 2007). Both of these footballers took part in the same group but the

changes they brought about as a result of their engagement were different and individual to them and their needs. Facilitators equally echoed observing positive changes, for example players successfully increasing their levels of community connection both through football and other leisure activities. HPs discussed players creating opportunities for engagement with group members, for example texting each other to arrange gym sessions or coffee trips. Therefore, this study found that for some players football did act as a medium to positively influence their perceived community connection, this being found in another study (Benkwitz & Healy, 2019).

However, all stakeholders in this study went on to discuss the barriers to building social connection in the K2R group and the challenges that footballers face when they do decide to explore community connections. Potential solutions to improve connection success in the group were explored and these findings fill a gap in research in exploring how engagement in football programmes impacts social connection and inclusion outside of the group environment (Moloney and Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healt, 2019; Friedrich & Mason, 2018; Magee, Spaaij & Jeanes, 2015; Brawn, Combes & Eilis, 2015; McElroy, Evans & Pringle, 2008).

In relation to connections made in the group setting, there were differing perspectives between stakeholder groups as to their purpose. For example, the HP group perceived group connections as being more about bridging the gap to further social interactions outside of the group rather than friendships between players themselves. This would not be in line with the value recovery theory places on reciprocal relationships, particularly those with other service users (Repper & Perkins, 2003). Footballers themselves stated although they had positive interactions with players, they were not forming friendships for a number of reasons. Some of these being personal preference and low participant numbers. Coaches also stressed the negative impact low participant numbers, being described as less than six players, had on their ability to be flexible in their facilitation of the group. They stated sessions can become repetitive or boring when numbers are low. Boredom poses a threat to the experience of flow in occupational engagement (Csikszentmihalyi, 2003) and therefore the flow experience and opportunity of escape for footballers in K2R is under threat by low numbers. This is an area that needs to be addressed to sustain the benefits valued by footballers in this programme and leisure literature (Iwasaki et al.,2014; Hargreaves, Lucock, & Rodriguez, 2017; Craik & Pieris, 2006; Repper & Carter, 2011). It’s also a new finding of this study as other research

describes low numbers but doesn't explore the impact this had on the experience of participants (Benkwitz & Healy, 2019; Moloney & Rohde, 2017).

When describing where footballers should form their relationships and social connections, some of the HP participants stated they'd prefer that group members have their own circle of friends and community so that they are not taking on the problems of other service users. Although the definition of 'social networks' in the recovery star values connections outside of services (MacKeith & Burns, 2008), this does not fit with HPs described experiences of referring people to the group who are often socially isolated and don't have these pre-existing connections. In comparison some HPs and all OTFs and coaches described meaningful connections and friendships being made and how they supported the community connection of isolated players. However, most examples given were in relation to footballers who had been engaging in the programme for over six months. All footballers in this study sample engaged for six to eight weeks and two out of three stated they were still not satisfied with the level of connection they had. The third footballer spoke of pre-existing connections being improved.

The recovery star examines change in the area of 'relationships' as the individual having time to learn what they want to gain and give in connections and eventually develop a sense of satisfaction (MacKeith & Burns, 2008). However, a six to eight-week period of an hour a week of contact does not appear to give footballers enough opportunity to develop these connections. In addition, CMOP-E identifies the importance of routine and pattern formation in allowing individuals develop self-identity and to self-actualise, both are markers for recovery success (Polatajko et al., 2007). This again suggests that the group does not have the scope to improve the connection of players in its current format. It also indicates that pre-existing connections are a likely requirement for this to occur in the current format, both of these points being new findings of this study. It also poses a challenge for existing studies who use a similar block length and have social connection or inclusion listed as an outcome (Moloney and Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healt, 2019; Friedrich & Mason, 2018; Magee, Spaaij & Jeanes, 2015; Brawn, Combes & Eilis, 2015; McElroy, Evans & Pringle, 2008).

The studies above, in addition to some participants in this study, perceived programmes like K2R as being the steppingstone to service users engaging in community-based sports groups. However, findings from this study demonstrate this is currently not the case. The

footballers in this study perceived most community sports groups as being beyond their abilities and an environment they weren't sure they could ever access. Most of the coaches confirmed this perception and explained that from their experience, players not experiencing mental health difficulties notice the disparity in social and football skills and make remarks. It was identified that because football is a competitive sport, players in community groups may not be as welcoming or supportive of players with a lower performance level due to mental health difficulties. This was noted and often result in players not being chosen for matches and therefore likely to be socially excluded. This mirrors a finding from Hutcheson, Ferguson, Nish, and Gill's (2010) study which found people with mental health difficulties are often at risk of being excluded from community sport.

The OTF and HP groups equally perceived an issue with players being excluded from community activities. In relation to community football groups specifically, examples were given of service users that tried to be involved but were left on the bench and not invited to social outings outside of training. As theorised by CMOP-E (Polatajko et al., 2007) and the recovery star (MacKeith & Burns, 2008), the social networks and environments individuals are included within or excluded from have a significant impact on their recovery success and the opportunities available to progress this process. This study has therefore found the need for facilitators to expand their domain of concern beyond the group setting to consider and potentially address barriers in wider social environments. This is in line with best practice which places addressing the ways in which social exclusion and stigmatisation operate within the client's environment as central to supporting recovery (Fieldhouse & Bannigan, 2014; Garverich, Prener, Guyer & Lincoln, 2020).

HPs went on to discuss the supportive environmental factors present in K2R that allow service users to engage that would be missing in community sport. Examples given were reduced staff support and lack of predictability. K2R is tailored for clients and removes a lot of the barriers and expectations present in community sport. Some HPs and OTFs discussed what they perceive to be unrealistic expectations currently placed on these types of interventions to connect people to their communities as it often doesn't occur easily. They perceived that more needs to be done to allow successful group engagement to transfer to successful community engagement and connection. This again demonstrates the need for intervention to be done on a community and societal level to advocate for the inclusion of service users to support their personal and social recovery

(Fieldhouse & Bannigan, 2014; Garverich, Prener, Guyer & Lincoln, 2020). There is a tendency for the consideration of how to remove social barriers such as stigma and disempowering interactions to be forgotten (Ramon et al., 2007), including in research.

Therefore, in this study, participant groups were asked about ways to address these issues and better connect service users to their communities through football. Suggestions included various additional supports in parallel to the group being provided on an ongoing and flexible basis. Support was defined as either professional support from the team or support from friends and family and it was concluded that overall, the gap between K2R and community inclusion is too vast for one group to address.

The coach group recommended pathways with local clubs and partnerships as one of the solutions. A study by Fenton et al. (2017) has identified the role of communities and sports partnerships in supporting the recovery of individuals through their involvement. Coaches suggested working with clubs and OTFs to form connections between K2R and sports partnerships and improving the carryover of perceived social inclusion from K2R to the community. One way of doing this was for players to have roles in clubs which would provide more structured interactions and reduce the likelihood of football and social skill disparities being a barrier to inclusion. The need for links between community football and mental health service-based football be seamless and allow people engage longer-term and transition more easily from services to mainstream engagement has been identified in existing studies (Curran et al., 2017; Darongkamas, Scott & Taylor (2011). This finding also addresses gaps in other studies that recommended the need for community pathways but didn't specify how this would come about (Mason & Holt, 2012; Lamont et al., 2017; Friedrich & Mason, 2018).

Another suggestion made by coaches was to use subtle actions and methods within K2R sessions to encourage connection formation. Examples included allowing other community groups to play on the same pitch and in the design of drills. Although there were concerns among coaches around the vulnerability of players and potential for negative responses from community players, there were instances that were perceived as positive by the coach and players. Coaches discussed the tendency for K2R players to have always been on the periphery of community groups and so these spontaneous interactions bred a true sense of inclusion. In relation to drill design, coaches encouraged steps such as the use of name calling when passing and purposely pairing certain players

together to bring about social interaction. The study by Filia et al. (2018) demonstrates that people being in the presence of others does not necessarily mean they are establishing connections or a perceived sense of inclusion. The methods used by the coaches appears to acknowledge this point and presents potential solutions. Again, these are new findings from this study about how connections can be made in football interventions like K2R.

In relation to interventions being provided on an ongoing and flexible basis, Darongkamas, Scott and Taylor (2011) recommend opportunities for sustainable, long-term engagement from which players can move from when they feel ready as the most recovery-focused design. OTFs and coaches state that more needs to be done before community settings are accepting of service users and so K2R should be provided on an ongoing basis at present. All OTFs equally acknowledged this need for K2R to be ongoing and the persistent barriers still present for footballers that need to be challenged. It was identified that engagement in a group like K2R doesn't easily transfer to being able to do other activities, particularly after only eight weeks. They spoke of players having negative experiences when trying to engage in the community. CMOP-E theorises occupation as being the connection between individuals and their environments (Polatajko et al., 2007). K2R was created as a tailored occupation that allowed this connection to occur for those with mental health difficulties. However, that does not resolve the issue of exclusion that remain in other environments. The approach as recommended by CMOP-E would be to continue to provide K2R on an ongoing basis to allow service users the opportunity for successful engagement while at the same time challenging and shifting the stigmas that exist elsewhere (Polatajko et al., 2007). This would be working towards normalising mental health difficulties in the opinion of wider society and improving the chances for service users to be included despite symptoms. Occupational therapists are well placed to undertake this change (Polatajko et al., 2007) and this approach is what's most in line with principles of mental health recovery (Health Service Executive, 2017; Roe, Rudnick & Gill, 2007; Davidson et al., 2006).

The suggestion of inviting family members or friends to engage in K2R was another idea that arose from the OTF group. However, when footballers reflected on whether including those outside the service would be beneficial, they described their concerns around not being included. Negative past experiences in groups with people who weren't educated in mental health were described. All coaches stated that although this opportunity may be

beneficial for players who have a longer involvement in the group, this would have more negatives than positives for the social connection of footballers. All groups commented on the ego-based behaviours and competitive pressures often present in community groups. The study by Magee, Spaaij and Jeanes (2015) expanded on these issues stating coaches interviewed found competition exacerbated mental illness for some players as it is difficult to maintain a focus on participation when a performance aspect is added. The study found that less skilled players were at risk of being teased and excluded by more competitive players which was said to defeat the purpose of the group.

This perspective is mirrored in the CMOP-E model which acknowledges the over focus on performance rather than engagement is non-congruent to facilitating occupation for those who need it most and led to the model being updated to reflect this (Polatajko et al., 2007). Priority for all groups in the current study was placed on getting people out and involved in a safe and inclusive space. Therefore, although a potential solution to address low numbers, external players being included must not be at the expense of service users being excluded when community groups have so many barriers. This finding challenges findings from other studies who included people both within and outside the service (Benkwitz & Healy, 2019; Hargreaves & Pringle, 2019; Magee, Spaaij & Jeanes, 2015). The solution to low numbers provided by footballers was to focus on building routine and momentum in the group as this will encourage sustained involvement. This approach is supported by the CMOP-E model which identifies the importance of routine and pattern formation for sustainable occupational engagement and the accessing subsequent benefits (Polatajko et al., 2007).

Finally coaches and OTFs recommended the incorporation of a social activity directly after the group, for example tea and coffee or going out for dinner, would provide a better chance for social connection outcomes to be met. The study by Moloney and Rohde (2017) incorporates a similar activity and footballers in this study emphasised the benefits it had for perceived social connection and inclusion.

The suggestions to promote social connection and eventual inclusion discussed above mirror those made by Repper and Perkins (2003). For example, creating links with the local community, challenging social exclusion in the community, facilitating contact between people with mental health difficulty, facilitating specialised groups in ordinary settings and supporting development of transferable skills. Therefore, it is likely if the

suggestions provided by study participants were complied with, footballers would perceive a better level of social inclusion through their engagement in K2R which in turn, would positively influence their recovery journey (Repper & Perkins, 2003).

To explore the experiences of healthcare professionals and methods used by FAI coaches and staff whilst supporting the recovery journey of service users engaged in the 'Kickstart 2 Recovery' programme

5.4. Theme three: Learning through participation in football

The CMOP-E model holds the assumption that occupations have therapeutic value and have the potential to positively influence well-being but also facilitate learning and development (Polatajko et al., 2007). This study found that all stakeholder groups included perceived that participants in the K2R programme learned and developed through their engagement. Repper and Perkins (2003) examine the difference between mental health recovery and management of mental health symptoms and state a recovery orientated focus would look to enable people to use and develop skills and strengths as the primary focus of interventions. Therefore, this is an important finding of this study. Those areas of discussed that reflected recovery outcomes included self-care, self-esteem and identity (MacKeith & Burns, 2008).

