

**“The ‘Kickstart to Recovery’ programme; a quantitative
evaluation of a football programme for mental health service
users in an Irish context.”**



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College, in total fulfilment of the requirements for the Degree of Master of Science
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Summary

In recent years there has been an increased use of football as an intervention for individuals with mental health challenges. The 'Kickstart to Recovery' programme is an Irish football-based mental health service intervention. It is a collaboration between HSE mental health occupational therapy and the Football Association of Ireland, which provides a community-based programme aimed to provide both social and physical activity opportunities.

The aim of this study was to investigate if participants of the 'Kickstart to Recovery' programme experienced a change after participating in the football programme.

In order to achieve this aim, a pre-post study design with quantitative analysis was used. The study objectives were drawn from a combination of a literature review and examination of the current study aims. An appropriate standardised assessment was sourced to measure change for each objective.

Study Objectives:

1. To measure change in the quality of life of mental health service users who participate in the 'Kickstart to Recovery' programme. This is measured by the Short Form 36 (SF-36) (Ware & Sherbourne, 1992)
2. To measure change in self-reported mental health recovery of mental health service users who participate in the 'Kickstart to Recovery' programme. This is measured by the Recovery Assessment Scale – Domain and Stages (RAS-DS) (Hancock et al., 2015).
3. To measure if participants experience change in the personal meaning of football after participating in the 'Kickstart to Recovery' programme. This is measured by the Engagement in Meaningful Activities Survey (EMAS), adapted with permission for football (Goldberg, Britnell & Goldberg, 2002).
4. To measure if participants experience social gains after participating in the 'Kickstart to Recovery' programme. In order to increase the accessibility of the questionnaire and reduce repetition, social gains are measured by isolating the domains of 'Social Functioning' of the SF-36 and 'Connecting and Belonging' of the RAS-DS.

This study obtained ethical approval from three HSE Research Ethics Committee Boards (HSE North-East, HSE South-East and U.L. Hospital Groups) and from Trinity College Dublin Research Ethics Committee Board. Data collection was conducted in seven different sites with a considerable geographical variance. From these sites, 40 participants were recruited at pre-test stage, with 27 of these completing the post-test questionnaire.

Descriptive statistics and inferential statistics were carried out on the data set using SPSS.

Two statistically significant improved results emerged from pre-test/ post-test comparison. These included the SF-36 domain of 'Energy/Fatigue' for the total sample and RAS-DS domain of 'Mastering My Illness' for the participants who completed the programme for the first time. Domains of 'Emotional Well-being' and 'Social Functioning' of the SF-36 also found statistically significant differences in comparing post-test scores for groups that had a social aspect imbedded in the session, to those that did not.

As it was not possible to implement a control in the study design, it is acknowledged that the 'Kickstart to Recovery' programme may only be attributed as a factor that contributed to the outcomes.

These results, however, provide valuable indications of the programme's benefits. Key findings include improved energy levels throughout participation in the football programme, the development of mental health symptom management in the early stage of joining the programme and improvements in social functioning and emotional well-being when a social aspect is included in the session's structure.

Results that did not have statistical significance also provide valuable information. The high scoring and lack of significant change for the EMAS indicates that participants value football prior to entering the programme and perhaps is the reason for joining. Other areas that showed no significant changes after participation in the programme indicate areas that require more attention and support. These include the development of hope, an important element of recovery, domains of quality of life, including both mental and physical health aspects, and social gains, for both the maintenance of current social functioning and development of new connections.

In addition to these results, this research focused on the structural aspects of the 'Kickstart to Recovery' programme and through review of the current literature, identified areas that may improve the outcomes for service users. Community integration, gender focus and recovery stage were elements identified as requiring more emphasis and structural reform.

Limitations of this study, in addition to the absence of a control group, a small sample size, unequal distribution of the sample among different sites and challenges in conducting research in 'real-life' settings. This study concludes with recommendations to advance current practice and areas that would benefit from further research.

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Chapter One: Introduction

1.1. Introduction

Mental health services in Ireland have undergone dramatic reform. With a history of large mental health hospitals and asylums, by the 1950s Ireland held the record for the highest use of psychiatric inpatient beds per head of population internationally (Brendan, 2014). Numbers in inpatient settings decreased by 82% from 1963 to 2003, following drastic changes in the domains of social, economic and human rights in Ireland and internationally (Kelly, 2007).

This change shaped our current mental health services. 90% of mental health problems are supported at primary care level and less than 10% in community mental health centres. Those remaining, at less than 1%, who require higher levels of support avail of inpatient mental health services (HSE, 2018). Within this new mental health service landscape, there is an emphasis on using existing resources based in the community, in line with the Recovery Movement (Mental Health Reform, 2015). This, however, will require new initiatives and evidence-based practice to meet the needs of service users.

1.2. Physical Activity and Mental Health

There is growing evidence in the field of mental health supporting physical activity for mental health service users, emphasised at government level through policies and frameworks. This includes '*Healthy Ireland*' (Department of Health, 2013), which aims to promote physical activity for vulnerable populations, '*A Vision for Change*' (Government of Ireland, 2006) which acknowledges the benefits of team or sports memberships and a number of other policy changes.

Recent research by Matthews and colleagues (2018) found that 72% of individuals with mental health challenges in Ireland did not meet recommended physical activity guidelines. The population of mental health service users also experience a significantly reduced life expectancy of approximately 15 years (Chang, et al., 2011; Lawrence, Hancock, Kisely, 2013), with cardiovascular issues presenting as one of the primary causes of these premature deaths (Vancampfort et al., 2017). Additionally, cardiovascular risk factors, including obesity, hypertriglyceridaemia, hypertension, glucose dysregulation such as diabetes, are common amongst people with mental health

illness (Gardner-Sood et al., 2015). The prevalence of these risk factors and higher mortality rates are closely associated with sedentary lifestyles (Gardner-Sood et al., 2015).

Physical activity is shown not only to counteract the risks of a sedentary lifestyle, but also brings additional benefits. For people with mental health challenges these benefits include improvements in cognitive functioning (Firth et al., 2017), management of positive and negative symptoms associated with psychotic spectrum disorder (Firth, Cotter, Elliott, French & Yung, 2015), mood, concentration and sleep patterns (Alexandratos, Barnett & Thomas, 2012). Sport, a specific form of physical activity that often includes interactions with others, can provide recovery-oriented benefits, such as social interaction and building a sense of self (Carless & Douglas, 2008).

Overcoming barriers, such as motivation and lack of time for participation in physical activity can be challenging for the general population (Taylor, 2017). For those with mental health difficulties additional barriers of low mood, stress and lack of support add to these pre-existing challenges (Firth et al., 2016). For people with mental health challenges, the primary motivators for engagement in physical activity have been found to be improvement in fitness and having an interest or enjoyment in the activity (Rebar & Taylor, 2017).

1.2.1. Occupational Therapy and Physical Activity

The national mental health policy, '*A Vision for Change; Report of the Expert Group on Mental Health Policy*' recommends that each mental health team should have input from occupational therapy (Mental Health Reform, 2015). Occupational therapists on mental health teams are recognised as providing a unique perspective of service users as occupational beings and having the skills to facilitate personal goal setting with service users (Brangan, 2009).

In Ireland, there is currently no mental health professional within the multidisciplinary team responsible for the promotion and delivery of physical activity interventions (Matthews, Cowman & Denieffe, 2018). Occupational therapists are suitably positioned in mental health services to bridge this gap and promote physical activity promotion, not only from understanding the health benefits highlighted above but also from an occupational approach to participation and engagement (Cole, 2014).

Occupational therapy's understanding of the difference between 'participating in' an activity and 'engaging in' an occupation has the potential to influence how physical activity interventions are approached in mental health services. Participating in an activity does not necessarily hold significant meaning for a person, as it may be valued or expected in society (Cole, 2014). Engagement, however, requires meaning and value in the action for it to be classified as an occupation (Creek, 2014). A critical aspect to client-centred practice is understanding the meaning one attributes to and takes from their involvement in physical activity, which an occupational therapy approach aims to obtain (Cole, 2014).

It is emphasised that occupational therapists should focus on evidence-based practice in mental health services in order to bring to the forefront the effectiveness of interventions (Lloyd & Williams, 2009). While occupational therapists have the potential to develop the evidence-based practice of physical activity in mental health services in their own domain, the drive for developing collaborations between mental health services and community resources at national policy level allows for a different, more community-based approach to be adopted (Mental Health Reform, 2015). Football may be an opportunity to further develop this.

1.3. Football in Ireland, the FAI and Football for All

A recent international survey conducted by Nielsen Sports found that 43% of the general population had an interest in football (The Nielsen Company, 2018). This popularity is emphasised further by Hulteen and colleagues (2017) who found football to be the most popular team sport to engage in as a physical and leisure activity among adults internationally.

In Ireland, football strongly competes with other national sports for popularity, such as hurling and Gaelic football, however it remains the country's most popular team sport (Sports Ireland, 2017). With the strong representation of both Irish men's and women's football teams in international competition and the important infrastructure, such as the Aviva stadium, football provides a symbol of national identity in the Republic of Ireland (Holmens, 2007). At a local level, 450,000 people are involved in football, with the majority of these at a volunteer or amateur level (Football Association of Ireland, 2016).

As Ireland's governing body for football, The Football Association of Ireland (FAI) provides support and resources that aid in fostering this popularity. Established in Dublin

in 1921 and joining the international football community in 1923 following FIFA membership acceptance (Football Association of Ireland, 2009), the FAI has strived to provide opportunities for persons of all ages and abilities in the sport. This is demonstrated through their mission statement;

‘to enable every Irish person to participate in our game, to allow all involved in the game to reach their full potential, whatever level that might be, and to inspire the nation through international success at the highest level’ (FAI, 2016, p.12).

Football’s popularity supports it as an important medium for tackling social issues. In 2002, Jürgen Griesbeck formed ‘Street Football World’, which uses football as a catalyst to connect and empower communities. Within this, ‘Common Goal’ emerged, which asks professional footballers to donate 1% of their salary to support societal change initiatives (Common Goal, n.d.). Discussing the role of football in societal change Griesbeck states;

“Football speaks to many people, it’s sort of a universal language. Young people are attracted to it and motivated to participate regularly and long enough to build a trust base and work on behavior change. It’s only a tool, but it’s a very powerful tool.” (Poulsen, 2018, p.2)

The FAI recognise the powerful ‘tool’ that is football, and in 2002 set about developing a societal initiative of their own- ‘Football for All’. This initiative provides opportunities for participation and engagement in football for those who experience challenges in doing so. An innovative first step in Irish sporting culture, steered by a National Development Coordinator appointed to grow pathways to these programmes. Since its establishment in 2002, ‘Football for All’ has expanded to incorporate a variety of new programmes, including but not limited to football programmes for those with visual impairments, wheelchair users and those with amputations (Football Association of Ireland, n.d.).

While a broad spectrum of opportunities were provided for individuals from physical disability sectors, the FAI had not yet found a pathway to support opportunities for mental health. That was until 2011, when the ‘Kickstart to Recovery’ programme was formed by the FAI and HSE.

1.4. ‘Kickstart to Recovery’ Programme

Mental health support initiatives were highlighted as an area of development by both the FAI and HSE. HSE mental health services required community-based practice that

supported recovery and physical activity, while the FAI sought to expand their 'Football for All' initiative to further populations experiencing disability, including those with mental health challenges. To meet both needs, a collaboration was formed between occupational therapy and the FAI National Development Coordinator. This new relationship led to the development of the 'Kickstart to Recovery' programme, under the original name 'Kickstarting Recovery'.

In 2011, the first pilot 'Kickstart to Recovery' programme was run for four weeks in a single site in Dublin for 8 participants. The success of the pilot led to the expansion of the programme to all North Dublin City Mental Health Services in 2013 (Johnston, Moloney & Jordan, personal communication, 2015). As of 2017, there are 15 programmes running nationally (Football Association of Ireland, 2017).

The 'Kickstart to Recovery' programme structure is outlined in the Louth/Meath Mental Health Service 'Kickstart to Recovery' booklet (Louth/Meath Mental Health Service, personal communication, 2017). This booklet aims to provide a framework for those facilitating the sessions to plan, structure and review the programme. It was formulated using data collected from an internal service audit and is available for consultation by request from the author, Occupational Therapist, Jenny Johnston of the Louth/Meath Mental Health Service. Conducting research on an intervention requires detailed description of the expected format, which in turn provides intervention fidelity, improves reproducibility and ensure that translation into evidence-based practice can be achieved (Slaughter, Hill & Snelgrove-Clarke, 2015; Keen & Otter, 2014; Lloyd & Williams, 2009).

A FAI coach is assigned to a 'Kickstart to Recovery' programme by the National Development Coordinator. Prior to commencing the programme block, the occupational therapist and the FAI coach facilitating the sessions are advised to meet in order to discuss the objectives of the programme, any relevant medical conditions of service users, the importance of confidentiality, structure of the sessions and goals set out by service users (Louth/Meath Mental Health Service, personal communications, 2018).

There are two pathways into the 'Kickstart to Recovery' programme. An individual can self-refer to the programme or be referred by a health care professional from their service. Inclusion is not limited to mental health diagnosis, however to be eligible to partake in the programme, the service user must satisfy the Physical Activity Readiness Questionnaire (PAR-Q) and be given medical clearance from their General Practitioner (GP). Prior to commencing the programme, it is advised that the occupational therapist meet with all participants individually, to discuss their expectations for the programme and to develop goals, using the Goal Attainment Scale (GAS). At the end of the session

block, it is advised that the occupational therapist meets again with each participant to review these goals (Louth/Meath Mental Health Service, personal communications, 2018).