In relation to self-care, footballers changed their diet to include healthier foods and started waking earlier in the day. This occurred on the day of the group only at first but then became a more regular habit. Engagement in personal hygiene activities were also found to be prompted by the group, for example wanting to shower after sessions. HPs had experiences of seeing these changes in players that were involved in the group and found players often smoked less and drank more water on a daily basis. From their perspective, footballers who were supported to engage in exercise or healthy habits through the group tended to continue to engage in these themselves on a regular basis. In addition, some players developed an interest in fitness and physical activity which resulted in them exploring new community-based avenues. These findings offer a different perspective from those in existing research. The studies by Friedrich and Mason (2018) and Mason and Holt (2012) have smoking cessation and increased engagement in physical activity as outcomes of their intervention which would not be considered recovery orientated. However, the current study has shown that these outcomes can still come about when successful and meaningful engagement in activity in the focus. This supports the perspective of CMOP-E that meaningful engagement supports health and well-being (Polatajko et al., 2007).

The change most often mentioned was in relation to self-esteem and identity which was often given the label of 'confidence' by study participants. Footballers themselves experienced having more confidence to try new things both in existing leisure outlets and when considering new ones. The coach group discussed experiences of meeting players outside the group who once couldn't look them in the eye in sessions and now could have full a conversation with them in public spaces. The HP group stressed the impact this improvement in social skills could have on the ability of players to socialise in other environments and the importance of this to allow community engagement and overall recovery. These findings are similar to those of another study (Mason & Holt, 2012) and again demonstrates the centrality of social connection and inclusion for mental health recovery (Health Service Executive, 2017; Hutcheson, Ferguson, Nish, & Gill, 2010).

In relation to how these changes occurred, facilitators in this study revealed the methods they used to create learning opportunities and support recovery change. The coach group created subtle tasks and challenges during sessions that encouraged learning while supporting performance and ensuring footballer enjoyment of the group was not interfered with. An example of this was how self-care changes were supported by coaches. They would encourage and prompt players to shower after groups and explain why these habits are important. In addition, education around appropriate clothing and agreements in relation to smoking cessation during sessions were made. However, this encouragement would be given informally and for the purpose of players being able to perform better in sessions as opposed to pushing them to make these changes consistently. This allowed players to decide themselves when, how and if they would incorporate habits into their daily lives, preserving their sense of autonomy which is vital for recovery (Repper & Perkins, 2003). The OTF group would be aware of every participant's past exposure to football and what leisure characteristics would make an activity meaningful for them. They would communicate these to the coach to be sure to incorporate these characteristics as much as possible into the tasks presented in sessions and would allow players to choose what challenges they wanted to take on. Facilitating a just right challenge and for activities to be presented in the most meaningful way positive is in line with the CMOP-E perspective (Polatajko et al., 2007) and is again vital for recovery (Repper & Perkins, 2003).

This is also an important finding as existing studies don't appear to clearly outline methods used by facilitators to bring about recovery outcomes (McArdle, McGale &

Gaffney, 2012; Brawn, Combes & Eilis, 2015) which has been shown to be needed in the Irish healthcare context (O'Doherty, Stevenson & Higgins, 2012). However, differing opinions and experiences were present among stakeholders about what methods worked best to enable change. CMOP-E theorises enablement as creating opportunity for building a sense of empowerment and capacity with clients. It calls on supporters of enablement to be aware of the social construction of power imbalances in systems and environments that cause disempowerment to occur for both individuals and populations and to challenge these issues (Townsend et al., 2007,). The CMCE enablement continuum (Townsend, Whiteford, Polatajko, Craik, & Hocking, 2007) describes enablement as being a continuum and the enablement achieved being a result of enablement skills within the context of environmental and activity restraints.

Whether incorporation of more directed learning opportunities in the K2R programme would better address areas such as physical health and lifestyle change was an area of debate. Direct educational approaches have been used in other studies with mixed results. For example, the study by Benkwitz and Healy (2019) included workshops on education, fitness, nutrition and local services after sessions. This study found footballers can experience inclusion of educational pieces into the football as preventing the natural benefits of activity engagement from taking place. This potentially answers questions asked by other studies as to whether this method is appropriate (McGale, McArdle & Gaffney, 2011). The study by McArdle, McGale & Gaffney (2012) found that although footballers valued education in these areas, it may not be appropriate to do so in a way that interferes with the flow of sessions. Therefore, workshops delivered externally to sessions and potentially in a different environment appear to be more successful.

The footballer perspective in this study was that the addition of more directed learning would be harmful for their group experience and overall recovery as it would interrupt flow and draw attention back to the service user identity. Suggestions provided by footballers were to arrange education in clinics as part of the group that they can choose to attend. CMOP-E and the HSE recovery framework discuss the importance of control for the recovery of service users and in supporting future engagement in activity (Health Service Executive, 2017) (Polatajko, Davis, Cantin, Dubouloz-Wilner & Trentham, 2007). None of the facilitator groups, when discussing learning opportunities, mentioned suggestions made by footballers. This is similar to existing studies in the area (Robertson et al., 2013; Brawn, Combes & Ellis, 2015; Moloney & Rohde, 2017; Mason & Holt, 2012) and

identifies the need for co-production to be an area that is more considered in these types of intervention. Although it can't be guaranteed that footballers weren't consulted and facilitator approaches mirror football preferences, it would be crucial that footballers are given choices and power in programme design and delivery (Health Service Executive, 2017). This would guarantee interventions are in line with standards in recovery-orientated services and that effective enablement is achieved. Centralising the lived experience of service users and resisting the urge to fit narratives into what is hoped interventions are achieving is an issue in interventions that facilitators need to be aware of (Mathison, 2018).

Overall, the experiences of footballers and facilitators in this study imply that effective enablement was achieved. This is indicative of facilitators working to remove barriers and tailor tasks to meet the needs of clients in a manner that is perceived to be sustainable. For clients themselves their perceived engagement ability and satisfaction appeared to have changed in an effective, positive and meaningful way which indicates effective enablement (Townsend et al., 2007). There is a risk, however, that minimal or missed enablement could occur if concerns of facilitators aren't addressed. For example, those presented in Theme One – Participation over Performance which included physical and mental health limitations. It is crucial for the sake of preserving the programme's current state of effective enablement that HPs work alongside OTFs to accommodate the needs of players as much as possible.

Players identified that if learning tasks were facilitated during the football sessions or were not done in a subtle manner that they would disengage with the group, resulting in missed enablement taking place (Townsend et al., 2007). Footballers enjoyed the separation between K2R and the mental health clinic. For them, the learning and change opportunities should come across organically in order to allow football to bring about its natural benefits. All footballers perceived health education and other mental health interventions as being important for recovery but that they should be separate to and not interfere with the football sessions. These findings challenge the suitability of the approach used by Magee, Spaaij and Jeanes (2015), McGale, McArdle and Gaffney, (2011) and McArdle, McGale and Gaffney (2012) who provide workshops, MDT support or psychological interventions during football sessions.

All facilitators perceived the subtle methods used by coaches and OTFs as the main reason for the positive changes observed. Coaches state the basis of their education is taking life values and skills and giving opportunities for footballers to engage in challenges that develop these areas in the group. They don't coach football skills and let other skills develop from that, they fit in life values first and the football comes second. Engagement in session is used as motivation for footballers to make changes with the aim of making sessions more enjoyable. OTFs had experiences with seeing these methods work successfully in addition to group members making unexpected discoveries that brought about change. For example, players comparing themselves to other group members and being surprised at their performance ability which may have been lower than expected. This often resulted in them making connections between unhealthy habits, such as smoking, and poorer performance and deciding to make changes. Although footballers may have been told these habits were unhealthy by others in the past, experiencing it and being allowed to choose to make changes themselves was important. The majority of OTFs therefore stressed keeping sessions as occupation focused and resembling a regular football session as possible was the best way to meet outcomes. Again, this is in line with the CMOP-E perspective (Polatajko et al., 2007), Irish recovery guidelines (Health Service Executive, 2017) and is a new finding of this study.

The natural benefits associated with football was a second reason for positive changes observed. This supports findings by other studies which claim football positively influences both physical and mental health outcomes (Plant, Richardson & Pringle, 2019) in addition to social confidence, autonomy and independence (Soundy et al., 2015). Finally, the transferability of skills learned was stressed by the facilitator groups and is supported by findings in another study (Hargreaves & Pringle, 2019). Scenarios were described of how skills such as interacting with new people, following instructions and building confidence, were being transferred to the community setting. OTFs had experiences of seeing other transferable skills brought about by the requirements and demands of football as a sport. For example, concentration, assertiveness, social skills and planning. All facilitators stated this resulted in people feeling more capable and empowered to make change despite symptoms and to continue on their recovery journey. Again, this supports the assumption of CMOP-E that successful engagement in meaningful activity brings about skill development and an improved sense of identity (Polatajko et al., 2007).

5.5. Theme two: Need for pathways and opportunities

This study found that the K2R programme is perceived by both service users and facilitators as one of the few opportunities for individuals to engage in a culturally valued activity, particularly within sport. Some methods used by facilitators to create additional opportunities within sessions for footballers to engage with were discussed. However, the main findings of this theme include the challenges faced by facilitators providing the K2R programme and the need identified for there to be exit pathways and additional opportunities to better meet intervention outcomes. This is to allow footballers continue to develop and engage in environments outside of the K2R group alone. Although facilitating specialised groups in ordinary settings is a key method in supporting recovery for mental health service users, the creation of links with the local community must go in tandem (Repper & Perkins, 2003). This theme was therefore interpreted as an important finding due to the relevance it held in the context of recovery-orientated practice (Repper & Perkins, 2003) and the CMOP-E perspective on occupational opportunities (Polatajko et al., 2007).

The CMOP-E model theorises that in order for any individual to feel connected to the world and to develop their identity, they require regular opportunities to engage in those activities that support their identity and to also trial new ones (Polatajko et al., 2007). It is the environments that a person has access to that will determine the activities available and the social value and circles attached to each one. It is a common occurrence for people with disabilities to have experiences of being unable to access both environments and the activities within them for a multitude of reasons, making the development of an identity beyond their diagnosis difficult (Polatajko et al., 2007). Therefore regular engagement opportunities and exit pathways to further develop and expand these is crucial. This, however, poses a challenge for existing studies that have fixed block lengths for service users to engage (Moloney and Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healt, 2019; Friedrich & Mason, 2018; Magee, Spaaij & Jeanes, 2015; Brawn, Combes & Eilis, 2015; McElroy, Evans & Pringle, 2008). This may result in some players losing their only outlet for engagement in valued activity and being unable to sustain positive identity changes made during their group involvement. This theme will outline suggestions for exit pathways and opportunities that stakeholders perceived could better meet recovery outcomes.

Physical health was one of the outcome areas discussed by stakeholders. Changes had been seen in some participants and described as positive due to the prevalence of physical health issues among mental health service users (Stubbs, Vancampfort, De Hert & Mitchell, 2015; Vancamopfort et al., 2014; Holt, de Groot & Golden, 2014; Dorning, Davies & Blunt, 2015). In addition, good physical health is a marker for recovery progress (MacKeith & Burns, 2008). However, footballers and coaches in this study identified physical health as more of a barrier to engagement than an outcome. It was identified that additional opportunities and pathways would be needed to address it as an outcome. The coaches and OTF groups criticised the claim of the programme to have the scope to address physical health as this would not be possible in a once weekly hour session over eight weeks. The Government of Ireland (2013) 'Healthy Ireland' framework states that adults require at least thirty minutes of moderate exercise five days a week, meaning players engaging in K2R alone would not be meeting this recommendation. Outcomes worsen again if players are unable to source another exercise outlet once the group is complete.

Although coaches and OTFs would be encouraging players to continue habits started within the group, it was suggested that additional exercise and gym programmes be offered in tandem with football sessions. The experiences of facilitators were that although improved physical health should be addressed within mental health services, it should not be an outcome of K2R sessions themselves. They recommended that K2R be part of a wider exercise regime that service users can engage with. It was perceived that the K2R programme should maintain its focus on overall mental health recovery and that the physical health benefits that may occur, while beneficial, would not be the main aim. The study by Lewis, Reeves and Roberts (2017) with a non-clinical population demonstrates a potential design to deliver this. Football sessions were facilitated as normal but in addition, lifestyle education sessions covering various topics would be run afterwards or on another occasion that players could opt in to. Further research would be beneficial to explore this approach for clinical populations and to incorporate suggestions from service users as to what topics would be covered. This would allow a pathway for co-production which is a crucial aspect of recovery-orientated services (Health Service Executive, 2017), supporting ongoing engagement in meaningful activity as theorised by CMOP-E (Polatajko, Davis, Cantin, Dubouloz-Wilner & Trentham, 2007) and is what many football programmes appear to not be doing (Robertson et al., 2013; Brawn, Combes & Ellis, 2015; Moloney & Rohde, 2017; Mason & Holt, 2012).

The physical limitations associated with age was another mentioned challenge. For the oldest footballer in this study, a fifty-five-year-old with a longstanding history and interest with football, physical limitations were seen as a barrier to engagement being maintained. Non-clinical studies tended to include players of this age, for example the study by Lewis, Reeves and Roberts (2017), but it was noted the age brackets seen in some studies with clinical populations did not include footballers who were over fifty (Moloney & Rohde, 2017; Friedrich & Mason. 2017). The study by Lamont et al. (2017) suggests walking football as a potential alternative to accommodate this group. They state walking football should be offered alongside the regular football group for older players and those with less interest in traditional football drills but enjoy the social aspects. A coach in the current study also recommended the addition of walking football and claimed it was a growing area in the FAI.