The programme runs for an average of 6 to 8 weeks per block, once a week for one hour. An average of 4 or 5 blocks are completed annually (Johnston, Moloney & Jordan, personal communication, 2015). Each group uses a community-based facility external to the HSE-site, which varies from indoor halls to outdoor pitches and all-weather facilities (Johnston, personal communication, 2018). The sessions are structured on a football framework, which is incorporated in the FAI's coach training outlined in the Coach Training Pathway (FAI, 2017). The sessions may vary with coaches' style of training and service user's needs, however will commonly include a warm up, skill building drills, teambuilding drills, a short match and a cool down.

An emphasis is placed on the active involvement of the occupational therapist in the sessions (Johnston, personal communication, 2018). The occupational therapist's involvement can create co-occupation experiences for service users by providing opportunities for social engagement (Pierce, 2003). From a structural perspective, the occupational therapist's role is also stated to adapt and grade the sessions and activities as appropriate (Moloney & Rohde, 2017).

The 'Kickstart to Recovery' programme booklet outlined the aims of the 'Kickstart to Recovery' programme (Louth/Meath Mental Health Service, personal communication, 2017). These were summarised as follows;

- To promote social gains, such as community integration, reduced social isolation and enhanced social skills through participation in a leisure activity, namely football.
- To promote the benefits of physical activity.
- To promote mental health recovery and improve the quality of life of service users.
- To promote fun and enjoyment in a supportive environment.

To date, one qualitative study by Moloney and Rohde (2017) has been conducted on the 'Kickstart to Recovery' programme. This research, which will be discussed in detail in the following chapter, provides the foundation for the current programme structure and requires additional evidence to support and develop this intervention.

1.5. Outline of this Study

The need for this research was identified by the stakeholders of the 'Kickstart to Recovery' programme, which included the occupational therapists of the HSE and FAI National Development Coordinator, as a lack of evidence for football interventions in Irish mental health services was available to guide their practice.

Furthermore, the use of physical activity and sport as a means of supporting recovery in mental health is a recently developed concept (Faulkner & Taylor, 2005). Additionally, the use of collaboratively designed and facilitated, occupation-focused programmes within the community are emerging as important resources for mental health services, requiring evidence to support their use and design.

An external researcher to the FAI and HSE was sought through the Occupational Therapy Department in Trinity College Dublin in order to provide a non-biased, academically supported research.

1.5.1. Aim and Objectives of the Study

The aim of this study is to investigate if change occurs for community mental health service users after participation in the 'Kickstart to Recovery' football programme. The specific changes that are investigated are outlined in the objectives of the study.

The objectives of this study emerged from a combination of a review of relevant literature, examining current aims of the programme and drawing from current national policies and frameworks influencing the mental health sector.

An extensive review of literature focusing on football as an intervention for mental health service users was conducted. In addition to identifying gaps in the literature, this review also highlighted the importance of policy documents and frameworks in shaping mental health services.

The current aims of the 'Kickstart to Recovery' programme, outlined above, were examined and critiqued. It is important to justify these aims to support evidence-based practice. For this reason, these aims set the foundation for the objectives of the study, which were refined and added to by the literature review findings. These factors that influenced the formation of the research aims are illustrated in **Figure 1** below.

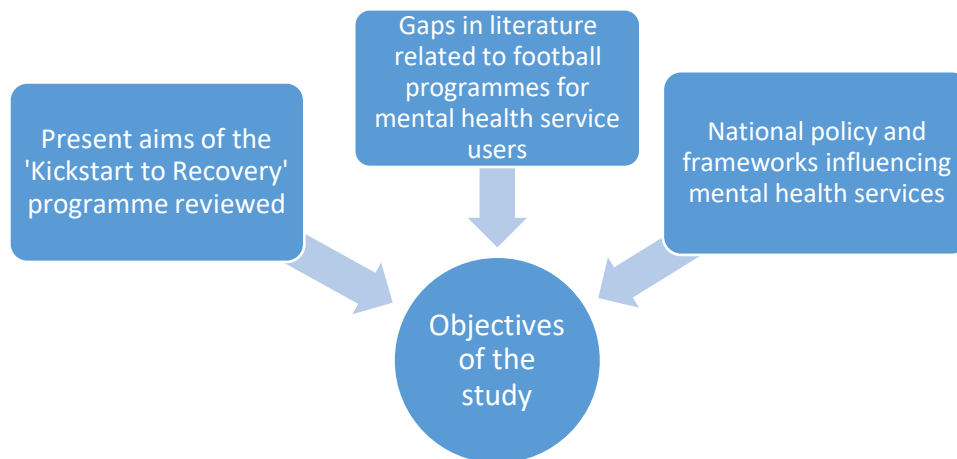


Figure 1 Forming the objectives of the Study

From this process emerged the specific changes that are being measured, outlined as the following objectives of this study;

1. To measure change in the quality of life of mental health service users who participate in the 'Kickstart to Recovery' programme.
2. To measure change in self-reported mental health recovery of mental health service users who participate in the 'Kickstart to Recovery' programme.
3. To measure if participants experience change in the personal meaning of the football after participating in the 'Kickstart to Recovery' programme.
4. To measure if participants experience social gains after participating in the 'Kickstart to Recovery' programme.

1.5.2. Research Methods

This study utilised quantitative methods to achieve the research aim and objectives. In order to measure if the objectives of the programme are achieved, a pre-post research design was used (DePoy & Gitlin, 2011).

The questionnaire contained the following outcome measures; Short Form 36 (SF-36)(Ware & Sherbourne, 1992), which measured quality of life, Recovery Assessment Survey – Domains and Scales (RAS-DS)(Hancock et al., 2015) which measured recovery-oriented change and the Engagement in Meaningful Activities Survey (EMAS) adapted for football (Goldberg, Britnell & Goldberg, 2002), which measured the meaning of football for the participant. To avoid repetition, social gains was measured by isolating the social domains of the SF-36 and RAS-DS.

Data was analysed using descriptive statistics and statistical analysis was conducted using non-parametric tests (Pallant, 2016).

1.5.3 Limitations at the Outset of the Study

Prior to commencing this study, it was acknowledged that conducting research in community environments, outside clinically controlled settings, would present challenges to the study. This was a result of possible external factors influencing the participants and/or their environments, which may impact the data they provide in the study.

It was also acknowledged that, despite numerous efforts, it was not possible to include a control in this study. Throughout this study, it is clearly outlined that the limitation of this on the study's results is well understood, particularly when attributing change to the "Kickstart to Recovery" programme. This is discussed further with other limitations of the study in more detail in Chapter 3.

1.5.4. Operational Terms

'Kickstart to Recovery' programme: The 'Kickstart to Recovery' programme, also referred to in early stages of development as 'Kickstarting Recovery', is a football intervention for mental health services in the Republic of Ireland. It is the product of a collaboration between the FAI and the HSE.

Football: Defined as a sport played by two teams, with an aim to score goals by kicking the ball into a large net (Collins, 2018). It is also known as 'association football' or 'soccer'. As is the term used by the sport's Irish governing body, the FAI, it will be referred to as 'football' in this study.

FAI coach: For the purpose of this study, FAI coach is the coach facilitating the 'Kickstart to Recovery' programme.

Service user: For the purpose of this study, a service user refers to an individual who currently avails of a mental health service.

Mental Health Challenge/Problem/Illness: Mental health challenges, problems and illness will be used interchangeably throughout this study. The terms cover the broad range of difficulties that has a significant impact on daily living one may experience with their mental health. Mental health is defined by the WHO as 'a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community' (World Health Organisation, 2018)

Recovery: As there is no one definition of recovery, the definition used in the 'National Framework for Recovery in Mental Health 2018-2020' will be also used for the purpose of this study; "Recovery is a deeply personal unique 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 the limitations caused by illness. Recovery involves the*

development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993, p. 527).

Quality of Life: As there is no one definition for quality of life, that adopted by the WHO is used for the purpose of this study, as it captures the concept's multiple aspects and different dimensions of health; "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment" (WHO; The WHOQOL Group, 1995, p. 1405)

1.5.5. Abbreviations Used

HSE – Health Service Executive

FAI – Football Association of Ireland

NHS – National Health Service

WHO – World Health Organisation

SF-36 – 36-item Short Form Survey

RAS-DS – Recovery Assessment Survey; Domains and Scales

EMAS – Engagement in Meaningful Activities Survey

1.6. Conclusion

This chapter has introduced the study and outlined the need for and justification of its completion. The context and background of the 'Kickstart to Recovery' programme was presented and a brief outline of the research process is given. The following chapters detail a literature review, followed by a description of the methodology used, analysis of results attained by the research, discussion of the information gained and completed with a conclusion drawn.

Chapter Two: Literature Review

2.1 Introduction

The purpose of this chapter is to review the literature in relation to the practice and studies completed on this intervention.

This chapter also examines the cultural context of mental health in Ireland, including the policies and strategies that are currently impacting mental health in Ireland. The concepts of recovery and community integration will be discussed in depth, as they lay the foundation for the objectives of mental health services and how occupation can be used as an enabler in recovery and inclusion. The use of football as an occupation and intervention will be discussed and critiqued, highlighting the gaps in the body of research and providing justification for this research study on the 'Kickstart to Recovery' programme.

2.2. Search strategy

This search was conducted using numerous databases and sources both internal and external to the university. Trinity College Dublin libraries were utilised to search for books and journals relevant to the topic. Databases including *AMED*, *CINAHL*, *PubMed*, *PsycINFO*, *PsycARTICLES*, *OT Search*, *OT Seeker*, *Cochrane Library*, *MEDLINE* and *EBCOHOST*. In addition, due to the relevance of its target market to the topic, the *Journal of Physical Activity and Mental Health* was searched for relevant studies, as well as relevant Irish policies, frameworks and strategies in order to determine the context in which this research takes place.

Boundaries were set in order to source the most relevant resources. Search words were identified by using key words from the research questions. These were then broken down into similar or interchangeable words, such as football and soccer, which were sourced through examining key words of articles found in these areas. Table 1 states the search terms identified. Different combinations of these terms were used during the search and the universal suffix was applied to ensure variations of a word were not excluded (example sport or sports). This is identified by a * symbol.

Table 1 Search Terms

Football/Sport	Mental Health	Intervention
• Football • Soccer • Sport* • Team sport* • Exercise • Physical Exercise • Physical Activity	• Mental Health • Mental Illness • Mental Ill Health • Mental Health Disorder* • Psychiatric Disorder*	• Intervention • Community intervention* • Programme* • Program • Group* • Project* • Community Service* • Community • Community-based project* • Community group*

While it is acknowledged that there is a body of research focusing on the impact sport and football can have in preventing mental health challenges emerging (Heun & Pringle, 2018; Wood, Harrison & Kucharskaa, 2017), this literature review and research will focus on the impact of football for service users with pre-existing mental health challenges.

As the use of football as an intervention for mental health service users is a growing area of research with a large body of new research, the searches were restricted to the last ten years, in order to produce the most relevant findings to current practice. If, however, an older study that met the inclusion criteria of the search was identified through reference lists in more recent journals, it was included in the analysis.

A limitation in the research search strategy was the lack of peer-reviewed literature on the 'Kickstart to Recovery' programme. Grey literature are forms of documentation not controlled by commercial publishing, for example presentations, unpublished reports or audits (Farrah & Mierzewski-Urban, 2019). As there is limited published research on the football programme, when discussing the development and structure of the 'Kickstart to Recovery' programme much of the resources will fall under the category of grey literature and is cited as 'personal communications' (American Psychological Association, 2010)

2.3. Ireland's Current Mental Health Culture

De-institutionalisation is a positive step in demonstrating the reform of the mental health services in Ireland (Kelly, 2017). In our current political and societal environments mental health has been gaining attention. In 2010 the 'See Change' campaign, Ireland's national mental health reduction partnership was launched. It aims to reduce mental health stigma and discrimination in Ireland by increasing awareness of mental health difficulties and how they are viewed as part of the human experience (Coyle, Lowry & Saunders, 2016). In 2017 research conducted by Kantar Millward Brown on the 'See Change' campaign indicated that 3 out of 4 individuals are now talking about mental health in their everyday lives (See Change, 2017, p. 6).

2.3.1. Policies and Strategies that are Shaping Mental Health in Ireland

Policies can have a profound impact on the everyday lives of individuals as they influence the resources one has access to and shapes the environment that they are in (O'Toole, 2011). Within the mental health sector there are a number of influential policies published in the early 2000's that now shape our service delivery.

In 2006, the national mental health policy in Ireland, '*A Vision for Change; Report of the Expert Group on Mental Health Policy*' was launched (Government of Ireland, 2006). It was developed in response to shortcomings of the '*Planning for the Future*' policy which was published twenty-two years previously. The original document suggested that mental health services be community-based and that a multidisciplinary approach should be adopted (Study Group on the Development of the Psychiatric Services, 1984). A '*Vision for Change*' adopted these suggestions, which was welcomed by stakeholders of mental health services, including service user groups (Johnston, 2014; Kelly, 2017). The policy brought forward recommendations of a population-based approach to service delivery. This included community and primary care resources being made available, service user driven services as well as family, carers and support networks (Government of Ireland, 2006; Kelly, 2017). As such, the interventions recommended in the policy aim to maximise recovery in mental illness by using service user's social networks and local resources to achieve meaningful community integration and participation (Mental Health Reform, 2019).

Although A '*Vision for Change*' policy had the potential to achieve a progressive and recovery-oriented mental health services in Ireland, its shortcomings in implementation to date have led to it being viewed as a policy with "all vision but no change" (Johnston,

2014, title). A *'Vision for Change Nine Years On: A coalition analysis of progress'* highlighted social inclusion as an area of the policy with the most significant shortcomings, with stigma and discrimination remaining an issue for those with severe mental illness (Mental Health Reform, 2015). The *'Evidence Review to Inform the Parameters for a Refresh of 'A Vision for Change'* further emphasises this shortcoming with recommendations of expansion of peer support initiatives in mental health (Cullen & McDaid, 2017).

Despite this, *'Vision for Change'* has placed a spotlight on the importance of a recovery-oriented approach for mental health services, providing guidance and direction for mental health policy makers and professionals. This is evident in the *'Best Practice Guidance for Mental Health Services'* document (HSE; Mental Health Services, 2017a), that endeavours to provide professionals with the tools to deliver optimal services. A strong element of this guidance document is the empowerment of service users to be active agents in both decisions involving their care and the service itself. The understanding of the service user's lived experience as being a valuable resource in developing and delivering mental health services is acknowledged and promoted in a number of service documents, including the *'A National Framework for Recovery in Mental Health 2018-2020'* (HSE; Mental Health Services, 2017b). This framework emphasises the benefits of utilising the lived experience of mental health service users, including fostering hope, increasing empowerment and improving the value placed on the services.

'The National Service Plan 2019' (HSE, 2018) endorses the implementation of both strategies put forward in the *'Best Practice Guidance for Mental Health Services'* (HSE; Mental Health Services, 2017a) and *'A National Framework for Recovery in Mental Health 2018-2020'* (HSE; Mental Health Services, 2017b). This service plan outlines the means of providing quality service with the funding allocations for 2019. It outlines the aim for the majority of mental health services to be provided at a primary care level, with less than 10% requiring referral to specialist mental health services.

Another important framework that takes a population approach to health and wellbeing is the *'Healthy Ireland'* framework (Department of Health, 2013). This framework focuses both on the physical and mental health of Irish citizens, with all sectors of the Government and all groups in society included in its goal to improve people's quality of life. It promotes the development of programmes that encourage physical health, including as a means of promoting positive mental health.

'Healthy Ireland' is the foundation for a number of other guidelines and action plans which focus on particular aspects of the framework. One such guideline is the *'Let's Get Active Guidelines'*, which provides information on how mental health professionals can support service users with mental health challenges to become physically active (HSE; Mental Health Services, 2018). This document demonstrates the shift in attitude towards mental health and physical health, emphasising the significant connection between the two and how one can benefit from the other.

Also stemming from the *'Healthy Ireland'* framework is the *'National Men's Health Action Plan Healthy Ireland 2017-2021'* (HSE, 2016). This action plan strives to achieve the goal of *'Healthy Ireland'* to reduce health inequalities in Ireland. It is supported by previous policy documents related to the topic of men's health, such as *'Equal but Different'* (National Women's Council of Ireland, 2012), which outlines the need to focus on inequalities in health between men and women in Ireland and *'Getting Inside Men's Health'* (Richardson, 2004), which calls for an understanding of what it is like to be a man in Ireland today and how this impacts health behaviours. These documents act as guides to tackling the issue of under-detection of men's mental health challenges.

2.4. Recovery

At the heart of most policies, frameworks and guidance documents for mental health services is the concept of recovery and promoting recovery-oriented approaches to practice.

The Recovery Movement changed the approach to mental health services by placing value on the expertise of those who embody the lived experience of having a mental health challenge (Read & Stoffel, 2019). Stemming from a civil rights movement, recovery in mental illness does not focus on the alleviation of symptoms, but instead focuses on how an individual can maintain or regain their rights and responsibilities as citizens, especially in the areas of social inclusion and self-determination (Davidson & Roe, 2007).

Recovery is both a process and an outcome for the individual (Torrey, Rapp, van Tosh, McNabb & Ralph, 2005). Strong themes that emerged from the literature on the process of recovery are hope, empowerment and meaningful life activity (Torrey, Rapp, van Tosh, McNabb & Ralph, 2005). In discussing recovery as a process, Davidson and Roe's (2007) concept of recovering *in* mental illness, instead of *from* mental illness, is brought

to the forefront. This concept captures the importance of prompting recovery and the themes above, even in the presence of active mental health symptoms. As recovery moves to an outcome, learning to manage mental health symptoms becomes the important aspect to consider for the person (Torrey, Rapp, van Tosh, McNabb & Ralph, 2005).

Recovery is rooted in the lived experience of the person with the mental health challenges (Repper & Perkins, 2003). This core belief is present as a key component in many of the mental health policies discussed above, as Irish services strive to provide recovery-oriented services. While emphasis is placed on the individual's ownership of their recovery journey (Davidson, Tondora, Pavlo & Stanhop, 2017), support of mental health services can aid in this process. Services adopting a recovery-oriented approach have a responsibility to support individuals to manage and pursue their life in the manner they wish, even in the presence of mental health challenges. This support must facilitate recovery by removing barriers, adapting environments and providing community support. (Davidson & Roe, 2007). Although a uniquely individual process for each service user the underlying principles of hope, empowerment, choice and self-determination aid to develop, structure and evaluate recovery-oriented approach of mental health services and resources (Tondora, Miller, Slade & Davidson, 2014).

2.5. Community-Based and Community Integration

One of the main focuses of recovery and the reform of mental health services has been to move mental health services into community-based settings and to promote community integration for users of these services.

Communities are groups of social networks, that share common interests, concerns or identities, which provide support and friendship to one another. (WHO, 2009; Read & Stoffel, 2019). These groups may or may not be connected in proximity, however in delivery of community-based mental health services, proximity is an important aspect to consider.

European countries, including Ireland, committed by means of the '*Mental Health Declaration for Europe*' (WHO, 2005), to developing community-based mental health services and to integrate these into primary health care. This development over the past decade is evident within our policies, especially in '*A Vision for Change*', as the focus shifted from institutionalisation to community mental health services (Department of Health, 2006).

For community-oriented mental healthcare, it is fundamental that community-based services are close to where service users live and can be accessed with ease (Thorincroft et al., 2011). Restricted accessibility can be created both by a lack of transportation availability and the burden of financial costs to use available transport. These factors may hinder the service user's ability to attend services, which potentially will impact the justification to continue service provision in certain areas due to the apparent lack of need (Creek, 2014).

A sense of community and belonging has been shown to positively impact both physical and mental health, in addition to creating a resilience to difficult life situations (Harding, 2019). Although proximity is important to promote participation, an individual's physical presence in a community does not correlate to their belonging in the community (Repper & Perkins, 2003). Community integration requires valued acceptance by others, a sense of purpose and incorporates how one engages, participates and gives back to the community (Read & Stoffel, 2019). As noted above, communities may not be connected by physical proximity but by factors individuals have in common, which exposes a significant difference between community-based and community integration.

2.6. Occupation as a Support for Recovery and Community Integration

There is growing evidence to support the use of enjoying valued, community-based activities as an effective means in promoting recovery and social inclusion (Fenton et al., 2016; Parkinsons, 2014). Occupations, these valued activities within temporal, physical and sociocultural context (Kielhofner, 2008), are essential aspects of well-being and positively contribute to one's quality of life (Wilcock, 1999).

Human nature has an innate desire to 'do', which is the essence of occupation (Kielhofner, 2008). People with mental health difficulties often disconnect from roles and lose meaning in valued activities. Finding meaning is, therefore, a core element of many people's recovery journeys' (Repper & Perkins, 2003). Personal meaning does not necessarily come from occupational participation, as social or cultural values and expectations may influence the importance placed on doing (Hitch, Pepin & Stagnitti, 2014a). Occupational engagement does however require personal meaning, including elements of emotional connections, commitment and an experience of pleasure while doing (Pepin, 2017).

The internal reward for occupational engagement is the sense of “flow” (Wright, 2004, p. 66). Occupational flow refers to the immersion in an activity, that provides goal-oriented focus, concentration on the activity, a sense of control, reduced self-consciousness and alteration of the experience of time (Csikszentmihalyi, 2002). The experience of flow comes from such a deep immersion in doing that the person forgets everything except what they are doing (Csikszentmihalyi & Rathunde, 1992). This is the optimal experience from occupational engagement.

The impact, experience and degree of meaning obtained from occupational engagement is determined by the context in which it is performed (Creek, 2014). As humans are never isolated from their environment, we are constantly being shaped by our experiences within it (Pizur-Barnekow & Davel Pickens, 2019). Occupation provides the bridge between the person and their environment (Polatajko et al., 2007). To support a person's recovery journey, it is ideal if the environment within which people experience occupation is in their community, to enable community integration and social connectedness.

In forming social connections, individuals develop a sense of belonging (Cordingley & Pell, 2014; Reberio, Day, Semeniuk, O'Brien & Wilson, 2001). Achieving a sense of belonging is a journey, where occupation supports one to move from simply doing, to becoming part of something and to then belonging (Hitch, Pepin & Stagnitti, 2014b). Belonging supports the reciprocity of connections, in that both the elements of giving and receiving are present in the relationship (Hitch, Pepin & Stagnitti, 2014b). The Development of social connections is a self-identifiable indication of recovery. (Jacobson, 2001). Occupation, therefore, can act as a means of empowering the individual as they embark on their recovery journey and provides opportunities for community integration to occur.

2.6.1. The Occupation of Football

As explained by Creek (2014), an action of doing may be classified as either a task, activity or occupation depending on the context and how the individual experiences it. For many people, football would be considered an occupation, as it is meaningful, in addition to providing other aspects, such as enjoyment, sense of belonging, an identity and social connections.

Football can be an occupation at many levels, from a player, who depends on their performance capacity of their skills and fitness to perform well (Kielhofner, 2008) to

supporters, who view football as part of their self-identity (Heun & Pringle, 2018). It is also a valued sport in many communities, which entices individuals to participate and gain that experience of belonging and meaning (Repper & Perkins, 2003).

2.7. Football and Mental Health

In recent years, football has become a popular means of providing mental health interventions in a non-clinical setting. It has been used in multiple mediums, such as watching matches, using football as a metaphor to discuss mental health issues and participation in the physical activity of playing football (Pringle, 2009). The focus of this review will be on football as a physical activity.

2.7.1. Football Programmes for Mental Health Service Users

The use of football as an intervention is not a new concept, with different programmes being run in various countries. The following section will describe studies found through the search strategy described in Section 2.2. The studies reviewed each describe research conducted on at least one football programme specifically designed for individuals experiencing mental health challenges. Nineteen studies were identified, with nineteen football programmes in total discussed, nine of which are named programmes. As ten of these programmes are not named, it cannot be definitively stated they are a different programme to those with names provided. The studies are outlined in Appendix 1, stating each study's authors, title, research methods used and the programme's name.

Football is not only England's most popular sport, but it has also been used as a medium to tackle social issues, such as racism through the 'Kick Racism out of Football' campaign. It is therefore unsurprising that England produced the most research on football programmes for those with mental health difficulties, with fourteen studies identified including eight named programmes (Mason & Holt, 2012; Friedrich & Mason, 2017; Friedrich & Mason, 2018a; Friedrich & Mason, 2018b; Dyer & Mills, 2011; Henderson, Mills, Thronicroft & Webber, 2014; Benkwitz & Healy, 2019; Brawn, Combes & Ellis, 2015; Hynes, 2008; Darongkamas, Scott & Taylor, 2011; Oldknow & Grant, 2008; Butterly, Adams, Brown & Golby, 2006; Hargreaves & Pringle, 2019; Magee, Spaaij & Jeanes, 2015).

Four studies were conducted on the 'Coping Through Football' (CTF) project, which is an east London mental health football programme (Mason & Holt, 2012; Friedrich & Mason, 2018a; Friedrich & Mason, 2018b). The project aims to improve mental, physical and social health of mental health service users. It was developed by multiple agencies

such as local professional football clubs, local National Health Service (NHS) bodies and other local charity organisations. This project provides an emphasises on exit routes to community-based activities, which are discussed and supported by the occupational therapists who attend and co-facilitate the sessions with the coaches from the football club.

'Imagine Your Goals' (IYG) started as a casual kick-around, which evolved into a structured programme, including a league with other English-based groups. It is a three-year football programme running in multiple locations and includes elements of coaching and refereeing, in addition to playing football. Two studies were conducted on this programme (Dyer & Mills, 2011; Henderson, Mills, Thronicroft & Webber, 2014).

'Think Football' is the most recent programme identified, both in its development and to produce research (Benkwitz & Healy, 2019). This programme began as a pilot in March 2017, promoting itself as a football group for personal and mental well-being. It encourages self-referral of those in the community with low level mental health illnesses, hence no mental health service referral was required to attend. Like the CTF and IYG, this programme was developed through a collaboration of parties, such as local mental health trusts, sporting organisations and universities.

With a different format from the previous programmes discussed, the 'Mental Health and Well-being Football League' in north-west England operates a first and second division league, with opportunities for teams to be relegated. This league was established and is run by a service user lead charity and aims to widen social opportunities for its participants.

A similar league based in London is the Positive Mental Attitude (PMA) Football League, which was set up by an occupational therapist with the National Health Service (NHS), who was also previously a professional footballer and Football Association (FA) trained coach. No research was published on this project, but an article was published by Hynes (2008) describing the league in detail, successes to date and future plans. Spanning two years, twelve teams were registered to the league from six NHS mental health trusts, which included 350 participants.

Park House United is another English football scheme established in 2007 for men with mental health challenges. It was established as a voluntary group, aiming to empower

service users to steward the groups facilitation. As of 2011, the group had 15 members (Darongkamas, Scott & Taylor, 2011).

The REACT (Recreational Enterprise Assisted Client Training) Football Training Academy is a forty-week programme, run by service users who are trained football coaches, an occupational therapist technician and a support worker, that not only focuses on developing football skills, but also other skills such as photography and first aid and knowledge of healthy lifestyles and eating. On completing the programme, different options are available to the participant, such as repeating the programme, joining the training team or opportunities to access facilities, such as colleges, where they can further their skills. The methods used in the evaluation of the programme conducted by Oldknow and Grant (2008) are not clearly outlined.

MUSCSEL (Meeting Up for Social Contact, Sport, Exercise and Leisure) is a multi-physical activity project for mental health service users based in Leeds, England. The project includes a mixture of individual sporting activities (swimming and gym) and group sports (walking group, tennis, gym group), with football being the most popular activity with 32 participants.