A second challenge discussed was in relation to generating referrals for the programme and communication between facilitators. There were differences between the opinions of HPs compared to the coach and OTF groups as to when the best time for an individual to engage in the group would be. Coaches and OTFs perceived that there were service users who had more symptoms or were earlier on in their recovery journey that would be interested in and benefit from the programme. The coach group in particular expressed frustration at not having control over who was referred and the limitations this posed for the drills and activities they could provide in sessions. However, the experiences of the HP group were that the group benefitted those who were nearing discharge from the service best and that those with active symptoms struggled more to participate.

Some OTFs identified a potential reason for this. It was perceived that HPs not involved with the group would need to see evidence of change occurring with a particular intervention before they would support it with referrals. The coach group perceived a lack of feedback from OTFs and HPS on how participants progressed after the programme and how coaches could improve sessions. There was also a discrepancy between these groups as to who the leader facilitator was. OTFs perceived coaches as being the group leader but HPs perceived the OTFs to be in this role. Existing studies examining football interventions that include coaches and healthcare professionals in their samples analysed their perspectives as a whole (Benkwitz & Healy, 2019; Magee, Spaaij & Jeanes, 2015; Friedrich & Mason, 2018; Robertson, et al., 2013; Mason & Holt, 2012), rather than treating them as separate groups, making these findings from the current study new.

The HSE recovery framework (Health Service Executive, 2017) stresses the importance that all staff supporting the recovery of service users communicate and support each other to provide the best service possible. This study has found a need for coaches, HPs and OTFs to communicate more regularly and for roles to be clearly identified. In addition, K2R facilitators need evidence for football interventions to exist in order to feel confident in identifying it as an intervention that should be offered to service users. The study by Mason and Holt (2012) discusses this tendency for professionals to want proof and evidence for clinical changes before they refer to a programme. Although evidence-based practice is important in achieving recovery outcomes (Health Service Executive, 2017), facilitators of K2R and similar programmes should be careful to not sacrifice their focus on achieving recovery outcomes to instead focus on those that are more easily measured, such as improving mental health symptoms (Weitz, 2013). They need to remain focused on improving quality of life and meaningful engagement as this will have the greatest positive impact on their recovery (Polatajko et al., 2007; Repper & Perkins, 2003). This finding shares similarities to those made by Magee, Spaaij and Jeanes (2015).

A third challenge experienced by facilitators was the unrealistic expectations placed on the programme and facilitators themselves to achieve these. This was particularly relevant for the OTF group. Similar to the achievement of physical health outcomes in the timeframe available, OTFs identified that recovery outcomes cannot be achieved in eight weeks. For example, improving the community connection of players. This point is supported by CMOP-E which identifies the importance of habituation in maintaining positive change and allowing the benefits they bring to come about (Polatajko et al., 2007). OTFs also described the assumptions of MDT professionals that it is the occupational therapy role to facilitate groups whilst facing the simultaneous lack of value placed on these programmes due to the dominance of medical model approaches. Although occupational therapy has been shown to have the skills needed to successfully manage group dynamics and goal attainment of individuals in the group setting (Cole, 2014), this study found that some occupational therapists need more support from their team. Group engagement can help overcome barriers often faced by those with mental health difficulties (Cole, 2010) and so it would be in the team's best interest to offer their support. Furthermore, as mentioned, a service strategy that all staff commit to follow is required for recovery-orientated services and a unanimous team approach to successfully support service users (Health Service Executive, 2017).

Transport, funding and equipment were additional challenges experienced by group facilitators. Footballers not having finances to avail of transport to the group and buy needed equipment was described as an issue. OTFs identified experiences of facilitators having to go outside of their role to overcome these barriers. For example, personally collecting players and driving them to the group. In addition, the availability and price of community facilities and equipment was a barrier. Facilitators had experienced players being excluded from engaging in the group due to the lack of availability or high price to access sports facilities in the evenings due to mainstream sport using them. Players who worked or had other commitments during working hours were then unable to take part which limited the variations in demographics and dynamic that could be achieved in sessions in addition to group numbers. Although facilitators were required to go beyond their role, their actions demonstrate an awareness of the social imbalances that their service users are often subjected to and a willingness to address it however they could to enable engagement (Townsend et al., 2007,).

Sports partnerships were identified as the solution to this issue. The inclusion of professional facilities and coaches was perceived as both essential to the programme but at present a barrier to the provision of the group on a continuous basis and to creating flexibility in it's delivery. Coaches identified the need for sports facilities and partnerships to recognise the barriers that interventions like K2R are facing and to help support them to succeed, for example subsidising renting fees. A study by Hargreaves and Pringle (2019) discusses this need and the positive impact sports partnerships bring to football interventions. The current study is in line with this and in addition has shed light on the potential barriers sports partnerships create and the role they can play to remove them.

The inclusion of competition into the K2R programme was an opportunity that all stakeholder groups has different opinions of and different experiences with. Although the presence of competition would allow players the opportunity to interact with other service users and take on roles in the group, in some programmes it has been seen to bring about negative experiences. For example, in the study by Magee, Spaaij and Jeanes (2015) players found the competitive element negatively impacted their experience of the programme as it became the focus for some. Similarly, coaches in this study had experiences of feeling pressurised to take part in competition and some decided not to as it may have taken away from the programme's inclusive ethos by focusing on performance over participation. The experience of the footballers in this study was that the

absence of pressure from the programme was positive as they had experienced and disliked it in other groups. This would indicate that although competition is a positive opportunity in some circumstances, it would need to be navigated with care for those footballers who would disengage in response to its presence. This absence of competition was reflected on by HPs when discussing the safe environment of K2R that supports fun, enjoyment and willingness to accept challenges. HPs had some experiences of working with clients who had experienced competition in gyms and other team sports and disengaged as a result, leaving them isolated. This highlights the importance of including players in the design of interventions provided (Health Service Executive, 2017) and knowing what aspects of the activity will hold the most meaning for those involved and allow them to gain the most benefits (Polatajko et al., 2007).

In the face of challenges mentioned, stakeholders equally had experiences of the programme succeeding in certain areas and suggestions as to what pathways could be added to improve it. The accessibility of K2R was something that all stakeholders praised. The HP group in particular stressed the importance of this as when referring clients to community groups, there is often uncertainty around whether the service user will be adequately supported. However, when referring to K2R, the experiences of HPs was that the client would always be supported to engage to the best of their ability. This finding is reflected in more detail in the theme 'participation over performance' and again indicates the need for programmes like K2R to be provided on a regular basis for players who are struggling to access community opportunities (Moloney and Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healt, 2019; Friedrich & Mason, 2018; Magee, Spaaij & Jeanes, 2015; Brawn, Combes & Eilis, 2015; McElroy, Evans & Pringle, 2008).

The need for K2R to be run on a continuous basis rather than in set eight-week blocks was suggested the most by all groups. The experiences of the coach group were that routine made engagement easier for footballers and that the gaps between blocks often slowed the recovery-orientated changes from occurring. This finding is supported by other research in the area (Lamont et al., 2017; Hargreaves & Pringle, 2019). This study found that although a break can be beneficial to renew interest and allow players to rest, breaks of more than two to three weeks begin to have a negative impact on the programme's outcomes and the experience of players. OTFs agreed with the importance of routine formation and provided examples of those players who placed value on their engagement

in the group and who's recovery would be negatively impacted by an end to this routine. Footballers themselves suggested that their preference would be to run the K2R programme alongside the seasons of mainstream football. This would allow players to maintain positive change and the intervention to bare more resemblance to how mainstream football is run, allowing footballers feel more a part of the social norms within the sport as theorised by CMOP-E (Polatajko et al., 2007).

Existing studies mirror this suggestion stating the opportunity for mental health service users to engage in football needs to be part of mainstream care and facilitated over a longer time in order to ensure sustained recovery and community connection (Darongkamas, Scott & Taylor, 2011; Mason & Holt, 2012). People who face issues of stigma and social exclusion need more opportunities for sustainable and meaningful engagement. HPs echoed this need for re-engagement opportunities. Their experience was that K2R on an ongoing basis provides a pathway for footballers to have a choice as to whether they re-engage or not and an outlet in the interim of accessing community-based options. Furthermore, opportunities for choice are a necessity of recovery-orientated services (Health Service Executive, 2017) and the 'just right' challenge is required for successful engagement in the occupation presented (Polatajko et al., 2007). However, this opportunity for 'just right' engagement is only successful if it is part of a wider network of pathways from which players can choose from. This would players to decide when and how they will gradually grade their engagement from within K2R to other settings without the support of services (Polatajko et al., 2007).

Finally, stakeholders made suggestions for changes that could be made within K2R sessions. An example from the footballer group was additional structure for those who have difficulty initially settling into the group or during social periods such as water breaks. The benefits of ice breaker type activities has been echoed by Benkwitz and Healy (2019) and is important in the tailoring of programmes to centralise service user experiences (Health Service Executive, 2017). The option of footballers co-facilitating the sessions is one that arose in this study and in the study by Lamont at al. (2017) who states collaboratively facilitated groups are the way forward. However, one footballer in this study had coaching experience and spoke of his enjoyment of being able to receive formal coaching in a way he perceived to be typical of 'regular club' sessions, as opposed to co-facilitating as guidelines would recommend. This would indicate normalising the experience for players involved may be more important. The study by Benkwitz and Healy

(2019) provides a potential solution as footballers in their study volunteered to lead an aspect of the session, such as the warm-up. They stated that this sharing of roles is a frequent occurrence in mainstream football. This suggests that the opportunity to take on additional roles or opportunities in the group would still be in line with the desire of normalcy from footballers whilst meeting recommendations of recovery-orientated services (Health Service Executive, 2017). This would again allow players to maintain resemblance to how mainstream football is run, allowing footballers feel more a part of the social norms within the sport as theorised by CMOP-E (Polatajko et al., 2007).

Similarly, footballers identified the efforts of coaches to provide education around the inner workings of professional football as a positive opportunity to learn more about the sport. This education increased the interest and enjoyment for footballers when engaging in drills and had a positive impact on social interactions outside of sessions. Footballers gave examples of interactions they had been able to have with family and peers around information they had been taught in the group that they were not able to have before. Coaches explained that knowing the professional tactics in the sport supports footballers to engage in conversation more easily and to have an opportunity to be the knowledgeable person in the group which is influential for those who normally struggle with social skills and inclusion. Methods that allow service users a chance to be more included in social interactions and norms are in line with recovery-orientated aims (Health Service Executive, 2017) and encourage an identity beyond that of a service user alone (Repper & Perkins, 2003; Health Service Executive, 2017). This is a new finding from this study not identified by existing research which shows the value of supporting service users to more easily access socially valued occupations and (Polatajko et al., 2007).

5.6. Study conclusion

To conclude, this study successfully met it's aims to explore the perceptions of K2R stakeholders of whether the programme had a positive impact on recovery outcomes and the methods used to try and achieve this.

This research found that the stakeholders of K2R do perceive the group as having a positive influence on recovery outcomes, in particular the areas of managing mental health, identity, self-esteem and trust and hope (MacKeith, & Burns, 2008). However when it comes to the outcome of connectedness, this study found that at present the K2R programme is not perceived to be capable of meeting this. Social connection and inclusion is considered essential and a longstanding challenge for recovery (Health Service Executive, 2017; Hutcheson, Ferguson, Nish, & Gill, 2010), making this an important finding of this study.

When investigating the experiences and methods used by facilitators, subtle ways of supporting service user learning and development through leisure engagement was a prominent finding. Learning is an important stage in achieving recovery (MacKeith, & Burns, 2008) and doing so through leisure is particularly valuable and under researched for people with mental health difficulties (Iwasaki et al., 2014). Stakeholders perceived a need for more opportunities within K2R to better meet group outcomes, for example physical health. Good self-care and physical health is a prominent issue for people with mental health difficulties which needs to be addressed (Stubbs, Vancampfort, De Hert & Mitchell, 2015; Vancamopfort et al., 2014; Holt, de Groot & Golden, 2014; Dorning, Davies & Blunt, 2015) and an important area for recovery (MacKeith, & Burns, 2008). Finally, stakeholders suggested creating clear exit pathways for service users to move on and progress their engagement in community settings. The complexity of social inclusion and community integration is known and requires a multifaceted approach (Filia et al., 2018), making these perceptions and suggestions important findings.

5.7. Literature gaps addressed and implications for further research

The current study addressed a number of the research gaps outlined in Chapter Two – Literature Review and indicated areas future research could explore.

A gap in research was identified for a study that considers whether positive change and learning within football intervention sessions was transferable to other environments for footballers and if so, how this was happening. This study found that skills learned in K2R sessions were transferable to other environments and that the key factor in the facilitation of this learning was subtlety. This was a new finding for the research area among which many studies incorporated explicit learning opportunities, for example the studies by Magee, Spaaij and Jeanes (2015), McGale, McArdle and Gaffney, (2011) and McArdle, McGale and Gaffney (2012). Future research should incorporate follow up data collection to explore whether these changes are sustained and within what environments.

Another gap noted was the absence of studies analysing intervention facilitation and benefits from a leisure perspective. This study found that the footballers involved experienced an escape from their difficulties, were constantly challenged by the activities presented and got to experience enjoyment and fun which they were missing in other life activities. These experiences have been deemed invaluable for those living with mental health difficulties and are unique to leisure-based activities (Iwasaki et al., 2014; Hargreaves, Lucock & Rodriguez, 2017). Further research should be carried out using a leisure perspective to add to or challenge the findings of this study as recommended by other research (O'Doherty, Stevenson & Higgins, 2012).

Whether physical health can and should be addressed by football interventions and how sustainable this would be was another research gap. This study found that although physical health should be a focus in mental health services, football sessions alone cannot be relied upon to make notable and sustainable changes. This was due to the current eight-week design and the fact that sessions don't meet the recommended weekly amount of exercise for adults. It was found that additional exercise sessions and opportunities should be added to football sessions to form a wider regime, the design by Lewis, Reeves and Roberts (2017) with non-clinical populations being a potential model. If this model is created, further research would be needed to explore it's effectiveness in comparison with the current design.

Similarly, the question of whether interventions such as K2R can influence experiences of social inclusion for service users was asked and if they can, how does this occur. This study found that football interventions alone are not capable of bringing about change in this area and that again, additional social opportunities both within football sessions and outside are required to do so. This contradicts findings in existing studies (Moloney and Rohde, 2017; Lamont et al., 2017; Hargreaves & Pringle, 2019; Benkwitz & Healt, 2019; Friedrich & Mason, 2018; Magee, Spaaij & Jeanes, 2015; Brawn, Combes & Eilis, 2015; McElroy, Evans & Pringle, 2008). Again, the suggestions to improve this made by participants in this study should be trialled and research should be carried out to analyse their effectiveness compared to the current design.

An additional research gap identified was the absence of studies that split staff participants into different groups for data analysis and considered the impact staff, particularly female staff, taking part in sessions could have on dynamics. This study found that there were differing experiences and perspectives among each staff group on almost every concept discussed. This suggests a need for further research including staff perspectives to split them into separate groups for analysis. In addition, the current study did not explore in detail why each group had differing perspectives. Although the level of exposure to the phenomenon was considered, future studies should consider the professional responsibilities that each staff group has to abide by and the subsequent impact this may have on their perspectives. With regards to staff taking part in sessions, this study found the involvement of female staff in particular was perceived as positive by footballers. It created an inclusive dynamic in the group and made footballers more willing to engage.

With regards to the impact female staff can have on counteracting gender-based health behaviours and the experiences of female players in football interventions, neither of these areas were explored in the current study. There were two females involved in the groups at their outset and it was hoped they would take part in the study. However, they disengaged from the group in the early stages. Future research should explore the reasons why low numbers of female players get involved with these interventions and whether there are characteristics of the group that discourage them from staying engaged. Although meeting the recommended amount of physical activity is an issue for most adults, women are less likely to do so (Pringle & Pringle, 2016).

Finally, there is research that has criticised the effectiveness of football interventions and stated there is little evidence to show benefits of either playing or watching football (Heun & Pringle, 2018; Andersen, Ottesen & Thing, 2018). This study has added to the field demonstrating evidence for the use of football interventions to positively impact recovery outcomes for community mental health service users. It is also only one of the two studies found that analyse K2R and from an occupational therapy perspective (Moloney & Rohde, 2017).). However, the need remains for further research analysing the use of football interventions in community mental health services and in particular, studies that includes trials of the suggestions made by the participants in this study to improve the K2R programme.

5.8. Study limitations and actions taken

The evaluation of this study's quality was guided by Yardley's (2000) principles. These are: 1) Sensitivity to context 2) Commitment and rigour, 3) Transparency and coherence 4) Impact and importance.

5.8.1. Sensitivity to context

No non-coach FAI staff came forward to take part in the study. This was thought to be caused by the participant information being tailored to coaches with facilitation experience as opposed to those involved in programme design and administration. Although this limited the sample variation of stakeholders, on reflection coaches had more exposure to the phenomenon of supporting the recovery of service users and likely provided perceptions more relevant to the research questions. In addition, coaches from different geographical locations were recruited to provide perspectives from various environmental contexts.

This study was originally to implement a pre and post interview design with the footballers. However, upon provision of the study information, footballers reported they did not want to carry out two interviews. They stated this was strenuous and requested if one interview at the end of the programme could be carried out instead. The pre and post interview schedule questions were therefore combined and footballers were asked to answer pre questions in retrospect during the post interview. Although this may have caused inaccuracies in the footballers reports of pre group perspectives, this study maintained it's

recovery-orientated approach and allowed participants to have choice and control with the research design.

5.8.2. Commitment and rigour

It was decided that a demographics form would not be used for this study. Although demographic data is an important contributor to the rigour of the study and transferability of findings (Connelly, 2013), participants were instead encouraged to give the details they were comfortable with as opposed to a set list. This was to maintain a recovery-orientated approach and allow participants more control over what data was held about them. Demographics freely given in interviews by all participants that related to the research phenomenon was then listed.

5.8.3. Transparency and coherence

The OTF group were added late in the data collection process which resulted in questions not being fully tailored to their level of knowledge and exposure to the phenomenon being studied. They were added in response to a healthcare professional with facilitator experience expressing a different perspective to other professionals and to low recruitment numbers of the footballer group. However, flexibility is encouraged for researchers undertaking qualitative research as although a late change, it allowed unexpected areas to be explored. Another perspective was added to the research which allowed the perspectives and experiences of stakeholder groups not seen in existing studies to be explored.

The choice to undertake a qualitative research design in itself poses limitations. Although the collection of qualitative data using semi-structured interviews provides insightful information, the findings are not generalisable and bias is almost unavoidable (Almeida, Faria & Queiros, 2017). However, this study does not claim to be without bias and a number of actions were taken to attempt to improve transparency and transferability. Examples of this include a declaration of previous exposure and experiences of the researcher being clearly disclosed, a detailed audit trail being kept, samples of how data was coded and the number of times each code being provided. This information can be found in Appendices and full methods used are outlined Chapter Three – Methodology. These efforts were also made in response to a gap identified in research for studies providing clear details of how the study was carried out.

5.8.4. Impact and importance

As discussed, the perspectives of female footballer players were not explored due to no female players remaining involved till the end of the programme. This limits transferability of findings to all service users. In addition, the number of male footballers recruited did not meet the target sample number of five to ten individuals and this is thought to be the main limitation of this study. This occurred as there were less than half the numbers of participants than expected by the facilitators from which the sample was recruited. This meant the researcher did not seek ethical approval from more sites and it was then not possible to obtain this in the data collection time remaining. Furthermore, it was difficult for the researcher to build rapport with footballers that were involved.

The positive influence good therapeutic relationships between staff and service users within community mental health settings is shown in literature (Farrelly & Lester, 2014; Priebe, Richardson, Cooney & Adedegi, 2011). However, a research gap had been identified for research within which the data collection was not carried out by intervention facilitators which was the case in most of existing studies include (Darongkamas, Scott & Taylor, 2011; Moloney & Rohde, 2017; Mason & Holt, 2012; McArdle, McGale & Gaffney, 2012; Pringle et al., 2013; Robertson et al., 2013; Hargreaves & Pringle, 2019; Benkwitz & Healy, 2019). Although the sample number in this study wasn't achieved, it is likely that the footballers who were interviewed were much less likely to have been reluctant to give constructive feedback for fear of it negatively impacting their relationship with facilitators and future treatment. In addition, staff interviewed were encouraged to relay both positive and negative comments that footballers were reporting to them about the programme. A combination of these factors makes the findings from this study a valuable addition to the field. However, further research would be needed to explore the perspectives of the footballer group if the suggestions from this study are incorporated into the K2R programme and across the different geographical locations and genders that this study could not access.

5.9. Implications for practice

5.9.1. Occupational therapist facilitators

- This study identified that programmes such as the K2R can be restricted by medical model approaches in the services within which they are run. Therefore, it

is recommended that HPs involved with K2R support OTFs in advocating for the role of interventions like K2R in the area of mental health recovery.

- This study found that the programmes need to be flexible in their delivery in order to meet the needs of individual participants. It is therefore recommended that the structure and duration of the programme be revisited to include a flexible approach.

5.9.2. Healthcare professionals

- This study found that referral to the programme was limited by the point in time of an individual's recovery and the individual's physical and mental fitness. It is therefore recommended that the referring agents work alongside OTFs to overcome barriers faced by clients rather than deferring their referral for fear of the individual being negatively impacted.

5.9.3. Coaches

- This study found that coaches were not given any feedback as to the benefits of the programme for individuals. It is therefore recommended that feedback from health professionals in relation to how the group benefited participants be given to coaches which in turn would enable them to improve the group experience.
- This study found that footballers are often excluded from local sports settings which could play a role in combating social exclusion. It is therefore recommended that coaches act as a bridge between service-run sport and community sport to support access and inclusion of mental health service users.

5.9.4. Community integration

- This study found that social and community inclusion often don't occur after an individual takes part in the K2R programme. It is therefore recommended that social inclusion and community integration are made intentional outcomes of the group by offering social activities after sessions, inviting family members and friends if the group allows, encouraging friendships within the group and ensuring the K2R is a programme that is continuously offered for those not yet accepted by their communities.

5.9.5. Empowerment

- This study found that the choices of footballers are supported within group activities but don't appear to be extended outside of the group environment. It is therefore recommended that pathways and exit routes from K2R to community

sport and activities are offered for individuals to choose from and that footballers are invited to contribute to the design and content of K2R sessions.

5.9.6. Physical health

- This study found that the current regularity and structure of K2R is not capable of addressing the physical health issues for most mental health service users. It is therefore recommended that K2R is incorporated into a wider health and exercise programme with options for service users to choose from, without interrupting the football sessions themselves.

CHAPTER SIX – REFERENCES

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CHAPTER SEVEN - APPENDICES

7.1. Studies critically appraised for literature review

Study	n=	Location	Methods	Primary focus	Findings
McGale, McArdle & Gaffney, 2011	Eighty-four footballers	Community non-clinical setting	Randomised control trial. Mixed methods. Descriptive statistics and thematic analysis.	To investigate the effectiveness of a football/ psychosocial intervention aimed at the mental health of young men.	An individual exercise programme has equal or more benefits than a combined football/ psychosocial intervention.
McArdle, McGale & Gaffney, 2012	Fifteen footballers	Community non-clinical setting	Qualitative study with interviews and focus groups. Interpretive thematic analysis.	Qualitative investigation of experiences of men engaging in a football/ CBT intervention.	Delivering mental health interventions through football is a successful method, the best structure for doing so being unclear.
Brawn, Combes & Eilis, 2015	Seven footballers	Community clinical football league	Qualitative interviews. Narrative analysis.	Explore the impact of engagement in competitive sport on mental health recovery.	Participants rediscovered their sense of identity and developed a sense of community connection.
Darongkamas, Scott & Taylor, 2011	Ten footballers	Community clinical football club	Mixed methods based of a previous service review.	Evaluation of a community football club for mental health service users with a focus on sense of social inclusion and health changes experienced.	Participants gained a sense of community inclusion, made meaningful connections with other players and experienced physical and mental health benefits.

Study	n=	Location	Methods	Primary focus	Findings
Mason & Holt, 2012	Nineteen participants. Twelve footballers, two health professionals and two coaches.	Community clinical football group with sports partnership	Qualitative interviews. Analysis guided by grounded theory.	To explore the implications of community football projects on the relationships, quality of life and health of service users from their perspective and those of coaches and healthcare professionals.	Regained or built a new sense of identity through sort and gained motivation for further community engagement.
Moloney, L. & Rohde, D. 2017.	Six footballers with psychosis	Community clinical football programme	Qualitative interviews. Thematic analysis	Explore the experiences of men with psychosis in an occupational therapy programme.	Engagement in football had both physical and mental health benefits and can be a regular addition to community mental health care.
Lamont et al., 2017.	Eighteen footballers and seven staff.	Two community clinical football programmes, one normal football and one ‘walking football’.	Qualitive, focus groups for footballers and staff separately. Thematic analysis.	Explore the experiences of healthcare professionals and footballers involved in a collaborative football group.	Physical and mental health benefits and a perceived positive impact on recovery were reported by all participants, more work is needed to secure community support.