Two studies were conducted on unnamed English football groups for people with mental health difficulties. The most recent, by Hargreaves and Pringle (2019), describes a weekly football mental health intervention delivered by the local professional football club. The other research carried out in an English context was by Magee, Spaaij and Jeanes (2015) on three unnamed football programmes (P1, P2, P3). The first programme (P1) was funded by the NHS, with the other two programmes (P1 and P2) charity funded. All had the same structure, run twice a week, in ten-week blocks over a three-year period. Each programme had three elements; the Football Programme, Healthcare Treatment Programme and Support Workshops Programme. The football element consisted of bi-weekly football sessions, with participants who had greater football skills and ability provided the option to participate in additional academy sessions. The first programme (P1) was facilitated by a head coach and assistant coach and the second programme (P2) by the Director, who was a qualified football coach. Both these groups also participated in a league for competitive football for people with mental health illnesses. The third programme (P3) was facilitated by local qualified football club coaches but did not attend competitive leagues. The second element was a combination of formal, informal and some group meetings with participants and medical staff (clinical psychologist, clinical nurses, clinical psychiatrists). These were participant-led and were

flexible around or during the football sessions. The final element of the programmes involved external agencies providing workshops on a range of areas, including employment, education and housing information, financial management, drugs, alcohol, sexual awareness, diet and nutrition advice. These were run after the football sessions.

Adding to the English context literature, Lamont, Harris, McDonald, Kerin and Dickens (2017) investigated four unnamed groups, two football (F1 & F2) and two walking football (W1 & W2) based in Scotland. Three of these groups were facilitated in the community and one in an inpatient setting. The weekly groups were organised collaboratively by service users and mental health staff. The 'football only' groups were comprised of men only and often participated in football matches against other services.

Boasting the most FIFA World Cup Titles, football is also Brazil's most popular sport. Similar to Ireland, Brazil has undergone reform in its mental health service system in order to reduce in-patient care and move supports into Psychosocial Care Centres (PSCC) (Abib, Fraga, Wachs & de Paula Alves, 2010). As a result, initiatives to increase social and community interactions are being promoted, such as the use of football as a means of improving health and well-being. Abib, Fraga, Wachs and de Paula Alves' (2010) research on an unnamed Brazilian based football workshop for mental health service users is an example of this. Sessions ran for an hour and a half weekly on a football field for hospital employees, with staff from the PSCC also attending.

Here in Ireland, the use of football as a means of mental health intervention has been adopted by two programmes. The first, 'Back of the Net' (BTN), which has had two research studies conducted on it (McArdle, McGale & Gaffney, 2012; McGale, McArdle & Gaffney, 2011), uses a combination of Cognitive Behavioural Therapy (CBT) techniques and the sport of football. The programme included twenty sessions over ten weeks. A five-a-side match played at the end of every session, which during half-time, a team talk on a different mental health theme, using cognitive behavioural techniques and football language, was discussed. This programme included 'homework', which the players would be given a task related to the themes discussed. The facilitator of the group required a football coaching qualification, but only a minimal understanding of CBT, as the sessions are outlined in the BTN manual.

The final programme with related research to be discussed is that of the 'Kickstart to Recovery' programme itself. As discussed in Chapter One, 'Kickstart to Recovery' is an Irish-based football programme, which is a collaboration of the HSE and the Football

Association of Ireland (FAI). At the time of Moloney and Rohde's (2017) research, the programme was titled 'Kickstarting Recovery' and focused on men with psychosis.

2.7.2. Research on Current Football Programmes for Mental Health

Service Users

There is currently a strong body of literature investigating the use of football programmes for mental health service users. In comparing these studies, both commonalities and differences became apparent and are discussed further below.

2.7.2.1. Methodology

As different methodologies have different qualities, there is no 'best' choice of research design (Katz, 2015). Most research questions are not answered by one means of investigation, hence it is positive to find a diversity in methods used in investigating football for mental health service users. Qualitative methodologies were the most common form of study design in the identified literature (Benkwitz & Healy, 2019; Hargreaves & Pringle, 2019; Moloney & Rohde, 2017; Mason & Holt, 2012; Abib, Fraga, Wachs & de Paula Alves, 2012; Fredrich & Mason, 2018a; Friedrich & Mason, 2018b; Brawn, Combes & Ellis, 2015; McArdle, McGale & Gaffney, 2012; Lamont, Harris, McDonald, Kerin, Dickens, 2017; Magee, Spaaij & Jeanes, 2015). Qualitative methods allow for service-user's individual experiences in specific context to be captured, which can gather information that would be difficult to quantify. As the focus of football programmes is on individuals with mental health challenges, it is important to gain insight into their experience when designing and evaluating programmes, both to create recovery-oriented programmes and to gain an insight into the lived experience of participation in such interventions. Qualitative methodology, however, is difficult to generalise as it is solely based on the content provided by participants in a given interview, hence is limited in its findings (Green & Thorogood, 2004). Abib, Fraga, Wachs & de Paula Alves (2012) used ethnography methods as a means of data collection, which allows for the cultural patterns and experience of the football sessions to be observed and documented (DePoy & Gitlin, 2011), along with documented statements from participants during sessions. While the addition of field diaries provides a unique perspective of the sessions, the service user's comments are brief, and as a result the findings lack depth. This method in combination with the interview methods used in the other studies, may have provided a richer dataset.

Two of the nineteen studies were noted as 'evaluations' of the programmes, with poor descriptions of the methods used. Oldknow and Grant (2008) describe comments made by participants, but it is not clear if these are obtained through the use of quantitative or qualitative methods. Hynes (2008) provides a detailed description of the PMA Football League structure using anecdotal accounts of participants' experiences, stating the benefits of the programme, but does not discuss any research conducted to support this. The value of this article is the description of the structure, but the lack of adherence to a formal research method does not provide valid or reliable findings and hence will not be discussed in this critique.

The remaining six studies used either mixed methods (Darongkamas, Scott and Taylor, 2011; Dyer & Mills, 2011; Butterly, Brown & Golby, 2006) or quantitative methods when investigating the football interventions (Fredrich & Mason, 2017; McGale, McArdle & Gaffney, 2011; Henderson, O'Hara, Thronicroft & Webber, 2014). The complementary mixed methods approach can be advantageous in triangulating data (Hissong, Lape & Bailey, 2015). In order to be effective, this approach requires the researcher to have both qualitative and quantitative skills.

The use of quantitative methods in health-related research addresses aspects of causality, generalisability and degrees of effect (Fetters, Curry & Creswell, 2013). This methodology can produce high quality research, such as McGale, McArdle and Gaffney's (2011) randomised control trial (RCT) on the BTN programme, which is considered a high level of evidence (Burns, Rohrich & Chung, 2011). However, there are limitations of quantitative methodology noted in these studies that may impact results. This includes the small sample sizes in comparison to the total programme's population, which is noted in all studies. Attrition rates are also noted in the studies using a pre-post study design, such as Fredrick and Mason's (2017) study, which reported dropping from 72 to 32 participants for the one year follow-up, McGale, McArdle and Gaffney's (2011) sample falling from 84 participants in total, to 69 at week 10 and dropping further to 33 at the 8 week follow-up and Henderson, O'Hara, Thronicroft and Webber's (2014) sample dropping from 196 to 163 participants. Finally, the absence of a control, in all but McGale, McArdle and Gaffney's (2011) RCT can limit the impact of the results.

The quantitative measures in both the mixed methods and quantitative approaches vary in the use of standardised measure and self-designed measures. Those that used standardised outcome measures focused on areas such as well-being, social capital (Henderson, O'Hara, Thronicroft & Webber, 2014), quality of life, self-esteem, physical activity (Fredrich & Mason, 2017), mood and social relationships (McGale, McArdle &

Gaffney, 2011). No two studies used the same outcome measure, however all had good reliability and validity, which provides strong evidence-based results. Although self-designed have the advantage of targeting questions relevant to the programme itself, they are disadvantaged by the evidence to support their reliability and validity. All three studies that used self-designed questionnaires conducted mixed methods research, perhaps as a means of more closely comparing the qualitative findings (Darongkamas, Scott and Taylor, 2011; Dyer & Mills, 2011; Butterly, Brown & Golby, 2006). The self-designed measure utilised by Darongkamas, Scott and Taylor's (2011) posed questions specific to football and participation in the programme, which provided justification for its use in this context. The remaining two studies (Dyer & Mills, 2011; Butterly, Brown & Golby, 2006), however, posed questions related to well-being, physical health, mental health stigma and participation in sport, with no football specific questions asked. There was a potential to investigate these areas using existing reliable and valid outcome measures, which would have produced higher quality results.

2.7.2.2. Cultural Context

The cultural context is an important factor to consider when introducing sport as an intervention. Sport brings with it a culture of its own; with an identity, routine, social network, traditions and social norms (Jarvie, 2012). This is embedded and shaped by other cultures at play, such as the country context and environment in which it is executed. In the studies identified, English programmes dominate the body of literature found (Mason & Holt, 2012; Friedrich & Mason, 2017; Friedrich & Mason, 2018a; Friedrich & Mason, 2018b; Dyer & Mills, 2011; Henderson, Mills, Thronicroft & Webber, 2014; Benkwitz & Healy, 2019; Brawn, Combes & Ellis, 2015; Hynes, 2008; Darongkamas, Scott & Taylor, 2011; Oldknow & Grant, 2008; Butterly, Adams, Brown & Golby, 2006; Hargreaves & Pringle, 2019; Magee, Spaaij & Jeanes, 2015). This high figure is no surprise with the huge popularity of the sport in the country, driven by championships such as the Premier League (Premier League, 2019). This popularity is also experienced in Scotland, at a different level, with famous sporting teams Celtic and Rangers drawing a significant fanbase, as in Ireland as with significant football teams, such as Dundalk F.C., Cork City F.C. and Shamrock Rovers F.C.. Although all similar western cultures in close proximity, the intensity and popularity of football may vary between these areas, creating different cultural norms for the sport (Jarvie, 2012). These norms may be very different for other cultures, such as Brazil, which has a significantly different cultural to that of the western countries, may impact the way football is perceived and engaged in (Benson & Sinnott, 2007).

The Irish context for football may also differ due to other dominant sports in the Irish culture, such as the Gaelic Athletic Association (GAA), including hurling and Gaelic football, which competes with football for the most popular team sports in Ireland (Irish Sports Monitor, 2018). Football, in most cultural contexts, has the advantage of being a globally played sport. As such, even in an Irish mental health service context, it is more likely to appeal to different nationalities that may attend the service as opposed to national sports, such as GAA.

2.7.2.3. Community-based Settings

With the exception of one inpatient group in Lamont and colleagues' (2017) study, all programmes above were run in community-based settings. By having football programmes in a context external to a clinical setting, participants report having a different meaning associated with mental interventions they are involved in, hence reducing mental health stigma that would otherwise be associated with attending these (McArdle, McGale & Gaffney, 2012). When introducing a mental health intervention in a community-based setting, it is important that it is accessible for service users, so proximity is not a barrier to participation. 'Kickstarting Recovery' (Moloney and Rohde, 2017) was stated to be based in an urban setting, therefore would have access to facilities such as public transport, increasing accessibility and reducing barriers for service users. None of the studies explored in this review were based in a rural setting, therefore barriers this may present were not explored.

2.7.2.4. Gender

All studies in this review appeared to fall under one of two categories in regards to gender; either the group was designed for male-only or were open for both genders to attend but difficulties recruiting females was noted. Over a five-year period, Friedrich and Mason (2018a) found only 20 out of 329 participants were females in the programme. This is reflected in other studies, where those that attend the football groups are either predominantly men (Dyer & Mills, 2011; Lamont, Harris, McDonald, Kerins & Dickens, 2017; Magee, Spaaij & Jeanes, 2015; Hargreaves & Pringle, 2019; Butterly, Adams, Brown & Golby, 2006; Hynes, 2008; Benkwitz & Healy, 2019; Brawn, Combes & Ellis, 2015; Henderson, O'Hara, Thorincroft & Webber; Friedrich & Mason, 2018a) or did not include females in the recruitment process to the programmes (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffney, 2012; Moloney & Rohde, 2017; Darongkamas, Scott & Taylor, 2011;). Males are identified as a difficult to reach group. Often their mental health problems are left unsupported or are brought to health professionals' attention at a later stage than females (WHO, 2018; Lee & Owens, 2002).

Using interventions that are deemed as 'acceptable' to men was found by Pringle and Sayer's (2004) to be a means of improving engagement in services for men. Football was found to be a socially acceptable and appealing sport for men to engage in (Friedrich & Mason, 2018a) and non-threatening to their masculinity as there is no mental health stigma associated with football (McArdle, McGale & Gaffney, 2012). Structural features that reduced the competitive nature and increased co-operation, such as that of BTN, was found to reduce pressures of masculinity such as competitiveness and power over others (McArdle, McGale & Gaffney, 2012). Also, Magee, Spaaij and Jeanes (2015), highlight that football is also used as a medium to re-integrate those who disconnected from mental health services.

2.7.2.5. Duration of the Programmes

It is clear to see that there is a wide variance in the structures of the different football programmes. One such variance is the duration of the programmes. Few studies outlined the length of a programme they ran, with a number of programmes giving the impression that they had no restriction on duration. The 'Kickstarting Recovery' programme investigated by Moloney and Rohde (2017) only ran for four sessions, however it is acknowledged this was a pilot programme. The three programmes in Magee, Spaaij and Jeanes' (2015) study ran twice a week for ten-week blocks, as did BTN (McArdle, McGale & Gaffney, 2012). There is little discussion or investigation conducted on the optimal duration of programmes or if the continuous framework is more beneficial. McArdle, McGale and Gaffney (2012) did find participants wanted longer sessions (55 minutes) and longer programme length (10 weeks), however when the programme did end, the group developed their own group to continue their involvement. While this is acknowledged as a success of the programme, it must be acknowledged that the participants in this programme were not attending a mental health service and were recruited using posters in the community, hence their mental health challenges may not be as significant as those in other programmes.