Study	n=	Location	Methods	Primary focus	Findings
Hargreaves & Pringle, 2019.	Twelve footballers.	Clinical community football group with professional club partnership.	Qualitative design. Interviews. Template analysis.	Exploring behavioural changes and how to facilitate the group to support change.	The behavioural processes involved in changes observed in footballer intervention research.
Benkwitz & Healy, 2019	Seventeen participants, staff and footballers	Non-clinical community football health promotion group with professional club partnership.	Qualitative interviews. Theoretical thematic analysis	Explore the experiences of footballers and staff from personal and social recovery perspectives.	Areas of both personal and social recovery theory are addressed by football based mental health interventions.
Magee, Spaaij & Jeanes, 2015.	Thirty-eight people, mixture of footballers and staff.	Mixture of clinical and non-clinical football groups	Qualitative interviews. Thematic analysis.	Explore processes of engagement, stigma change and interaction between playing sport and formal therapeutic intervention across three football projects.	Football provides the opportunity for positive social interaction, connectedness and development of meaning.
Friedrich & Mason, 2018.	Thirty-five people, mixture of footballers and stakeholders	Clinical community football group with sports partnership.	Qualitative interviews. Thematic analysis.	Explore experiences of footballers and stakeholders in the 'Coping Through Football' programme.	Experiences in football interventions result in increased confidence and social skills with lifestyle and recovery being improved as a result.

Study	n=	Location	Methods	Primary focus	Findings
Robertson, et al., 2013	Seventy-four people, sixteen staff, fifty-eight footballers	Community non-clinical football programme.	Qualitative interviews. Thematic analysis	Explore at how positive benefits of engagement in a football programme come about.	Flexibility, trust between players and with staff and provision of interventions on a continuous basis were seen as necessary to support change.
Friedrich & Mason, 2017	Seventy-two footballers	Community clinical football programme	Quantitative study. Assessments examining physical activity and well-being. Baseline, fix months and twelve month follow up.	To evaluate the psychosocial and physical outcomes for players in involved in a football intervention.	Football interventions are a successful method to encourage people with mental health issues to engage in physical activity.
Lewis, Reeves & Roberts, 2017	Sixteen male footballers	Community non-clinical environment	Quantitative study, Assessments examining physical and mental wellbeing.	To evaluate the impact of a football-based intervention to positively influence mental well-being, health perceptions and lifestyle knowledge.	Football interventions are successful in promotion health in the group setting but the extension of this outside is unclear.
Pringle et al., 2013	Thirteen health trainers	Community on-clinical environment	Qualitative study, semi-structured interviews, thematic analysis.	To investigate key methods used to support the engagement of men in health promotion interventions.	Although men are more likely to get involved through these interventions, carryover into lifestyle is unclear.

Study	n=	Location	Methods	Primary focus	Findings
Curran et al., 2016	Not mentioned	Community non-clinical setting	Ethnographic and observational methods, analysis of field notes.	To investigate the challenges experienced by men when engaging in football interventions.	There are environmental barriers that prevent people from engaging in interventions despite wanting to.
McElroy, Evans & Pringle, 2008	One hundred and thiry one footballers	Community clinical football programme	Researcher formed questionnaire	To evaluate the emotional and wellbeing of those involved in the league.	Sense of inclusion, improved confidence and positive identity experiences were reported.

7.2. Ethical approval, amendments and site access

Coláiste na Tríonóide, Baile Átha Cliath
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Amy Tuite
Discipline of Occupational Therapy,
Trinity Centre for Health Sciences,
St. James Hospital,
James's Street,
Dublin 8

12th December 2018

Ref: 181003 Tuite

Title of Study: A Stakeholders Perspective on the 'Kickstart to Recovery Football Programme' in a community mental health service.

Dear Amy,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in October 2018. We are pleased to inform you that the above project has ethical approval to proceed.

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

pp Gloria Brown
Prof. Brian O'Connell
Chairperson
Faculty Research Ethics Committee

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15/1/19

Re/ **Research Study Proposal:**"A Stakeholders Perspective on the `Kickstart to Recovery Football Programme` in a community mental health service"

Dear Ms Tuite

I refer to your email correspondence of the 25/11/18 & 12/1/19 in response to issues raised by the HSE North East Research Ethics Committee (REC) in connection with the above study. I wish to advise that I have had an opportunity to review same.

I can confirm that you have met all the conditions of the Committee.

Approval is now given to commence the above Study.

If during the course of the research project, amendments or alterations to the proposed research are required, approval must again be sought from this Committee.

Please note a copy of the completed study should be forwarded to the Research Ethics Committee office on completion of same.

This approval will be formally noted at the next REC meeting.

Yours sincerely,

Ms Rosie Quinn
Chair, HSE North East Area
Research Ethics Committee

Copied to/ Ger McCormack, Business Manager, St. Brigids Campus, Ardee, Co. Louth
Dr Muhammed Niazi, Executive Clinical Director, St. Brigids Complex, Ardee, Co. Louth

Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Amy Tuite
Discipline of Occupational Therapy,
Trinity Centre for Health Sciences,
St. James Hospital,
James's Street,
Dublin 8

8th March 2019

Ref: 181003

Title of Study: 'A Stakeholders Perspective on the 'Kickstart to Recovery Football Programme' in a community mental health service.'

Dear Amy,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held February 2019, we are pleased to inform you that the above project (as amended with the following changes) has ethical approval to proceed.

Section: 2.4
Amendment:

1. *To explore the ability of the 'Kickstart to Recovery' model to connect mental health service users to their community environment through engagement in football.*
2. *To explore the ability of the of the 'Kickstart to Recovery' model to positively impact the mental health recovery journey of mental health service users through leisure engagement.*
3. *To explore the experiences of healthcare professionals and methods used by FAI coaches and staff whilst supporting the recovery journey of service users engaged in the 'Kickstart to Recovery' programme.*

Section: 2.5
Amendment:

- *The number of participants estimated to be recruited for each group has been altered based on feedback from recruiting OTs.*
- *Only one post group interview will not be carried out with the footballer group. Feedback was received and stated two interviews was too many.*
- *Phone interviews were requested by participants.*
- *An additional recruitment pathway through AOTI for healthcare professionals has been added.*
- *An email will be sent to FAI head office to circulate to all FAI coaches and staff involved with Kickstart to be invited to participate in the study.*

AMENDMENT

Willis Towers Watson

TO WHOM IT MAY CONCERN

Date: 18 October 2018

Our Ref AMM/EXT.6403

Dear Sir/Madam,

Re: Our Client - Trinity College Dublin

We act as Insurance Brokers to the above named Client, and confirm details of their Public liability insurance cover as follows:-

• **Insured Title**	Provost, Fellows, Foundation Scholars and other members of the Board of the College of the Holy and Undivided Trinity of Queen Elizabeth near Dublin	
• **Business Description**	Provider of Third Level Educational & Ancillary Services and Property Owners	
• **Renewal Date**	1st October 2019	
• **Insurer**	IPB Insurance CLG t/a IPB Insurance	
• **Policy Number(s)**	IEL00000947 & IPL0001747	
• **Limits of Indemnity**	**Employers Liability**	Not less than €13,000,000 any one event
	Public Liability	Not less than € 6,500,000 any one event
	Products Liability	Not less than € 6,500,000 any one period of insurance
• **Territorial Limits**	Worldwide	
• **Principal Exclusions**	Clinical Trials Any Employee acting as a qualified medical or dental practitioner while working in a professional capacity	

The policy provides an indemnity against legal liability for claims arising from the Insured's business including but not limited to research activities

Cover is subject otherwise to the terms, conditions and exceptions of the policies.

Willis
Willis Towers Watson House, Elm Park, Merrion Road
Dublin 4, D04 P231

T: +353 (0) 1 661 6211
E: info.irl@willistowerswatson.com
W: willis.ie

Directors: James Campbell (British), Brian Curtis, Ken Mahony, Jim O'Mahoney, Padraic White., Company Secretary: Eamon McGoldrick
Registered in Ireland number 78812
Registered office Willis Towers Watson House, Elm Park, Merrion Road, Dublin 4, D04 P231
Willis Risk Services (Ireland) Limited t/a Willis is regulated by the Central Bank of Ireland.

7.3. Pilot interview feedback sheet

Pilot Interview Feedback Sheet

Which question did you like answering and why?

Which question did you not like answering and why?

Did you find the interview was too long, too short or just right?

Did you find the order of questions appropriate? **YES/ NO**

Were you comfortable answering the questions? **YES/ NO**

Are there any prompts you feel should be included for certain questions?

Are the questions relevant to the title? **YES/ NO**

Are the questions easy to understand? **YES/ NO**

Have you any other feedback?

7.4. Participant information leaflets with consent forms, interview guides and GDPR information

7.4.1. Staff GDPR

GDPR information for staff

What data is being held about me for this study?

- Your phone number and/ or email address.
- Participant description used in the study that was given in your code letter.
- The recording of your interview.
- A transcript of your interview.
- A research consent form.

Why is this data being taken

- Your phone number/ email address are kept so the researcher can arrange the interview and send you your interview codes. Your contact details will be erased once the interview is done, transcribed and your code sent to you.
- Your interview is recorded to allow the researcher to accurately recall what was said. The transcript is done to allow the researcher analyse what was said and make codes.
- Your recording will be deleted once the transcript is complete. The consent form is to keep a record that you consented for your information to be used in the study while its being published.

How is my data being protected?

- Your phone number was saved to a research only SIM card which will be destroyed after the research is completed on September 30th 2019.
- The phone the SIM is in is password and fingerprint protected.
- Any emails sent will not have any of your personal information in it.
- Any documents sent via email will be password locked with the password sent in a separate email.
- Your consent form with your name on it will be stored in a locked cabinet in the office of research supervisor Dr. Clodagh Nolan for the five year period.
- The document that links your participant number to your name is password protected and will only be opened by the interviewer.
- The computer that your information is stored on has up to date anti-virus software and is password protected.
- Your phone number and transcript are pseudo anonymised.

Who has access to my data?

- Interviewer Amy Tuite will be the only person who will have access to the document linking your participant number to your name.
- The research supervisor of Amy Tuite, Dr. Clodagh Nolan, will have access to your pseudo anonymised transcript. This is to give Amy advice on how best to analyse it.
- The codes from your interviews and some quotes will be present in study write up and publications.

How will my data be destroyed when the interviews are finished?

- The SIM card with your phone number will be shredded.
- Your emails and email address will be deleted.
- The recording of your interview will be deleted once it is transcribed.

What are my rights in this study?

- To be given a copy of all documentation related to you.
- Know exactly how and why your data is being held and processed.
- To make any corrections or deletions to your data.
- To withdraw entirely from the study at any time without being penalised and without having to give a reason.

Why is some data being held for five years?

- Your transcript will be saved onto a USB and locked in a cabinet in the office of Dr. Clodagh Nolan. After five years this USB will be wiped and your consent form will be shredded.
- This time is to allow you opportunity to pull out of the study. Your information will be removed from any publications following your removal. Any publications already completed will still contain your information
- This time also gives opportunity for research credibility to be checked if required.

What articles of data protection law is being used?

Article 6(1)(a) and 6(1)(e)

'the data subject has given consent to the processing of his or her personal data for one or more specific purposes'

'processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller'

Article 9(2)(a) and 9(2)(j)

'processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) based

on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.'

Where do I go if I want to complain?

Email info@dataprotection.ie

Got to https://www.dataprotection.ie/en/individuals/raising-concern-commission to fill out a complaints form online.

7.4.2. Footballers GDPR

GDPR information for footballers

What data is being held about me for this study?

- The demographics used in the study that were given in your code letter.
- Your phone number and/ or email address.
- The recording of your interview.
- A transcript of your interview.
- A signed research consent form.

Why was this data taken?

- Demographics are used in order for the researcher to assess what kind of people take part in the group. This is to find out what factors may make the programme more or less beneficial for footballers and to consider the ways it could be altered to make it more worthwhile.
- Your phone number/ email address were kept so the researcher could arrange the interview and send you your interview codes.
- Your interview was recorded to allow the researcher to accurately recall what was said. The transcript is done to allow the researcher analyse what was said and make codes.

How is my data being protected?

- Your phone number was saved to a research only SIM card which will be destroyed after the research is completed on September 30th 2019.
- The phone the SIM is in is password and fingerprint protected.
- Any emails sent will not have any of your personal information in it.
- Any documents sent via email will be password locked with the password sent in a separate email.
- Your consent form with your name on it will not leave the HSE community site you attend.
- The document that links your participant number to your name is password protected and will only be opened by the interviewer.
- The computer that your information is stored on has up to date anti-virus software and is password protected.
- Your phone number and transcript are pseudo anonymised.

Who has access to my data?

- Interviewer Amy Tuite will be the only person who will have access to the document linking your participant number to your name.
- The research supervisor of Amy Tuite, Dr. Clodagh Nolan, will have access to your pseudo anonymised transcript. This is to give Amy advice on how best to analyse it.

- The codes from your interviews and some quotes will be present in study write up and publications.

How will my data be destroyed when the interviews are finished?

- The SIM card your phone number is saved on will be shredded.
- Any emails and text messages will be deleted.
- The recording of your interview will be deleted once it is transcribed.

What are my rights in this study?

- To be given a copy of all documentation related to you.
- Know exactly how and why your data is being held and processed.
- To make any corrections or deletions to your data.
- To withdraw entirely from the study at any time without being penalised and without having to give a reason.

Why is some data being held for five years?

- Your transcript will be saved onto a USB and locked in a cabinet in the office of Dr. Clodagh Nolan. After five years this USB will be wiped and the HSE site will shred your consent form.
- This time is to allow you opportunity to pull out of the study. Your information will be removed from any publications following your removal. Any publications already completed will still contain your information
- This time also gives opportunity for research credibility to be checked if required.

What articles of data protection laws are being used?

Article 6(1)(a) and 6(1)(e)

'the data subject has given consent to the processing of his or her personal data for one or more specific purposes'

'processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller'

Article 9(2)(a) and 9(2)(j)

'processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.'

Where do I go if I want to complain?

Email info@dataprotection.ie

Got to https://www.dataprotection.ie/en/individuals/raising-concern-commission to fill out a complaints form online.

7.4.3. Participant information leaflet healthcare professionals

Healthcare Professional Information Leaflet

Study title: A Stakeholders Perspective on the 'Kickstart to Recovery' Football Programme in a community adult mental health service.

Researcher Name: Amy Tuite

Telephone number of Researcher: 089 490 4809

Email of the Researcher tuiteam@tcd.ie

Research Supervisor Name: Dr. Clodagh Nolan

You are being invited to take part in a research study to be carried out in conjunction with the Louth/Meath Mental Health Services and Football Association of Ireland. You are being invited because your caseload includes clients that have completed at least six out of eight sessions of the 'Kickstart to Recovery' programme in the last five years. Before you decide whether or not you wish to take part, you should read the information provided below carefully. Don't feel rushed and don't feel under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'. You don't have to take part in this study and a decision not to take part will not affect your future involvement with the Mental Health Services. You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out. You don't have to give us a reason. If you do opt out, rest assured it won't affect your work with the service.

Why is this study being done?

This research aims to find out whether or not the 'Kickstart to Recovery' model has the scope to connect service users to their community environment, support their mental health recovery journey and to explore the experiences of staff and coaches whilst working towards recovery. We

would like to know if you have observed any changes in the community involvement, confidence in the potential for mental health recovery and barriers to engagement for service users engaged in the programme. It is hoped that the outcomes of this study will enable the programme facilitators to improve the football programme to meet the needs of future mental health service users.

Why am I being asked to take part?

You are being invited because your caseload includes clients that have completed at least six out of eight sessions of the 'Kickstart to Recovery' programme in the last five years.

How will the study be carried out?

If you agree to take part in the study, you will be invited to do one interview with the researcher Amy Tuite. This will be either in person or over the phone depending on your preference. You will be asked to fill out a consent form, which is included in this pack. The list of questions is also included in this pack and the interviewer would go through all forms with you before starting the interview.

Your interview will be voice recorded and transcribed by Amy Tuite. Once your interview has been transcribed your recording will be deleted. It will then be analysed and a list of the main themes that came up will be made. An example of a theme could be 'increased confidence'. This list of themes will then be written into a letter and given to you by the receptionist at the clinic with which you work.

The themes from your interview will be used as the study results and for publication. The written transcript of your interview will be kept on file for a period of five years to allow the research to be published, which will take about two years, and for you to access it again if you wish. This study is also part of an academic qualification for researcher Amy Tuite. If at any time you decide you no longer want some or all your information included in the research, please contact Amy Tuite and your information will no longer be in the study.

What are the benefits?

You will not benefit directly from your participation in this study. However this study may allow those designing and organising the 'Kickstart to Recovery Programme' to improve the football programme for future service users.

What are the risks?

There are minimal risks associated with this study. Researchers will aim to prevent any unlikely distress or discomfort, however if you become upset during the interviews you will be offered to take a break or stop the interview if you wish. You can decide if you want your interview to be used in the research or not at that time or you can change or remove your information anytime in the future. You are free to withdraw from the study anytime without incurring any penalties or benefits you had before entering the study.

Will it cost me anything to take part?

There is no cost involved in being a participant of this research.

Is the study confidential?

Yes your identity will remain confidential. Your name will not be published and will not be disclosed to anyone but the interviewing researcher Amy Tuite. You will be assigned a number which will replace your name on your transcribed interview, thus keeping it confidential. The study is also covered by insurance from Trinity College Dublin and the HSE.

Where can I get further information?

If you have any further questions about the study now or at any time in the future, please contact us on the details below. Please also contact us if you would like to express an interest in taking part in the study before April 1st.

Amy Tuite

Occupational Therapy Masters student

Trinity College Dublin

Phone: 089 490 4809 between 9-5 Tuesday to Friday

Email: tuiteam@tcd.ie

HEALTHCARE PROFESSIONAL INTERVIEW QUESTIONS

Q1: How did you hear about the group and do you think it held meaning for the people you have worked with?

Q2: Have you observed any changes in the health of players involved with the group? If so can you tell me about it?

Q3: Do you think there are barriers/ challenges for service users to engage with the group or their community in general? If so can you discuss these?

Q4: In your opinion, does the structure of the group/ how it's run have an impact on how service users see themselves and their abilities?

Q5: In your opinion, has the Kickstart Programme acted as a catalyst to support individuals in their recovery journey? If so how?

HEALTHCARE PROFESSIONAL CONSENT FORM

PROJECT TITLE: A Stakeholders Perspective on the 'Kickstart to Recovery Football Programme' in a community mental health service.

RESEARCHER: Amy Tuite

Please go through the list below carefully before signing this form:

I have read and understood the Information Leaflet**.**	**Yes** ☐	**No** ☐
I have been given a copy of all forms for my records.	**Yes** ☐	**No** ☐
I agree to take part in one interview for max 1 hour.	**Yes** ☐	**No** ☐
I agree for my interview to be voice recorded and transcribed.	**Yes** ☐	**No** ☐
I understand that I don't have to take part and can opt out at any time.	**Yes** ☐	**No** ☐
I understand that I don't have to give a reason for opting out and my future involvement with the Mental Health Services or 'Kickstart to Recovery Programme' won't be affected.	**Yes** ☐	**No** ☐
I am aware of the potential risks of this research study.	**Yes** ☐	**No** ☐
How my information will be kept and processed has been explained to me.	**Yes** ☐	**No** ☐
I consent for my data to be analysed and kept for a period of five years.	**Yes** ☐	**No** ☐

I am aware that this study will be published and is part of an academic qualification.	**Yes** ☐	**No** ☐

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: ……..

CONTACT DETAILS: ……..

PARTICIPANT'S SIGNATURE: ……..

Date:…….

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S

SIGNATURE:…… Date:……

7.4.4. Participant information leaflet FAI coaches

Coach and FAI Staff Information Leaflet

Study title:	A Stakeholders Perspective on the 'Kickstart to Recovery' Football Programme in a community adult mental health service.

Researcher Name:	Amy Tuite
Telephone number of Researcher:	089 490 4809
Email of the Researcher	tuiteam@tcd.ie
Research Supervisor Name:	Dr. Clodagh Nolan

You are being invited to take part in a research study being carried out in conjunction with the Louth/Meath Mental Health Services and Football Association of Ireland. You are being invited because you are coaching/ have coached the 'Kickstart to Recovery' programme or are involved in the design of the programme being run over the last five years. Before you decide whether or not you wish to take part, you should read the information provided below carefully. Don't feel rushed and don't feel under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'. You don't have to take part in this study and a decision not to take part will not affect your future involvement with the Mental Health Services. You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out. You don't have to give us a reason. If you do opt out, rest assured it won't affect your work with the service.

Why is this study being done?

This research aims to find out whether or not the 'Kickstart to Recovery' model has the scope to connect service users to their community environment, support their mental health recovery journey and to explore the experiences of staff and coaches whilst working towards recovery.

We would like to ask you about the values of the programme that address mental health recovery, potential benefits of football as a leisure activity for service users and methods used to support meaningful engagement for clients. It is hoped that the outcomes of this study will enable the programme facilitators to improve the football programme to meet the needs of future mental health service users.

Why am I being asked to take part?

You are being invited because you are coaching/ have coached the 'Kickstart to Recovery' programme or are involved in the design of the programme being run over the last five years.

How will the study be carried out?

If you agree to take part in the study, you will be invited to do one interview with the researcher Amy Tuite. This will be either in person or over the phone depending on your preference. You will be asked to fill out a consent form, which is included in this pack. The list of questions is also included in this pack and the interviewer would go through all forms with you before starting the interview.

Your interview will be voice recorded and transcribed by Amy Tuite. Once your interview has been transcribed your recording will be deleted. The written transcript will then be analysed and a list of the main themes that came up will be made, an example of a theme could be 'increased player confidence'. This list of themes will then be written into a letter and posted or emailed to you, depending on your preference.

The themes from your interview will be used as the study results. The transcript of your interview will be kept on file for a period of five years to allow the research to be published, which will take about two years, and for you to access it again if you wish. This research will also be used for an academic qualification by Amy Tuite. If at any time you decide you no longer want some or all your information included in the research, please contact Amy Tuite and your information will be no longer be used in the study.

What are the benefits?

You will not benefit directly from your participation in this study. However this study may allow those designing and organising the 'Kickstart to Recovery Programme' to improve the football programme for future service users.

What are the risks?

There are minimal risks associated with this study. Researchers will aim to prevent any unlikely distress or discomfort, however if you become upset during the interviews you will be offered to take a break or stop the interview if you wish. You can decide if you want your interview to be used in the research or not at that time or you can change or remove your information anytime in the future. You are free to withdraw from the study anytime without incurring any penalties or benefits you had before entering the study.

Will it cost me anything to take part?

There is no cost involved in being a participant of this research.

Is the study confidential?

Yes your identity will remain confidential. Your name will not be published and will not be disclosed to anyone but the interviewing researcher Amy Tuite. You will be assigned a number which will replace your name on your transcribed interview, thus keeping it confidential. The study is also covered by insurance from Trinity College Dublin and the HSE.

Where can I get further information?

If you have any further questions about the study now or at any time in the future, please contact us on the details below. Please also contact us if you would like to express an interest in taking part in the study before April 1st.

Amy Tuite

Occupational Therapy Masters student

Trinity College Dublin

Phone: 089 490 4809 between 9-5 Tuesday to Thursday.

Email: tuiteam@tcd.ie

COACH/ FAI STAFF INTERVIEW QUESTIONS

Q1: Why did you get involved with the group and what are the main values of the programme?

Q2: What do you think the benefits of playing football are compared to another sport/ type of exercise in the community?

Q3: How is the group you're involved with tailored to the recovery of the service users involved?

Q4: Have you observed any changes in the participants involved in the group? If so, do you think these changes impact everyday life outside the group?

Q5: Is there anything you did/ would do in the group to encourage/ support the engagement of participants in the group? What do you strive to make participants feel/ experience during the group and why?

Q6: What challenges are provided to participants and how do they meet these?

COACH AND FAI STAFF CONSENT FORM

PROJECT TITLE: A Stakeholders Perspective on the 'Kickstart to Recovery Football Programme' in a community mental health service.

RESEARCHER: Amy Tuite

Please go through the list below carefully before signing this form:

I have read and understood the Information Leaflet**.**	**Yes** ☐	**No** ☐
I have been given a copy of all forms for my records.	**Yes** ☐	**No** ☐
I agree to take part in one interview for max 1 hour.	**Yes** ☐	**No** ☐
I agree for my interview to be voice recorded and transcribed.	**Yes** ☐	**No** ☐
I understand that I don't have to take part and can opt out at any time.	**Yes** ☐	**No** ☐
I understand that I don't have to give a reason for opting out and my future involvement with the Mental Health Services or 'Kickstart to Recovery Programme' won't be affected.	**Yes** ☐	**No** ☐
I am aware of the potential risks of this research study.	**Yes** ☐	**No** ☐
How my information will be kept and processed has been explained to me.	**Yes** ☐	**No** ☐

I consent for my data to be analysed and kept for a period of five years.	**Yes ☒**	**No ☐**
I am aware that this study will be published and used for academic qualification.	**Yes ☐**	**No ☐**

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: ……..

CONTACT DETAILS: ……..

PARTICIPANT'S SIGNATURE: ……..

Date:……..

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S

SIGNATURE:…… Date:……

7.4.5. Participant information leaflet footballers

Footballer Information Leaflet

Study title: A Stakeholders Perspective on the 'Kickstart to Recovery' Football Programme in a community adult mental health service.

Researcher Name: Amy Tuite

Telephone number of Researcher: 089 490 4809

Email of the Researcher tuiteam@tcd.ie

Research Supervisor Name: Dr. Clodagh Nolan

You are being invited to take part in a research study to be carried out at the Louth/Meath Mental Health Services. You are being invited because you are due to start the next programme starting in January 2019. Before you decide whether or not you wish to take part, you should read the information provided below carefully. Don't feel rushed and don't feel under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'. You don't have to take part in this study and a decision not to take part will not affect your future involvement in the Louth/Meath Mental Health Services or place on the 'Kickstart to Recovery' Programme.