2.7.2.6. Exit Pathways from the Programme

This finding does highlight the issue of exit pathways and what structural elements are available for participants to move from a service-based group to community-integrated groups. In McArdle, McGale and Gaffney's (2012) BTN, the participants self-designed a group to continue their involvement in football, however this was a spontaneous effort of the participants and was not a structural element of the programme. Exit pathways were incorporated into the structure of a number of football interventions for mental health services. A number of these included workshops from community resources such as

employment or education advice (Magee, Spaaij & Jeanes, 2015; Benkwitz and Healy, 2019; Fredrich & Mason, 2018 a; Friedrich & Mason, 2018b; Mason & Holt, 2012). Others used football as a means of building on other skills, such as coaching, refereeing or photography, which enticed participants to continue into employment or education, thus advancing skill attainment (Oldknow & Grant, 2008; Dwyer & Mills, 2011; Henderson, O'Hara, Thronicroft & Webber, 2014). In CTF the occupational therapists discuss and plan exit routes with participants throughout sessions (Friedrich & Mason, 2017). The REACT programmes provides a very clear exit pathway with a number of options for participants once they have completed the programme; they can access various education centres to enhance the skills they have started to develop, they can join the training committee or team if appropriate, or they can repeat the programme. This clear exit plan prevents service users unnecessarily remaining in the programme as no alternative avenues are provided. A participant of Lamont and colleagues' (2017) study makes a valid argument that the purpose of the groups differs for each service user, with some requiring a programme that provides exit routes, while for others the programme is "their main activity" which provides a resource to reduce hospital admissions and improve weight loss. While this is acknowledged, participants may be reluctant to move beyond the perceived safety of service provided groups into community groups (Lamont, Harris, McDonald, Kerin & Dickens, 2017). This has been a difficult element to capture, as the researcher often cannot collect data from those who have already left the programme (Mason & Holt, 2012; Fredrich & Mason, 2018b).

2.7.2.7. Influence of Professionals Involved in the Programme

As is seen above the professionals involved in the football programme can play a significant role. Professionals involved include the coaches, mental health staff and volunteers, however, the role of each varies between programmes. In CTF, the occupational therapists attend and facilitate the sessions, with a role of monitoring the physical and mental well-being of participants, in addition to working on personal goals and planning exist routes from the project and service (Friedrich & Mason, 2017). An occupational therapist, who is also an ex-professional footballer facilitates the PMA Football League (Hynes, 2008), providing expertise from both a football and mental health perspective. In 'Kickstarting Recovery' (Moloney & Rohde, 2017) the occupational therapist's role was to grade and adapt the sessions.

Butterly, Adams, Brown and Golby (2006) found that a barrier to being active was a lack of expert advice. In the majority of programmes, professional coaches were used, which may help overcome this barrier. It was found that their presence not only enhanced the

football skills education, but also enhanced the self-worth of the participants as they felt they were important (Pringle & Hargreaves, 2019; McArdle, McGale & Gaffney, 2012). Moloney and Rohde (2017) found that the professionalism of the Football Association of Ireland (FAI) coaches provided support and facilitated participation. The BTN coach has a professional coaching qualification but is only required to have a basic understanding of CBT (McArdle, McGale & Gaffney, 2012). This role specification highlights the importance placed on football skills over the mental health intervention.

2.7.2.8. Leagues and External Matches

Throughout the literature on football programmes for mental health services, there is a conflict on opinion of the use of leagues and external matches against other teams. Brawn, Combes and Willis (2015) describe the benefits of the league format as being motivating for participants to do more to improve their fitness, which they anticipated would increase their potential of winning the league. Group goals developed for winning matches can be instrumental to teamwork and a benefit of external matches (Hargreaves & Pringle, 2019). Hargreaves and Pringle (2019) identified the need for the degree of challenge to be measured and matched to the group, so that a 'just right challenge' was provided. The need for appropriate intensity was for both the physical activity levels and the level of competitiveness. When playing leagues with large numbers of people and more difficult-to-control environments, it can be challenging to meet this 'just right challenge' needs. Two of the three programmes in Magee, Spaaij and Jeanes (2015) research attended competitive leagues against other football groups for people with mental health difficulties. They found that the competitive nature of football can lead to exacerbation of mental health challenges, which led to the decision to remove one of the groups from the league as expectations of the programme changed and became more tactics focused.

2.7.2.9. Additional Elements to the Programmes

In addition to the football element, a number of the programmes identified had an additional element incorporated into the structure of the programme. BTN combined Cognitive Behavioural Therapy with football (McGale, McArdle & Gaffney, 2011; McArdle, McGale, Gaffney, 2012), while Imagine Your Goals (IYG) incorporated coaching and refereeing, made connections with Starbucks for training programmes and work placements and provided travel passes for the service users to attend the training sessions, in addition to the football sessions (Dwyer & Mills, 2011; Henderson, O'Hara, Thronicroft & Webber, 2014). REACT football training academy provide a 40-week basic training programme including development of football skills, healthy lifestyle promotion,

first aid and photography skills (Oldknow & Grant, 2008). CTF encourages its footballers to engage in tournaments, social gatherings and healthy living workshops, in addition to the weekly football training (Friedrich & Mason, 2017). 'Think Football' also incorporates non-football related workshops such as healthy eating, team-building and information on local services and supports. They also include an opportunity for informal conversations about football in a relaxed environment with tea and biscuits after sessions, as did the BTN programme (McGale, McArdle & Gaffney, 2011) and the 'Kickstarting Recovery' programme (Moloney & Rohde, 2017).

2.7.2.10. Social Benefits

The final element, the provision of an opportunity to socialise, supports the findings of a beneficial social development which was noted in all studies. These social gains included connecting with others, improving social confidence (Fredrich & Mason, 2018b; Butterly, Adams, Brown and Golby, 2006), building a social identity (Benkwitz & Healy, 2019), reducing social isolation (Benkwitz & Healy, 2019) and increased feeling of belonging and acceptance (Darongkamas, Scott and Taylor, 2011; Brawn, Combes & Ellis, 2015). These social improvements also created additional benefits, such as positive improvements in well-being (Fredrich & Mason, 2018b), increased access to individuals that can assist with specific matters (Henderson, Mills, Thronicroft & Webber, 2014) and provided a topic of conversation to aid in social interactions (Moloney & Rohde, 2017). It is highlighted that the peer support is a two-way exchange, where participants gain benefits and develop friendships by giving and receiving the support in and outside of the sessions (Lamont, Harris, McDonald, Kerin & Dickens, 2017). Both a means of creating and by-product of developing social networks is active citizenship, which is highlighted by Ramon (2018) as a means of improving social recovery. Benkwitz and Healy (2019) found the football intervention to be a medium to improve active citizenship as it allows exploration of communities and sourcing ways to contribute to these. Not only do participants gain social benefits from football, but Butterly, Adams, Brown and Golby (2006) found that a lack of an 'exercise buddy' acts as a barrier to being active. Hargreaves and Pringle (2019) found that social support acts as a means of overcoming barriers to engagement and reduces participant's reliance on mental health staff to accompany them to facilities. McGale, McArdle and Gaffney's (2011) BTN did contain this social element as part of their programme structure and results of their RCT showed no significant social change after participation. This may be as a result of the recruitment process, as participants were required to not be currently attending mental health services, nor be on antidepressants. Awareness of the programme is through

advertisement, hence most participants would have been out in their community to learn of the programme and research, therefore may already be active in their community.

2.7.2.11. Social Environments

In addition to the social benefits, the programmes also created a positive social environment for participants. As the group focused on football a normal social environment was created, where participants felt able to make friendships and felt like a valued member of the team (Darongkamas, Scott and Taylor, 2011). The environment created felt safe enough for participants of the 'Kickstarting Recovery' to be comfortable to encourage others to join and participate in the group (Moloney & Rodhe, 2017). McArdle, McGale and Gaffney (2012) found participants of BTN perceived that everyone in the group was present for similar reasons which aided in discussing personal mental health issues. This contrasts Lamont, Harris, McDonald, Kerin and Dickens' (2017) participants' view that the reason a person was in the group did not matter and referred to it as a football group, not a therapeutic group. The contrast emphasises the potential differences an altered structure can make, as BTN included therapeutic methods of CBT, while Lamont and colleagues' programmes focused on the activity of football.

2.7.2.12. Routine and Structure

Participants who enjoyed the programme found that it had the benefit of providing routine and structure to their daily lives, often being the motivation they required as they woke in the morning (Dyer & Mills, 2011). Hargreaves and Pringle's (2019) participants experienced automatic behaviours, that lead them to instinctively attend the sessions weekly. Described by Lamont, Harris, McDonald, Kerin & Dickens (2017) as an 'anchor point' in the participant's week, the football was attributed to providing an alternative to sedentary lifestyle and boredom (Moloney & Rohde, 2017).

2.7.2.13. Physical Activity Benefits and Energy Level Improvements

This alternative to sedentary lifestyle also had physical activity benefits and energy improvements. Physical health and fitness improvements are highlighted in a number of the reviewed studies and underlined as a motivational and enjoyable benefit of partaking in the football (Fredrich & Mason, 2018b; Hargreaves & Pringle, 2019; McArdle, McGale & Gaffney, 2012). Moloney and Rodhe (2017) found participants had more energy, improved fitness and were better sleep as a result of participation in the weekly session. Improvements in performance capacity of skills and abilities of the players, with knock-on impact on improvements in motor and processing skills were noted in 'Kickstarting Recovery' (Moloney & Rohde, 2017).

2.7.2.14. Management of Mental Health Symptoms

An important element of recovery is developing skills and strategies to manage mental health symptoms, so they do not have a significant impact on daily life. The football programmes described above have developed these coping skills and also act as a strategy in itself (Darongkamas, Scott and Taylor, 2011; Fredrich & Mason, 2018b). Hargreaves and Pringle (2019) found that participants used self-talk, peer support and goal setting as strategies for self-control management. Using football as a distraction technique from unhelpful thoughts was identified by both Moloney and Rohde (2017) and Lamont, Harris, McDonald, Kerin and Dickens (2017).

2.7.2.15. Rebuilding Personal Identity

Rebuilding personal identity and a sense of self was identified as a gain from participation in the football programmes. Building social identity is an important aspect to a person's recovery as it provides a bedrock for social confidence (Benkwitz & Healy, 2019). Service users identified improvements in self-confidence through participation in football. Those that previously played football were provided an opportunity to reconnect with pre-illness identities (Mason & Holt, 2012). With this new or renewed identity taken from being part of the team, participants felt they were no longer defined only by their mental health illness (Darongkamas, Scott and Taylor, 2011; McArdle, McGale & Gaffney, 2012). This supports Moloney and Rodhe's (2017) finding that participants experienced a new or rebuilt identity as a result of a role shift from a patient with a diagnosis to a team member.

2.7.2.16. Meaningful Activity

Sourcing activities that are meaningful to for an individual is an important aspect of recovery (Repper & Perkins, 2003). Football was found to be a meaningful activity for participants, acting as catalyst to inspire positive change through motivation and enjoyment (Benkwitz & Healy, 2019). As discussed above in the description of their study, Fredrich and Mason (2018a) used the PERMA positive psychology concept, which identified all concepts except Meaning in their analysis. This was attributed to the short interviews but may also be a finding contradicting that of Benkwitz & Healy's (2019) study, in that the football experience in the CTF programme was not meaningful to the participants. As discussed above in Section 2.5.1., occupations are meaningful activities in context, and what is considered an activity for one individual may be an occupation to another. Hargreaves and Pringle (2019) suggest that participants developed personal meaning towards football as a result of previous positive experience playing the sport, which would contribute to the transition of the experience from an activity to an occupation.

2.7.2.17. Hope

The concept of hope is highlighted as an important aspect of recovery, that is often challenging to support in clinical practice. In the most recent studies conducted on football programmes for mental health service users, hope and looking forward emerged as strong themes (Benkwitz & Healy, 2019; Hargreaves & Pringle, 2019). The element of enjoyment provided motivation and something to look forward to in the short term, but for Benkwitz and Healy (2019) it also created long term goals of pursuing football related opportunities outside of the mental health programme. This achievement of facilitating hope is also affiliated with community integration, providing a holistic recovery approach.

2.7.3. Gaps in Current Literature and Justification for Research

As discussed in the sections above, there is a large body of literature investigating the different football programmes designed for mental health service users. While providing a positive evidence-base for the use of football in mental health services, the reviewed literature also highlighted varying outcomes and challenges which emerge from different programme structures and cultural context. While the variation in research design is also noted. In highlighting the gaps in the current literature, justification and structure for research on the 'Kickstart to Recovery' programme emerges.

There is a growing body of research supporting football as a positive intervention for mental health service users in contexts where football is a popular sport. This includes Ireland, with the two programmes highlighted in the previous sections. Although BTN is a football programme in an Irish context, its unique inclusion of CBT techniques proves difficult to make comparisons with many factors of other programmes that focus solely on the football element. Moloney and Rohde's (2017) research of an early version of the 'Kickstart to Recovery' programme provides a closer comparison to other cultural contexts as its primary focus is football. Further evidence is required to justify such a programme in an Irish context as the outcomes are influenced by cultural differences, both in healthcare and football as a sport.

The majority of studies utilise qualitative methods to explore the value and meaning of football for the participants. As such, there is a distinct lack of quantitative studies that focus on these areas, particularly in using standardised assessments. With the foundation of Moloney and Rohde's (2017) quantitative perspective, further quantitative research would enhance the triangulation of evidence for the 'Kickstart to Recovery' programme.