You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out. You don't have to give us a reason. If you do opt out, rest assured it won't affect the quality of the services you get in the Louth/Meath Mental Health Services in the future or place on the 'Kickstart to Recovery' Programme.

Why is this study being done?

This research aims to find out whether or not the 'Kickstart to Recovery' model is connecting service users to their community, supporting the mental health recovery of service users and to find out the experiences of staff working with service users involved in the programme. We would like to ask you whether or not the importance of leisure to you and your confidence in your recovery journey has changed and whether or not your expectations for the group were met.

It is hoped that the outcomes of this study will enable the programme facilitators to improve the football programme to meet the needs of future mental health service users.

Why am I being asked to take part?

You are being asked to take part in this study as you are a footballer within the Kickstart to Recovery Programme.

How will the study be carried out?

If you agree to take part in the study, you will be invited to do one interview with the researcher Amy Tuite. This will either be in person or over the phone depending on your preference. If in person they will take place in the HSE Louth/Meath Community Mental Health Services clinic that you attend. You will also be asked to fill out a consent form, which is included in this pack. The list of questions for both interviews are also included in this pack and the interviewer would discuss through all forms with you before starting the interview.

The interview will be a maximum of 1 hour long and will be voice recorded and typed up by Amy Tuite. Once your interview has been typed up your recording will be deleted. Your interview will then be looked at and a list of the main themes that came up will be made. An example of a theme could be 'improved physical fitness'. This list of themes will then be written into a letter and given to you by the occupational therapist at your clinic, posted or sent via email, whichever you prefer. These themes will then be used as the study results and published.

The typed version of your interview will be kept on file for a period of five years to allow the research to be published, which may take about two years, and for you to access it again if you wish. This study is also being used by Amy Tuite for academic qualification. If at any time you decide you no longer want some or all your information included in the research, please contact Amy Tuite on the number provided and your information will no longer be used.

What are the benefits?

You will not benefit directly from your participation in this study. However this study may allow those designing and organising the 'Kickstart to Recovery Programme' to improve the football programme for future players.

What are the risks?

There are minimal risks associated with this study. Researchers will aim to prevent any unlikely distress or discomfort, however if you become upset during the interviews you will be offered to take a break or stop the interview if you wish. You will also be put in contact with your mental health team. You can decide if you want your interview to be used in the research or not at that time or you can change or remove your information anytime in the future. You are free to withdraw from the study anytime without incurring any penalties or benefits you had before entering the study. If you are a woman of childbearing age and think you may be pregnant while taking part in the programme, please contact your GP immediately to make sure you are safe to continue.

Will it cost me anything to take part?

Any transport costs that you have to attend appointments at the community mental health clinic may apply for this research. There are no other costs involved.

Is the study confidential?

Yes your identity will remain confidential. Your name will not be published and will not be disclosed to anyone but the interviewing researcher Amy Tuite. You will be assigned a number

which will replace your name on your typed up interview, thus keeping it confidential. The study is also covered by insurance from Trinity College Dublin and the HSE.

Where can I get further information?

If you have any further questions about the study now or at any time in the future, please contact us on the details below. Please also contact us if you would like to express an interest in taking part in the study at least one week before your last group session.

Amy Tuite

Occupational Therapy Masters student

Trinity College Dublin

Phone: 089 490 4809 between 9-5 Tuesday to Friday.

Email: tuiteam@tcd.ie

FOOTBALLER INTERVIEW QUESTIONS

Q1: What does football mean to you now having completed this programme? How important was this group to you? On a scale of 1-10 how good do you think you are at football? How fit are you?

Q2: Did you play football before the group/ do you play outside the group? If not do you think going forward you'll engage in football in the community?

Q3: Are you using community resources now? If so can you discuss this? If not why not?

Q4: Have you noticed any changes in your ability to manage your physical or mental health since starting the group? If so can you tell me about that?

Q5: What were the challenges you encountered whilst participating in the group and how did you meet them?

Q6: What was your goal for the group? Did you meet it? Did you think the group was facilitated in the best way for you to meet your goal? Have you set new goals?

FOOTBALLER CONSENT FORM

PROJECT TITLE: A Stakeholders Perspective on the 'Kickstart to Recovery Football Programme' in a community mental health service.

RESEARCHER: Amy Tuite

Please go through the list below carefully before signing this form:

I have read and understood the Information Leaflet**.**	**Yes** ☐	**No** ☐
I have been given a copy of all forms for my records.	**Yes** ☐	**No** ☐
I agree to take part in an interview for max 1 hour within the last two weeks of the programme.	**Yes** ☐	**No** ☐
I agree for my interview to be voice recorded and typed up.	**Yes** ☐	**No** ☐
I understand that I don't have to take part and can opt out at any time.	**Yes** ☐	**No** ☐
I understand that I don't have to give a reason for opting out and my future involvement with the Louth/Meath Mental Health Services or 'Kickstart to Recovery Programme' won't be affected.	**Yes** ☐	**No** ☐
I am aware of the potential risks of this research study outlined in the PIL.	**Yes** ☐	**No** ☐
How my information will be kept and processed has been explained to me.	**Yes** ☐	**No** ☐
I consent for my data to be analysed and kept for a period of five years.	**Yes** ☐	**No** ☐

I am aware that this study will be published and used for academic qualification.	**Yes** ☐	**No** ☐

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: ……

CONTACT DETAILS: ……..

PARTICIPANT'S SIGNATURE: ……..

Date:……..

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S

SIGNATURE:…… Date:……

7.5. Codes for each group

Table 19: Footballer code table

No.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FC1	Fun and social interaction were the best things about Kickstart.	8	Medium	Medium
FC2	Social environment enablers to engagement.	20	High	High
FC3	Benefit of staff taking part in group.	15	Medium	Medium
FC4	Physical environment enablers to engagement.	10	High	High
FC5	Barriers to community football.	9	High	High
FC6	Group supports footballers of different abilities in sessions.	19	High	High
FC7	Footballers engaged in Kickstart despite concerns/ challenges.	12	High	High
FC8	Benefit of staff treating footballers like footballers.	9	Medium	Medium
FC9	Impact of FAI being involved in programme.	10	Low	Medium
FC10	Footballer experience of session impacted by group numbers.	16	Medium	High

No.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FC11	Coach adapts session for low numbers.	4	Low	Medium
FC12	Suggested numbers needed for sessions.	5	Low	Medium
FC13	Suggestions of what to do if numbers are low.	15	Low	Medium
FC14	Feedback on current group structure.	12	Low	Medium
FC15	Suggestions on how to improve group structure.	18	Medium	High
FC16	Physical changes experienced.	8	High	High
FC17	Mental health changes experienced.	16	High	High
FC18	Importance of coach challenging participants in the session.	17	High	High
FC19	Interest in football is a bonus not a requirement	8	High	High
FC20	Group was accessible for footballers.	10	High	High
FC21	Footballers made health conscious changes outside of the group.	9	High	High
FC22	Level of competition in the group was positive.	3	Medium	Medium

No.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FC23	Barriers to engagement in Kickstart/ services.	6	High	High
FC24	Group increased footballer interest and enjoyment of football.	5	High	High
FC25	Group positively influenced social interactions outside of the group.	8	High	High
FC26	Group impacted the community engagement of footballers.	19	High	High
FC27	Social interaction/ support between footballers in sessions.	36	High	High
FC28	Experience of accessibility of local community.	17	High	High
FC29	Experience of accessibility of mental health clinic.	8	Medium	Medium
FC30	Importance of community-based support in mental health.	6	High	High
FC31	Personal enablers to engagement.	10	Medium	High
FC32	Importance of OT being present.	5	Medium	High
FC33	Playing football in itself has physical and mental health benefits.	38	High	High
FC34	Footballer feedback on goal achievement.	14	High	High

No.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FC35	Learning about football was the best thing about the group.	2	Medium	Medium
FC36	Importance of fun and enjoyment.	4	High	High
FC37	Players were immersed during sessions.	11	High	High

Table 20: FAI coach code table

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FAI1	Coaches not having mental health training is a positive.	3	Low	Medium
FAI2	Kickstart sessions are run like any community sport session.	6	High	High
FAI3	Coaches didn't need mental health training to carry out sessions.	2	Low	Medium
FAI4	Importance of experienced coaches doing the programme.	6	Medium	High
FAI5	Benefit of treating service users like footballers and not focusing on issues, giving responsibility.	27	High	High
FAI6	OT is needed to support mental health needs of players.	8	Medium	High
FAI7	Football is a mental health intervention without having a mental health focus.	3	High	High
FAI8	Flexibility to accommodate abilities of people in the group.	23	High	High
FAI9	Flexibility to accommodate people with different leisure interests.	18	High	High
FAI10	Treating people like footballers offers them an escape.	1	High	High
FAI11	Footballers experienced increased confidence through activities.	20	High	High

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FAI12	Footballers experienced sense of achievement through activities.	10	High	High
FAI13	Group alone is unlikely to improve fitness.	4	Medium	High
FAI14	Skills learned in group can be used outside of group.	9	High	Medium
FAI15	Experience of ‘feel good’ endorphins.	4	Medium	Low
FAI16	Social support and connection between players.	21	High	High
FAI17	Facilitating fun and enjoyment is the priority.	18	High	High
FAI18	Few people don’t come back after the first try.	2	High	Medium
FAI19	Group has little barriers for service users getting engaged.	2	High	High
FAI20	Football is an accessible activity.	10	High	High
FAI21	Low numbers limits activity variation.	1	Medium	Medium
FAI22	Low numbers makes sessions more physically strenuous.	1	Medium	Medium
FAI23	More than six participants needed for a worthwhile session.	2	Medium	Medium

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FAI24	Low numbers can reduce fun and cause boredom.	1	Medium	Medium
FAI25	Low numbers makes facilitating the group challenging for the coach.	3	Medium	Medium
FAI26	A mixed programme may not be accessible for all participants.	6	High	High
FAI27	A mixed programme may be accessible for some participants.	6	High	High
FAI28	Having the OT at the group creates a safe and relaxed environment.	3	Medium	Medium
FAI29	All participants being from the mental health service creates sense of safety and connection.	3	High	Medium
FAI30	Other options and opportunities should be combined with Kickstart.	7	Medium	High
FAI31	The group content/ approach should be adapted to meet participant needs.	18	High	High
FAI32	Interest in football is a bonus not a requirement.	10	High	High
FAI33	Those with no football history benefit from the group.	15	High	High
FAI35	Football is a varied sport.	5	High	Medium
FAI36	Football is about inclusion not competition.	8	Medium	Medium

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FAI37	Language influences group atmosphere.	2	Medium	High
FAI38	Gym requires the person to be motivated.	4	Low	Low
FAI39	Importance of venue being locally used.	7	High	High
FAI40	Importance of venue being fit for purpose.	1	High	High
FAI41	OT provides support/ information to the coach.	11	Medium	High
FAI42	Physical benefits	8	High	High
FAI44	Re-engagement in group results in more pronounced physical and mental changes.	3	High	High
FAI45	Improved social skills.	23	High	High
FAI46	People valued the group and didn't want to miss sessions/ wanted to come back.	11	High	High
FAI47	Participation in the group encouraged people to get involved more in community activity.	15	High	High
FAI48	Group members forming friendships.	2	High	High
FAI49	Group works and therefore contributes to low numbers issue.	4	Medium	High

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FAI50	OTs encourage participants to move on from group.	1	High	High
FAI51	Coach providing additional opportunities for activity engagement.	10	High	High
FAI52	Footballers' support network and skillset will impact engagement success.	7	High	High
FAI53	Competition should not be a part of Kickstart.	2	Medium	Medium
FAI54	Group breaks are times of control and social interaction.	3	Medium	Medium
FAI55	Importance of choice and control for footballers.	6	High	High
FAI56	Importance of flexibility in group structure to meet needs of groups.	16	High	High
FAI57	Gap can negatively impact players.	12	High	High
FAI58	Challenges of current structure for coaches.	8	High	High
FAI59	Barriers to people engaging in Kickstart.	9	High	High
FAI60	Importance of being open minded and willing to adapt session on the day.	8	High	High
FAI61	Group could benefit more people.	5	High	High

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
FAI62	Group engagement encourages people to engage in positive/ healthy behaviour.	21	High	High
FAI63	Competition provides opportunities for Kickstart players.	7	Medium	Medium
FAI64	Barriers to community sport.	5	High	High
FAI65	Importance of success and just right challenge.	16	High	High
FAI66	Group is a medium for facilitators to educate players.	15	Medium	High
FAI67	Importance of OT being actively involved in session.	7	Medium	Medium
FAI68	Group engagement allowed players to reduce medication.	1	High	High