The '*Best Practice Guidelines for Mental Health Services* state the need for recovery to be measured for service users (HSE; Mental Health Services, 2017a). In this body of research, recovery outcomes are primarily explored by qualitative methods, therefore lacking generalisation of results. Elements of recovery such as hope and management of mental health challenges emerge as themes in many studies, however measurement of change for these elements are not explored.

Similarly, the understanding of the meaning of football for the participants is required, as current literature presents contradicting findings. These differences may be a result of the programmes structures or may be personal factors of the participant. Further investigation into the factors that contribute to the meaning of the sport to the person and how this changes with participation in a football programme is warranted.

Torrey, Rapp, van Tosh, McNabb and Ralph (2005) outline the need for evidence-based practice to be conducted in conjunction with recovery in order to develop optimal services that have both a scientific basis and incorporated the lived experience of those with mental health challenges. The 'Kickstart to Recovery' programme requires this perspective and expertise in order to ensure the best quality service is being delivered within the Irish mental healthcare system.

The 'Kickstart to Recovery' programme is based in the Irish context, and therefore is influenced by the social and political environment that shapes its development in the mental health services. As such, the desired aspects from the programme are those that our policies and strategies strive for; community integration, recovery and improved quality of life for those that use the services. The use of occupation is a means of achieving these goals. Hence the areas that will be explored are quality of life, recovery-oriented change, social gains and the meaning of football for the person. With this research focused on, not only the outcomes of the programme but also, its structural aspects, it is anticipated that the elements that impact change will be identified.

2.8. Conclusion

This chapter explored the factors that presently influence mental health services in Ireland, through critique of relevant mental health policies and strategies in Ireland. The concepts of recovery, community integration and occupation were discussed as important objectives and enablers for mental health services.

A thorough review of current literature examining football interventions for mental health service users was conducted, with gaps in this body of research identified. In addition, the aims and objectives of the 'Kickstart to Recovery' programme, as outlined in the previous Introduction chapter, were examined. The combination formed the following research aim for this study;

'Examining the impact of the 'Kickstart to Recovery' programme through changes before and after participation in quality of life, recovery-orientation, social gains and the meaning of football for mental health service users.'

This and the objectives of this study are discussed in more detail in the following chapter.

Chapter Three: Methodology

3.1. Introduction

This chapter presents the methods used to achieve the research aim and objectives of this study. It will outline the rationale for the methods used and discuss their advantages and disadvantages. Within this, the variables and measures used to achieve the objectives of this study will be discussed, highlighting their value to this research. Following this, the data collection process will be outlined, highlighting barriers and strengths throughout. Finally, the data analysis and ethical considerations will be presented.

3.2. Research Aims and Objectives

With the growing emphasis on the profession of occupational therapy to produce evidence to support practice (Lloyd & Williams, 2009), it is important to evaluate current interventions and ensure they are meeting their expected aims. A means of understanding the effectiveness of an intervention for those with mental health challenges is measuring the change experienced by the individual (Rice, Stein & Tomlin, 2019). As such, the overall aim of this study is to investigate if change occurs for mental health service users after participation in the 'Kickstart to Recovery' football programme. The specific changes addressed in this study are presented in the study's objectives. As outlined in Chapter 1, three elements contributed to identifying the objectives of this study. These included exploring the programme's current aims, reviewing current literature to identify gaps and gaining an understanding of the importance of national policy and frameworks for mental health services.

As provided in Chapter 1, the 'Kickstart to Recovery' programme aims were outlined in the Louth/Meath Mental Health Service 'Kickstart to Recovery' booklet (Louth/Meath Mental Health Service, personal communication, 2017). These were summarised as the following;

- To promote social gains, such as community integration, reduced social isolation and enhanced social skills through participation in a leisure activity, namely football.
- To promote the benefits of physical activity.
- To promote mental health recovery and improve the quality of life of service users.

It is important to determine if the programme is meeting these expected outcomes in order to continue to utilise best practice methods. These aims, therefore set the foundation for the objectives of this study.

Once identified, gaps in the current literature on football programmes for mental health service users were utilised to build upon this foundation. It identified the need to measure recovery change for service users and to investigate the meaning of football for the service users as areas requiring additional focus.

Finally, a review of national policy and frameworks including '*A Vision for Change*' (Government of Ireland, 2006), '*Best Practice Guidelines for Mental Health Services*' (HSE; Mental Health Services, 2017a) and '*Healthy Ireland*' (Department of Health, 2013) was conducted to solidify the objectives of the study. These documents have shaped and influenced Irish political and social mental health culture and highlight priorities for developing mental health services, such as promotion of physical activity, recovery-oriented services and enhancement of social gains.

From this process emerged the four study objectives. These are:

1. To measure change in the **quality of life** of mental health service users who participate in the 'Kickstart to Recovery' programme.
2. To measure change in self-reported **mental health recovery** of mental health service users who participate in the 'Kickstart to Recovery' programme.
3. To measure if participants experience change in the **personal meaning of the football** after participating in the 'Kickstart to Recovery' programme.
4. To measure if participants experience **social gains** after participating in the 'Kickstart to Recovery' programme.

3.3. Research Design

3.3.1. Rationale for using a Quantitative Research Approach

A quantitative quasi-experimental research approach was undertaken for this study by using a pre-post format for evaluation. The need for additional quantitative research was identified through the literature review of the football programmes in Chapter 2. This form of research would also enhance the triangulation of the qualitative research conducted by Moloney and Rohde (2017), as it is currently the only research identified to be conducted on the 'Kickstart to Recovery' programme.

A quasi-experimental approach manipulates an independent variable to determine its effect on the dependent variable, without randomisation (Hissong, Lape & Bailey, 2015). Currently, it is not known if the aims of the 'Kickstart to Recovery' programme are being achieved, hence a quasi-experimental research approach was taken to determine this. This was adopted by basing the study's objectives on the aims of the 'Kickstart to Recovery' programme.

In choosing a research design, accessibility for service users was considered. There are a number of challenges encountered when conducting qualitative research with individuals who experience mental health difficulties, such as social demands of interviews and sustained concentration required (Drummond, 1996; Llyod & Williams, 2009). Quantitative research uses a more distant approach to data collection, which reduces these social pressures that may occur with qualitative approaches. Questionnaires are used by many health professionals (Ross, 2012), can ask unbiased questions (Drummond, 1996) and can allow participants to share information in a non-intrusive manner (Powell, 2014).

The advantages of including widely-used standardised assessments are that they are often extensively researched and contain administration instructions. Including such assessments in a study can add to the validity and reliability of the research findings (Drummond, 1996).

Three self-report outcome measures were chosen for this study with an aim to capture the participants' own perspectives of what is achieved through participation in the 'Kickstart to Recovery' programme. In keeping with the concepts of the Recovery Movement, the individual themselves are experts of their own condition (Davidson, 2016), and hence can provide the most accurate report of their outcomes. These measures are outlined in detail in Section 3.4.

3.3.2. Pre-Post Study Design

The pre-post study design is a three-part process; first the participants complete a questionnaire (indicated as O1 below) before commencing the 'Kickstart to Recovery' programme block, then the football programme block is run as normal (indicated as X below) and finally they complete the same questionnaire at the end of the programme (indicated as O2 below).

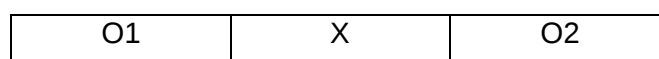


Figure 2 Representation of the pre-post study design

By comparing the pre and post questionnaires, partaking in the ‘Kickstart to Recovery’ programme can be attributed as a possible factor that influenced any change in scores (DePoy & Gitlin, 2011). It is acknowledged that the intervention cannot be attributed definitely to any change in scores as there are multiple factors that can threaten validity. These are outlined in Section 3.8.1.

As challenges with conducting research in non-clinical settings are prevalent, there is a need for more flexible approaches to evaluating health-related related initiatives (Friedli, 2000). Although this study design has limitations, the pre-post approach is advantageous in evaluating if change occurs for an individual after the ‘Kickstart to Recovery’ programme is introduced (DePoy & Gitlin, 2011).

3.3.2.1 Absence of a Control

The value a control has for pre-post study design is well documented (DePoy & Gitlin, 2011; Taylor, Kielhofner & Fossey, 2017; Brink, van der Walt & van Rensburg, 2012). For this reason, numerous efforts were made to include a control, however none were successful. It was attempted to source a “waiting list control”, however the nature of the referral system and number of referrals for the ‘Kickstart to Recovery’ programme resulted in all those interested in the programme being allocated a space.

As those availing of mental health services are a ‘hard to reach’ population, it was deemed unethical to allocate a control group from those referred, as the referral itself indicates a potential for the individual to benefit from this programme and they may be less likely to access other services (Spandler, McKeown, Roy, Hurley, 2013).

A time-series design, that allows for the group to act as its own control, was also considered. This design involves the standard pre-post study design with an additional lapse of time equating to the programme length with no intervention and an additional post-test after this period (Hissong, Lape & Bailey, 2015). Due to the programme’s structure, resources required for it to operate, time constraints, risk of high study mortality (described in Section 3.8.1.4.) and the number of referrals to the programme, it was not possible or practical for this design to be implemented.

Although numerous attempts outlined above were made, it was not possible to include a control group in this study and is considered a limitation of this study.

3.4. Data Collection: Questionnaire

As highlighted above, the use of standardised outcome measures in quantitative research enhances the research quality. This study utilises three standardised measures that are amalgamated to form the questionnaire. The following section includes a brief outline of the dependent variables and background of each chosen outcome measure included in the questionnaire (Appendix 2).

3.4.1. Quality of Life: 36-Item Short Form Health Survey (SF-36)

Enhancement of the quality of life of service users was highlighted as an important outcome of the 'Kickstart to Recovery' programme. Quality of life is defined by the World Health Organisation as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment" (WHO, 1995, p.1405). This definition encompasses the multi-factorial aspects of quality of life and emphasises the need to investigate multiple domains to gain a true understanding of its meaning for an individual. Engagement in meaningful occupations is closely linked to good quality of life and a lack of opportunity to engage in such can have a significantly negative impact on an individual's quality of life (Stadnyk, Townsend & Wilcock, 2010).

The first objective of this study is to measure if change occurs in the quality of life of mental health service users after participation in the 'Kickstart to Recovery' programme. From the multiple standardised assessments measuring quality of life, two were identified as having the greatest potential to meet this objective. This included the 36-Item Short Form Health Survey (SF-36) (Ware & Sherbourne, 1992) and the WHOQOL-BREF (WHOQOL Group, 1998). Both assessments were deemed suitable quality of life measures, therefore a review of relevant literature on both assessments, examination of questions posed in each measure and trial of both assessments in a pilot trial (described in Section 3.5.5.3) was conducted to identify which was to be included in the questionnaire.

After this rigorous process, the SF-36 was deemed the most appropriate assessment to address the objective of this study. A factor that determined the use of the SF-36 was the domains included in the measure. While both measures investigate similar factors of quality of life, the WHOQOL-BREF poses questions on multiple areas which combine to build a broad domain, while the SF-36 poses questions on a certain area to build a more

specific domain. For example, both measures explore energy levels. In the WHOQOL-BREF, a single question on energy level is incorporated within the domain of “Physical Health” (WHOQOL Group, 1998), while the SF-36 contains multiple questions to form the domain of “Energy/Fatigue” (Ware, 2000). This would allow more specific outcomes of the ‘Kickstart to Recovery’ programme to be identified.

The SF-36 is the most widely used quality of life outcome measure, including the assessment of individuals with mental health challenges (Su, Ng, Yang & Lin, 2014; Karow et al., 2014; Morton, Michalak, Murray, 2017). Multiple studies have supported the measure’s validity (Ware, 2000) and reliability (Tsai, Bayliss & Ware, 1997). Importantly, as a pre-post study design is implemented in this study, the SF-36 has shown to be sensitive to change (McDowell, 2006).

Written permission is not required for the use of the SF-36, however the use is subject to terms and conditions outlined in Appendix 3. These conditions are adhered to in this study.

The SF-36 is a self-report measure containing 36 questions. These questions are grouped to form the following nine domains; physical functioning, role limitations due to physical health, role limitations due to emotional problems, energy/fatigue, emotional well-being, social functioning, pain, general health and health change. A combination of Yes/No questions and Likert scales are used. Higher scores represent better health factors (Ware, 2000).

The use of a generic quality of life questionnaire can be criticized as not catering to specific challenges that would present for those with certain mental health difficulties (Morton, Michalak, Murray, 2017). The SF-36, however, was designed to represent “basic human values relevant to everyone’s health status” (Jenkinson, Layte, Wright, Coulter, 1996, pp 17) regardless of health status. It was chosen, therefore, over a condition-specific quality of life measure as the range of presenting mental health conditions in community mental health services can vary greatly and allows for a greater inclusion criteria in this research.

This outcome measures encompasses the multiple factors described in the WHO’s definition of quality of life, stated above. A clear observation is its strong focus on both the physical and emotional aspects of health, which reflects the ‘Kickstart to Recovery’ programme’s perspective that mental and physical health fundamentally impacts one’s quality of life.

3.4.2. Recovery- Oriented Change: Recovery Assessment Survey – Domains and Scales (RAS-DS)

The movement towards recovery-oriented services has been strongly emphasised over the last fifteen years, both nationally and internationally. The '*Best Practice Guidelines for Mental Health Services*' (HSE; Mental Health Services, 2017a) state the need for recovery outcomes to be measured to ensure our services are providing recovery-oriented supports. Recovery refers to an individual's unique journey of rediscovering a sense of self and purpose in life, despite the challenges that the lived experience of mental health illness brings (Deegan, 1988; Donskoy, Stevens & Bryant, 2013). It is closely linked to quality of life, as both emphasise the concept of living a meaningful life. However, investigating recovery-oriented change allows an insight into how the individuals' journey develops, regardless of symptoms (Repper & Perkins, 2003). Promotion of recovery is a significant aim for the 'Kickstart to Recovery' programme (Louth/Meath Mental Health Service, personal communication, 2017).

The second objective of this study is to measure the recovery-oriented change of mental health service users after participation in the 'Kickstart to Recovery' programme. As a standardised assessment specifically designed to explore the recovery related areas, the Recovery Assessment Scale - Domain and Stages (RAS-DS) (Hancock et al., 2015) was identified as the optimal measure to meet this objective. The RAS-DS was used in this study with permission from its author, Dr Nicola Hancock (Appendix 4).

Developed using Rasch-analysis, the RAS-DS is a self-report measure for mental health recovery (Hancock, Bundy, Honey, James & Tamsett, 2017). The RAS-DS has shown to be sensitive to change over time (Scanlan, Hancock & Honey, 2018) and has demonstrated good psychometric properties by producing reliable and valid mental health recovery results (Hancock, Scanlan, Honey, Bundy, O'Shea, 2015).

The RAS-DS comprises of 38 items and uses a four-point Likert scale, of "untrue", "a bit true", "mostly true" and "completely true". This consistent scale throughout the measure provides ease and familiarity for the participant completing it. Scoring of the RAS-DS provides both an overall "recovery score" and individual domain scores. A total recovery score is obtained by adding the scores of the 38 items, providing a score out of 152. The items are also divided into four domains; 'Doing Things I Value', 'Looking Forward', 'Mastering My Illness' and 'Connecting and Belonging'. These four domains focus on features of the recovery process including valued activity, hope, regaining control through management of mental health symptoms and importance of relationships

(Repper & Perkins, 2003). For both the total recovery and each individual domain, the scores represent a relationship with the individual's stage of recovery. Low scores represent an early stage of recovery, while higher scores represent a later stage of recovery (Hancock, Scanlan, Bundy & Honey, 2016).

Each domain has its own workbook, which further breaks down domains into modules, providing practical advice and guidance for the person on the recovery journey (Hancock, Everett, Honey, & Scanlan, 2016). For the purpose of this study, the modules outline the elements being measured in each domain. The domain of 'Doing Things I Value' explores doing things that one finds pleasurable, meaningful and are good for one's health, therefore may include occupations of value to the individual (Hancock, Everett, Honey, & Scanlan, 2016). The domain of 'Looking Forward' focuses on belief and hope, having future goals, understanding the complexity of the recovery journey and understanding that the individual is not the illness (Hancock, Everett, Honey, & Scanlan, 2016). The domain of 'Mastering My Illness' is focused on staying well, identifying early warning signs and developing an action plan based on past experiences of mental health (Hancock, Everett, Honey, & Scanlan, 2016). The domain of 'Connecting and Belonging' is described in section 3.4.4. with the other social measure of the SF-36.

With a key aim of the 'Kickstart to Recovery' programme to enhance the recovery oriented factors of its participants, inclusion of this standardised assessment in this study aims to measure change in recovery-oriented for mental health service users after participation in the 'Kickstart to Recovery' programme.

3.4.3. Meaning of Football: Adapted Engagement in Meaningful Activities Survey (EMAS)

To be classified as such, an occupation must be meaningful to an individual (WFOT, 2012). The 'Kickstart to Recovery' programme is a joint FAI and occupational therapy facilitated group. The programme aims to use the occupation of football as a medium to improve health and wellbeing, as well as provide an end product of skill enhancement, social connection and physical health improvement. For each individual the meaning of football may impact how they engage in the activity and the personal benefits they obtain from this involvement (Pepin, 2017). Furthermore, as highlighted in Chapter 2, engagement in meaningful occupations is shown to have strong links with good quality of life (Wilcock, 1999). This further emphasises the importance of exploring the meaning

of football to each individual, so to further understand the factors attributing to changes in quality of life.

No standardised assessment was identified for the measurement of meaning of football specifically. As such, the search for an appropriate assessment was broadened to include any measurements of occupational engagement. From this, the Engagement in Meaningful Activities Survey (EMAS) (Eakman, 2012; Goldberg, Britnell & Goldberg, 2002) was identified. As a measure designed for the occupational therapy profession, the EMAS addresses activity meaning and the extent of an individual's engagement in these activities (Eakman, 2012).

With permission from the author Dr. Aaron M. Eakman, the measure was adapted for the purpose of this study to address the activity of football only (Appendix 5). This allowed for to quantifiably capture the degree and change in meaning of football for the participants in the 'Kickstart to Recovery' programme. The self-reporting scale has 12 statements, with each starting with "The activities I do.." replaced with "Football.." and continued with the original statement. The author recommended reverting to the original 5-point scale used, of Never (1) to Always (5) (Goldberg, Britnell & Goldberg, 2002), which was utilised for this study.

Prior to being adapted for this study, the original survey has shown to have adequate internal consistency (Eakman, 2011). Similar positive findings have demonstrated satisfactory construct validity and convergent validity (Eakman, Carlson & Clark, 2010). Goldberg, Brintnell and Goldberg (2002) found the test–retest reliability to be acceptable when used with individuals with persistent mental health difficulties. The questions were designed to be easily understood and to accommodate individual with lower levels of literacy (Goldberg, Brintnell & Goldberg, 2002) The strong psychometric properties made the EMAS an attractive choice of measure for this study.

The EMAS adapted for this study will explore elements of meaning in the activity, namely football, for the person. This includes statements referring to the personal values, self-efficacy, competence in performance and satisfaction provided by football (Eakman, 2014). Furthermore, the adapted EMAS also evaluates the extent to which the meaning of football under these elements impact the individual through the rating scale.

The use of this outcome measure emphasises the occupation aspect of the programme, as it seeks to achieve the study's objective of measuring the change in the meaning of football for service users after participation in the 'Kickstart to Recovery' programme.

Using an adapted EMAS as an outcome measure provides an insight on the pre-engagement meaning of football for the participant but also allows the exploration of change in this meaning after participation in the programme.

3.4.4. Social Gains: Domains of “Social Functioning” of the SF-36 and “Connecting and Belonging” of the RAS-DS

Humans are innately social beings and without social interaction, we do not thrive (Creek, 2014). Socialisation is core to the concept of wellbeing (Wilcock, 1999), recovery (Repper & Perkins, 2003) and quality of life (WHO; The WHOQOL Group, 1995), hence the development of social connections and social skill enhancement are strong objectives of the ‘Kickstart to Recovery’ programme.

Multiple measures exploring different social elements were reviewed and considered for inclusion in the questionnaire. This included the Interpersonal Support Evaluation List-12 (ISEL-12) (Cohen, Mermelstein, Kamarck, & Hoberman, 1985), which focuses on functional social support, The Resource Generator-UK (RG-UK) (Webber & Huxley, 2007), measuring access to social capital and Social Provisions Scale (Cutrona and Russell, 1987), examining the social support provided by the individuals social relationships. All were reviewed for their relevance to the research objective, psychometric properties and practical features, such as wording of questions and duration to complete. Although all were considered appropriate measures for measuring social factors, the questionnaire was deemed inaccessible if another outcome measure was to be added. This was clarified during the pilot of the questionnaire, where feedback suggested the questionnaire was too long and similar questions were asked with the inclusion of any of the social outcome measures. In order to enhance the accessibility, enable sustained concentration and reduce repetition, an additional outcome measure focusing on social gains alone was not included.

Social benefits were strong findings in many studies examining football programmes for mental health service users in different contexts (Fredrich & Mason, 2018b; Butterly, Adams, Brown and Golby, 2006; Benkwitz & Healy, 2019; Darongkamas, Scott and Taylor, 2011; Brawn, Combes & Ellis, 2015; Moloney & Rohde, 2017). It is therefore recognised as an important aim of the programme and as such further evidence to support its presence as an outcome for service users required. When exploring the other objectives, social gains were found to be embedded in concepts of quality of life (WHO; WHOQOL Group, 1995) and recovery ordained factors (Reeper & Perkins,

2003), hence were found immersed in many identified outcome measures investigating these concepts.

As an alternative to adding an additional measure to the questionnaire, the domains of “Social Functioning” of the SF-36 and “Connecting and Belonging” of the RAS-DS were isolated and compared in order to investigate if change in social gains occurs. ‘Connecting and Belonging’ focuses on areas of building friendships, developing community connections and building on positive relationships (Hancock, Everett, Honey & Scanlan, 2016). ‘Social Functioning’ provides information on the impact physical or mental health has on the normal social activities of the person (Ware, 2000). While these will be explored when addressing the overall results of the RAS-DS and SF-36 measure, these two domains will be focused on under the heading of ‘Social Gains’ in analysis and discussion, in order to provide a view on the social outcomes.

The three outcome measures outlined above were combined into a booklet, with each marked as “Part 1”, “Part 2” and “Part 3”, in order to enhance accessibility, ease and flow for the participant when filling out the questionnaire. The scales and participant instructions remained as per the original in order to maintain standardisation.

3.5. Data Collection

3.5.1. Planning Data Collection

This study sought to recruit from a hard to reach population which required local ethical approval for each service area. As a result, this study had originally planned on recruiting participants from two HSE services in the north-east of the Republic of Ireland, which local ethical approval was granted.

Later in the data collection process, it became clear an expansion to the recruitment sites would enhance the study. A survey outcome report conducted by the South Meath Mental Health Service found 21 sites were currently running ‘Kickstart to Recovery’ programmes in the Republic of Ireland (Johnston, 2018, personal communication). The researcher reached out to all known sites facilitating a ‘Kickstart to Recovery’ programme and achieved contact with 13 occupational therapists of the services identified. Two reported that the ‘Kickstart to Recovery’ programme was not currently being facilitated within their service. The study was explained and the requested commitment from the service was presented to the occupational therapists facilitating the programmes.

Of the remaining sites, there was a positive response to inclusion in the recruitment process of the study, pending approval from managers and local HSE research ethics committees. The researcher attempted to source local HSE ethics research committees for each service area to submit an application. Challenges occurred primarily due to a lack of active ethics committee boards or boards not accepting applications at the time of the research. Additional challenges during this period were the loss of contact with occupational therapists or the lack of 'Kickstart to Recovery' programmes being facilitated during the research period.

Following this period, ethical approval was granted from two additional ethics boards, explained further in Section 3.7, allowing access to five additional sites in the south-east and mid-west regions of the Republic of Ireland. This provided a total of seven sites for recruitment.

3.5.2. Target Population

The study aimed to target service users of community mental health services in the north-east, south-east and the mid-west regions of the Republic of Ireland and who partook in the 'Kickstart to Recovery' programme during the time of the research. These individuals had a diagnosis of a mental health illness and were attending the community mental health service for support at the time of the study. Both male and females were welcome to participate, however it was known that all groups were predominantly attended by men.

3.5.3. Sampling Method

Convenient sampling was used to recruit from this target population focused on specific individuals who are currently engaging in the 'Kickstart to Recovery' programme (Hissong, Lape & Bailey, 2015). The recruitment was limited to the seven sites outlined in Section 3.5.1.

The number of possible participants, and hence the sample size, was difficult to predict as referrals to the programme and those who actually engaged varied between groups. However, as this study explores the specific intervention of the "Kickstart to Recovery" programme, it is deemed acceptable to include all those that meet the inclusion criteria into the study (Hissong, Lape & Bailey, 2015).

3.5.3.1 Inclusion and Exclusion Criteria

The criteria for participation in the study included any individual who has been approved to participate in the 'Kickstart to Recovery' programme. The participant must have completed both the pre-test questionnaire and attend at least one session of the programme during the research in order to complete the post-test questionnaire.

Originally the study was to include only individuals who's first time it was to complete the programme. As the study developed, however, and expanded to include multiple sites, it was deemed to be more appropriate to include both new and previous members of the programme as each group may provide a unique perspective of the programme's outcomes.

The exclusion criteria included those who were not deemed eligible to partake in the 'Kickstart to Recovery' programme. In order to be eligible, individuals required medical clearance from their General Practitioner (GP), including satisfying the PAR-Q, were not currently suicidal or experiencing suicidal ideation (Louth/Meath Mental Health Service, personal communication, 2017). The exclusion criteria also included those who did not complete the pre-test questionnaire or at least one session of the programme during the period the study was being conducted in that service. The inclusion/exclusion criteria is outlined in Table 2 below.

Table 2 Participant Inclusion/Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Approved to participate in the 'Kickstart to Recovery' programme running during the research period. • Completed at least one session of the current 'Kickstart to Recovery' programme. • Completed the pre-questionnaire.	• Not approved to partake in the 'Kickstart to Recovery' programme. • Did not complete at least one session of the current 'Kickstart to Recovery' programme. • Did not complete pre-questionnaire.

3.5.4 Recruitment Pathway

As outlined in Section 3.7, this study required local ethical approval for different site areas accessed for recruitment. As a result, different requirements were requested and adaptations had to be made to the research process to meet these requests. This included amendments to the recruitment pathway.

The first section discusses the recruitment pathway for Sites 1 and 2. This pathway was approved by the HSE North East ethics committee and is outlined in Figure 3.

Two occupational therapists who were not involved in the study were identified in both sites 1 and 2 to act as gatekeepers for the study. These gatekeepers contacted all those referred and approved for the 'Kickstart to Recovery' programme to request permission

to post Information Packs, including a letter of invitation (Appendix 6), participant information leaflet (Appendix 7) and consent form (Appendix 8). The letter of invitation included a time and date that the researcher would be present in each site if an interested group member wished to approach the researcher to ask questions about the study.

In both sites 1 and 2, the occupational therapist facilitating the programme met with each group member individually prior to commencing the programme. The researcher was present in the building during these pre-programme meetings. When checking in at reception, the group members were informed that the researcher was present and her location if they desired to take part in the study. After their meeting with the occupational therapist, they had the option to approach the researcher and complete the consent form and pre-questionnaire.