Table 21: Healthcare professional code table

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
HPC1	Feedback for the group is positive overall.	5	Low	Medium
HPC3	People are encouraged not pushed to get involved.	4	Medium	Medium
HPC4	Engagement in Kickstart gave people opportunities for positive change.	14	High	High
HPC5	Kickstart was important to players.	5	High	High
HPC6	Participants engaged in Kickstart for socialisation.	7	Medium	Medium
HPC7	Participants made social connections/ friendships with other players.	12	High	High
HPC8	Physical changes/ benefits observed.	16	High	High
HPC9	The importance of the group setting/ facility and FAI partnership.	19	High	High
HPC10	Players like that facilitators are positive and friendly.	4	High	Medium
HPC11	Positive impact of players having control and choice in the group.	5	High	High
HPC12	Group is supportive of players with different engagement abilities.	10	High	High
HPC13	Group engagement allows professionals to see a different side to participants.	11	Low	Medium

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
HPC14	Physical health issues can be a barrier to Kickstart engagement.	5	Medium	Medium
HPC15	Players who have physical health issues get supported by medical staff.	4	Medium	Medium
HPC16	Those who don't plan to continue with football still enjoy the group.	1	Medium	Low
HPC18	Group allows people engage for as long as they need/ want to.	3	High	Medium
HPC19	Facilitators support the abilities and health of players in the group.	4	High	High
HPC20	Barriers to community sports programmes.	16	High	Medium
HPC21	Service users are referred for physical reasons.	11	Low	Medium
HPC22	Kickstart is the link between the clinic and the community.	18	High	High
HPC23	Having a group with other service users supports the engagement of footballers.	10	High	Medium
HPC24	Kickstart has spin off for positive change in other areas of footballers' lives.	29	High	High
HPC25	Footballers are encouraged to have social connections outside of Kickstart.	1	Medium	High
HPC26	Social connections made in group supported community involvement.	6	High	High

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
HPC27	Challenges for participants to make social or community connections.	6	High	High
HPC28	Timing of referral to the group is important.	17	High	High
HPC29	Personal reasons service users didn't engage in Kickstart.	29	High	Medium
HPC30	Interest/ history of football is not a requirement but an enabler.	12	Medium	Medium
HPC31	Group is suitable for people of all abilities.	15	High	High
HPC32	Enablers to people engaging in Kickstart.	14	High	High
HPC33	Group environment is supportive of abilities and interests.	16	High	High
HPC34	Group allows education and awareness of healthy habits.	4	Medium	High
HPC35	Mental health changes observed	22	High	High
HPC36	Group engagement allows footballers an escape from difficulties.	26	High	High
HPC37	Staff work on overcoming barriers to group engagement.	31	High	High
HPC38	Considerations when recruiting participants.	6	Low	Medium

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
HPC39	Positives of having a group break.	13	Low	High
HPC40	Benefits of a three-four week break.	6	Low	High
HPC41	Benefit of having OT involved.	17	Medium	Medium
HPC42	Benefits of staff playing, importance of staff being involved.	8	Medium	Medium
HPC43	Engagement in Kickstart supports the work of other professionals/ the team.	26	Medium	High
HPC44	Opportunities unique to team sport/ Kickstart.	16	Medium	Medium
HPC45	Suggestions for group adaptations/ additions to help engagement.	15	Medium	High
HPC46	Service users referred for social reasons.	11	High	High
HPC47	Activity/ environmental reasons service users didn’t engage in Kickstart.	10	Medium	High
HPC48	Benefit of seasonal approach to breaks.	2	Low	Medium

Table 22: Occupational therapist facilitator code table

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
OTC1	Group was facilitated as it met the needs of the client group.	3	Low	Low
OTC2	Kickstart gives footballers opportunity for social interaction/ connection.	34	High	High
OTC3	Kickstart gives footballers opportunity for physical activity/ changes.	23	High	High
OTC4	Kickstart provides opportunity for positive mental health changes.	30	High	High
OTC5	Kickstart is a medium of educating clients of positive health behaviours.	23	Medium	High
OTC6	Kickstart was important to footballers.	18	High	Medium
OTC7	History/ interest in football is not a requirement but an enabler	7	High	High
OTC8	Facilitators working with participants to remove barriers.	15	High	High
OTC9	Personal barriers to engagement.	20	High	High
OTC10	Activity/ environmental barriers to engagement.	27	High	High
OTC11	All levels of interest and abilities are accommodated.	37	High	High
OTC12	Footballers were encouraged to engage in activities outside Kickstart.	8	High	High

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
OTC13	Social connections made in group supported engagement.	10	High	High
OTC14	Additions/ adaptations to group structure	24	Medium	High
OTC16	Engagement in Kickstart supported community engagement.	16	High	High
OTC17	Challenges for facilitators.	41	Medium	High
OTC18	Barriers in community sport/ groups.	50	High	High
OTC19	Barriers in general community environments.	3	High	Medium
OTC20	Feedback on break/ gap	13	Medium	Medium
OTC21	Positives of eight week structure.	11	Medium	Medium
OTC22	Suggestions for alternative structure.	30	Medium	High
OTC23	Kickstart engagement supported the work of other team members.	13	Medium	High
OTC24	Suggestions on how to handle low numbers.	13	Medium	Medium
OTC25	Enablers for engagement.	8	High	High

NO.	CODE	PREVALENCE	THEORETICAL RELEVANCE	QUESTION RELEVANCE
OTC26	Positive changes in habits as a spin off.	11	High	High
OTC27	Importance of flexibility and normalcy in sessions.	11	High	High
OTC28	Benefits of staff playing/ being involved.	20	Medium	Medium
OTC29	Workload of Kickstart.	18	Medium	High
OTC30	Environmental enablers to engagement.	18	High	High
OTC31	Skills participants gained from the group.	21	High	High
OTC32	Feedback on competition and blitzes.	8	Medium	Medium
OTC33	Value of FAI coach being involved.	19	Low	High

7.6. Transcript sample – initial coding (coach)

INT: Yeah. And what physical changes have you observed in people while being in the group?

FAIC: Physical?

INT: Yeah. I suppose you said earlier it's not really about that.

FAIC: It's not, not for me. There's such a different profile in the participants so you'll have participants who are physically fit. You'll have participants who have done nothing for years. I've seen participants suffering from forms of agoraphobia and couldn't leave the house and it was the only thing they'd do was come to the group. So physically I suppose I've noticed, you know, generally across the board increased balance. Certainly a bit of weight loss. Lung capacity and you know general fitness will be better. I think they're the basics that I'd see in every participant. Thoughts: This coach mentioned earlier that the one hour a week for the purpose of confidence building and entertainment isn't sufficient to carry out major physical changes. Some changes observed here. Code 42, code 43. And then after that you'll see different ones you know you'll see you know maybe dramatic weight loss or someone who is seriously overweight maybe over the period of a year or two. Thoughts: Period of a year or two, so not the 8 week structure. People would need to be in a service where they can reengage for that time, if they can't would that be a barrier? Important for services to be flexible to the needs of the people they have at the time? Code 44. You know they're the physical differences. I'm not, again when I'm not trying to create athletes and you know, it's only one hour a week. But certainly you know balance, general fitness has improved with anyone that sticks with the programme. Thoughts: Focus of the group is not the physical health side, physical health changes are maybe something that needs to be encouraged more outside the group then? Code 13. Code 43. There's a lot of, I see a lot of benefits away from the physical side. So you will see confidence you'll see quiet people open up and be a lot more talkative to everybody around them. Things like that. But physically just the basics of balance and physical fitness mainly. Thoughts: Confidence being mentioned again, a lot of confidence references, the most important/ strongest mental health benefit? Code 45. Code 5. Code 43

7.7. Sample participant code letter

Amy Tuite

MSc. Student

Discipline of Occupational Therapy

Trinity Centre for Health Sciences

St. James' Hospital

James' Street

Dublin 8

089 4904809

tuiteam@tcd.ie

Dear (NAME),

I hope you're well. This letter is to provide information on how your interview was used to create the results for the study titled "A Stakeholders Perspective on the 'Kickstart 2 Recovery Football Programme' in a community mental health service."

Firstly, I would like to sincerely thank you for giving up your free time to take part. Your interview was invaluable to the study being a success and I'm very grateful.

Secondly I will explain how your interview was read and coded to form the study results. The MP3 recording of your interview was written up into text format by myself and was then deleted. I then read through the document and attached labels to different things you said to summarise them, for example:

The quote: "I don't think there's any barriers I think the coaches are very balanced in the way they treat everybody."

Would be given the code of: ‘Impact of FAI being involved in programme.’

The full list of codes from your interview are as follows:

Kickstart sessions are run like any community sport session.

Benefit of treating service users like footballers and not focusing on issues, giving responsibility.

Flexibility to accommodate abilities of people in the group.

Flexibility to accommodate people with different leisure interests.

Footballers experienced increased confidence through activities.

Footballers experienced sense of achievement through activities.

Skills learned in group can be used outside of group.

Social support and connection between players.

Facilitating fun and enjoyment is the priority.

Importance of venue being locally used.

Importance of venue being fit for purpose.

Physical benefits.

Improved social skills.

Importance of OT being actively involved in session.

Importance of flexibility in group structure to meet needs of groups.

Challenges of current structure for coaches.

Group could benefit more people.

Importance of success and just right challenge.

Competition provides opportunities for Kickstart players.

We did not ask you for any personal information related to your age, gender or work setting. You did offer what you were comfortable including in the interview about your personal circumstances and I have included a copy here for your information as to how we treated this data.

Time coaching programme	Other experience/ training	Urban/ rural	Location
Four years	Not currently coaching.	Urban and rural	East Leinster

At interview you decided you did not want a written copy of your interview. However if you would like a copy of this in the future, or you would like any of your information changed or removed from the study completely, please feel free to contact me on the email address or phone number provided in this letter. The phone number will no longer be in use after September 30th 2019 so please contact me by email if you would like to make changes after this date. Your contact details will be deleted after this date. Further information on how your information will be stored is provided on the GDPR information sheet included with this letter. If you have any questions about this information please feel free to contact me.

Finally, I would like to again sincerely thank you for being involved in this study. It is hoped the information will help the programme designers and staff to improve the programme for future footballers. We are also hoping to hold an event to present the research findings and would love for you to attend. If this event is taking place we will contact you with an invitation.

Thank for your time and participation and I wish you all the best in the future.

Kind regards,

Amy Tuite

Amy Tuite

7.8. Audit trail extract

DATE	*ACTION*	*CONTENT*	*RESPONDING ACTION*
13/3/19	Meeting with Ashbourne football group	Researcher was approached by two service users. One requested a phone call interview and the other requested face to face. Consent forms signed and given to Ashbourne OT to lock in office. PILs and interview questions provided to one participant who could not find his copy at home. Other participant stated he had the information and knew what the study involved. Approached by coach who gave phone number and wants to be contacted next week RE study.	Contact participants on days requested on consent forms to arrange interviews. Contact coach on agreed day next week.
14/3/19	Meeting with Navan football group	Approached by two footballers who wanted to do face to face interviews. Appointments made for next week. Footballers requested if researcher could contact them to confirm. Consent forms secured in Navan service building.	Contact footballers to confirm appointments.
19/3/19	Participant contacts	Phone calls made to coaches who received PILs and footballers who approached researcher. Four coaches confirmed appointments for this week. Three footballers confirmed appointments in next two weeks.	Conduct interviews.
20/3/19	INTERVIEWS Phone call to another coach Consent forms and recordings	Two coach interviews One service user interview Stated they don't want their transcripts. Stated he is on leave for a week. Requested to be contacted on 1/4/19 Consent forms and recordings secured in college office in PM.	Secure consent forms in service sites Transfer recordings to Trinity computer and password protect Provide codes. Call and book interview appointment for coach on 1/4/19
21/3/19	INTERVIEWS	One coach interview. Stated he does	Secure consent form

		not want his transcript.	Transfer recording to Trinity computer and password protect Provide codes.
		Second coach cancelled. Requested to reschedule next week.	Contact coach on 25/3/19.
	Consent forms and recordings	Secured in office in PM.	
25/3/19	INTERVIEWS	Footballer phone call interview. Stated he does not want his transcript. Footballer interview - did not attend. Lost from study. Health professional interview. Does not want transcript.	Provide codes.
	Consent forms and recordings	Consent form from phone call provided to OT. Staff consent forms and recordings secured in college office in PM.	
26/3/19	INTERVIEWS	Coach interview. Footballer interview. Stated they did not want their transcripts.	Provide codes.
	Consent forms and recordings	Secured in college office in PM. Footballer consent form remained in health centre.	
27/3/19	Supervision	Discussed interviews and chapter writing. Agreed transcription, preliminary coding and methodology are priority for next three weeks. Discussed AOTI recruitment appeal and impact on study. Advised student that AOTI staff can be be a fourth participant group and should be accessed. Asked should conditions be mentioned if the study is using a social model of disability. Supervisor states this should be mentioned but not focused on.	Transcription, methodology and coding. Don't withdraw AOTI recruitment. Mention conditions when doing results but focus on issues described by participants that occupational engagement addressed.