The same procedure was carried out for the post-data collection, where those who had completed the pre-questionnaires met with the researcher after their post-programme meeting to complete the post-questionnaires.

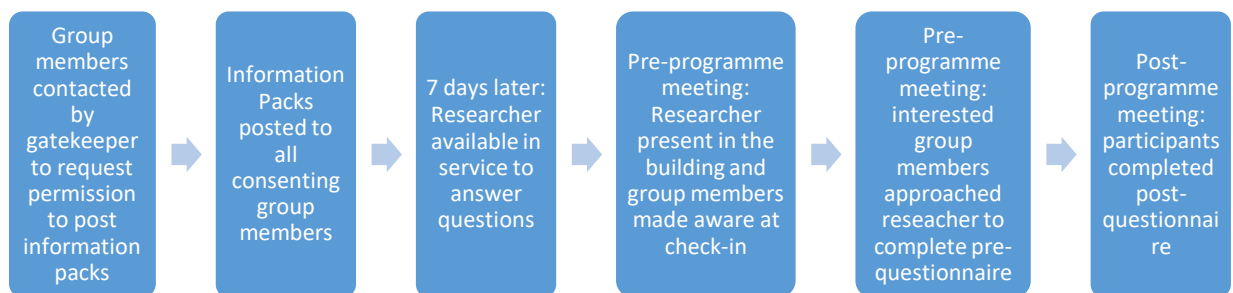


Figure 3 Recruitment Pathway of Sites 1 & 2

In order to meet the requirements of the HSE South East and University Limerick Hospitals Group ethics committees, an amended recruitment pathway was developed, which removed the need for posting the Information Packs to potential participants. The recruitment pathway for sites 3, 4, 5, 6 and 7 is outlined in Figure 4.

Posters were put up in each service to make group members aware of the study and included the researchers contact details. At least seven days prior to starting the programme, the group members for each service met for a pre-programme meeting. The researcher was present at the end of these meetings and any individuals who wished to discuss the study was invited to remain after the meeting concluded. At this point, any interested group members were given the Information Packs.

Depending on the services preference, the researcher was present before or after the first session. Group members who were interested in partaking in the research approached the researcher and completed the consent form and pre-questionnaire. The

same procedure was conducted for the post-data collection, where those who completed the pre-questionnaires met with the researcher before or after the final session to complete the post-questionnaire.

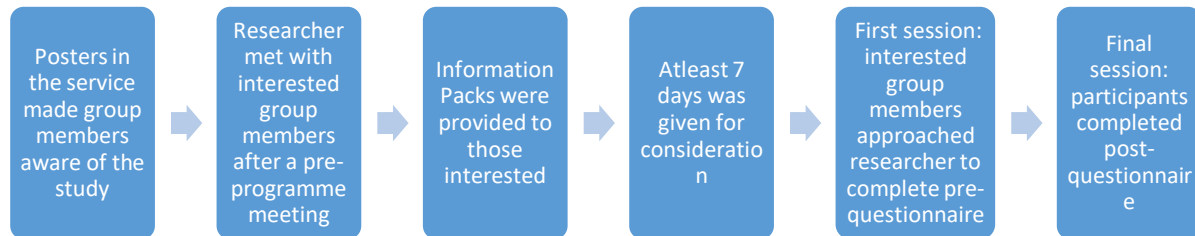


Figure 4 Recruitment Pathway of Sites 3, 4, 5, 6, & 7

3.5.5. Practicalities

When conducting a study that require multiple sites and hard to reach participants, it is important to consider practical factors that may impact the study's progress.

3.5.5.1. Context and Environment

The questionnaires were conducted in the presence of the researcher in order to allow for participants to clarify any question they do not understand, to avoid misinterpretation and maintain standardisation (Powell, 2014; Hissong, Lape & Bailey, 2015). It also reduced the risk of missing data and allowed the researcher to control factors that could impact the validity and reliability of the study (Powell, 2014).

The questionnaires in the first two sites were completed with the researcher and participant one-to-one, regardless of assistance required. Verbal feedback from participants was that this was not necessary as the questions were accessible and easy to understand. Hence, for the following five sites, questionnaires were conducted in a group setting, unless a participant requested to complete the questionnaire one-to-one with the researcher for assistance.

In the group format, adequate space between individuals was provided for privacy and headspace. Clipboards were given to each participant, which removed restrictions that may have been present at a table. A quiet environment was encouraged, with information provided to the group as a whole. While participants were completing the questionnaires, the researcher was present to answer any questions required. When the questionnaire was completed the researcher would "check-in" with the participant in regards to their feelings after its completion, if any question posed any difficulties or distress and made them aware that their occupational therapist was present in the building if they would like to "de-brief" about any aspect of the data collection.

3.5.5.2. *Pilot*

In order to provide sufficient information to potential participants about the commitment required and to insure they questionnaires were as accessible as possible, the time it would take to complete the questionnaire in full was measured. As the target group were a difficult to reach population, it was not appropriate to source individuals in this population for a time-trial and feedback session with the questionnaires. Five individuals who were not familiar with the questionnaires or measures used were sourced for a pilot. The two different quality of life measures, SF-36 and WHOQOL-BREF, were trailed in addition to the background information questions. Feedback was provided on the accessibility of the questions, the wording of the background information, the effort required to complete the questionnaire and the order of the measures.

The finalised questionnaire averaged on 15 minutes to complete. All reported that the questions were accessible. In order to accommodate individuals with lower levels of literacy a range of 15-30 minutes to complete the questionnaire was allocated.

3.5.5.3. *Changes from Pilot*

The pilot session highlighted that some individuals may require assistance to complete the questionnaire. In order to provide the opportunity for participants to give the most accurate responses all occupational therapists were asked to highlight any supports that may be required within their group in advance, so they could be put in place if the person decided to participate in the study. This included, but was not exclusive to, literacy difficulties, visual impairments or language barriers.

Individuals across various sites highlighted having a low literacy level and required one-to-one assistance by reading out the questions when completing the questionnaire. The statement on the questionnaire was only read to the participant and rephrasing or paraphrasing the question wasn't provided as this may inadvertently change the meaning of the question and reduce standardisation of the measure (Hancock, Scanlan, Bundy & Honey, 2016).

In exceptional circumstances it was impossible for the participant to answer the question without an alternative word provided. Words that had been identified as having a potential of requiring assistance in understanding were assigned synonyms so consistent paraphrasing or rephrasing was conducted. For example, the most common phrase highlighted as posing difficulties in understanding was "full of pep", which was assigned the synonym "full of life" ("pep", 2015). Both the participant and the assistant were provided with a copy of the questionnaire, to allow the individual to answer the question privately (Hancock, Scanlan, Bundy & Honey, 2016)

3.6 Data Analysis

Descriptive statistics was used to describe information collected on research participants and the 'Kickstart to Recovery' programmes in each service. Frequency tables and graphs were used to describe frequency distribution.

All statistical analyses were completed on the computer programme, IBM Statistical Package for the Social Sciences (IBM SPSS), v26. A Codebook (Appendix 9) was created to keep record of the labels used for each variable and the unique instructions to input the data collected into a format understood by IBM SPSS. The significance level was set to 0.05.

The data was screened for outliers and missing values prior to commencing analysis. If a missing value was identified, it was noted in the logbook (Appendix 10). If a missing value is identified, the corresponding response in the post-test data is also removed to maintain a balanced comparison.

An outlier is considered "a data point that is far outside the norm for a variable or population" (Osborne & Overbay, 2008, p.1).

In order to identify if an outlier is present the following steps are undertaken;

- Refer to the 'Descriptives' table and compare the 5% Trimmed Mean with the Actual Mean. Examine if there is a large difference between the two figures.
- Examine the histogram for data points out on the extremes of the chart.
- Examine the boxplot for data points identified as IBM SPSS outliers (external from the whiskers and identified with its participant number).

Data analysis for outliers within each data set is displayed in Appendix 11. If an outlier that may impact the results was identified, it was removed from the data set and recorded in the logbook.

If an outlier is removed from the pre-test data set, the corresponding post-test score for that participant will also be removed to maintain a balanced comparison.

The data used violates more than one assumption of parametric methods, therefore non-parametric methods were used in this study. The factors that allow for non-parametric methods to be used are the following;

- Sample size for those that completed both the pre and post-test was >30 (n=27) (Pallant, 2016)
- The sample is derived from a population with a skewed distribution. This was confirmed by examining the domains of each outcome measure's histogram to identify a lack of a normal distribution.
- The measures are ordinal.

As the variables do not have a normal distribution, descriptive statistics reported on are the median and the interquartile ranges (Habibzadeh, 2013).

Three different non-parametric tests were used to analyse data collected by the outcome measures SF-36, RAS-DS and the EMAS. The Wilcoxon Signed Rank Test was the most frequency used test in this study. It is the non-parametric test used to for repeated measures, which is appropriate for testing the pre- and post-test data.

The Mann-Whitney U Test is the non-parametric test used to test for differences between two groups by comparing each group's medians. Examples of the use of this test in this study was investigating if there was a difference in scores between those that lived in a city compared to those that lived in a town.

The Kruskal-Wallis Test is the final non-parametric test used in this study, which is used to compare differences between three or more different groups. An example of its use in this research is for comparing the scores of the three different duration of programmes (G1= 5 or 6 sessions, G2= 7 sessions, G3= 8 sessions) that were present in this research.

The output of IBM SPSS for each test run is recorded in the results (Chapter Four).

3.7 Ethical Considerations

3.7.1. Ethical Approval

Ethical approval was granted from the four following ethics research committee board:

- Trinity College Dublin Faculty of Health Sciences Ethics Board (Appendix 12)
- Research Ethics Committee, HSE, North East (Appendix 13)
- Research Ethics Committee, HSE, South East (Appendix 14)
- University Limerick Hospitals Group, Research Ethics Committee (Appendix 15)

All relevant documentation including participant information leaflet, consent form and questionnaires, including the participant's demographic information (Appendix 2), in addition to detailed description of the proposed research were sent to each committee board. Ethical approval was granted by Trinity College Dublin, with two additional amendments approved. This first amendment was to bring the participant information leaflet and consent form in line with that approved by Research Ethics Committee, HSE, North East prior to commencing the data collection. The second amendment was a request to expand to additional sites already approved by the two local ethics committees. Research Ethics Committees of HSE, South East and University Limerick Hospitals Group requested amendments to the recruitment pathway, as outlined in

Section 3.5.4., and the removal of the option to have a copy of their completed questionnaire kept in their client file of the service in order to meet their approval criteria. The participation information leaflet and consent form were revised to remove this option. The sections removed are shown in Appendix 16. These amendments were approved by Trinity Ethics Committee Board.

Although challenges were faced in an attempt to satisfy the requests of multiple ethics committees, the principles of ethics and the safeguarding of the participants were at the forefront of the process. The ethical principles of confidentiality, informed consent, autonomy and nonmaleficence are discussed in context of this study.

3.7.2. Confidentiality

Ensuring the participant's data and their identity remain private was necessary for the study. In order to ensure this, the data was pseudonymised, by allocating a research number to each participant. The participants name and researcher number were recorded on a document referred to as the 'key'. In order to further protect the data, this 'key' was stored in a sealed envelope, marked as "private and confidential" and stored in a locked cabinet or drawer in the corresponding HSE-site. Each 'key' was returned and opened by the researcher for re-identification of the participant to the research number during post-data collection. Once the post-questionnaires were transported to the location of data analysis and pre- and post-questionnaires have been matched according to the research number, the researcher instructed the occupational therapist onsite to shred the 'key', which was enclosed in an envelope to maintain confidentiality, hence making the data anonymous.

The consent forms and completed questionnaires were stored in two separate locked cabinets in the Principle Investigators office in the Occupational Therapy Department in Trinity Centre for Health Sciences. No identifiable information is recorded on the questionnaires, nor is there information that would identify the participant research number on the consent forms.

The sites in this study were also pseudonymised and are referred to in terms of region, rather than county, in order to further protect the identity of their service users.

The HSE North East Research Ethics Committee requested that the participant be provided with the option to have a copy of their completed questionnaire kept in their client file of the service if they desired. The participants in the first two sites were provided with information in their participant information leaflet about this option, including the

impact on confidentiality. This was presented as a choice of YES or NO on the consent form, which the participant ticked to indicate their preference.

This option was not available for the remaining five sites as it was not approved by local ethics committees. This information was removed from the participant information leaflets and consent forms for these sites.

During data analysis, scores of the questionnaires were recorded onto a scoring sheet for each participant, designed on Microsoft Word. Following this, these scores were transferred onto an Excel Document for analysis. Each document, both for the scoring sheets and overall scores, was encrypted, password protected and stored on a password protected computer.

3.7.3. Informed Consent

Informed consent is the process of providing the potential participant with enough information regarding the study prior to deciding to participate, which will allow them to make an informed decision regarding their participation or not (Workman, Kielhofner & Taylor, 2017).

For consent to be classified as informed consent it must be presented in an accessible manner for the individual to fully understand its content. The participant information leaflet was provided in written format. When meeting with each group to provide the information, the researcher gave a summary of the research aims and purpose, what was involved if one decided to participate and provided an opportunity for questions. The consent form was enclosed in the participant information pack, which the potential participants were asked to read prior to deciding to participate. This allowed for more than one opportunity to see this form prior to signing it. The researcher's contact details, for the purpose of the research only, were included on the leaflet and was highlighted for the potential participants to use if they had any questions. Prior to leaving each group, the researcher offered to read aloud the information leaflet for any participant that self-identified difficulties with literacy.

Prior to completing the questionnaire, the researcher discussed the study again and allowed time for any outstanding questions to be asked and answered to their satisfaction. Time was also allocated to completing the consent form and a signed copy of this was provided to the participant.

3.7.4. Autonomy

Voluntary participation is an important element in any research and including being able to withdraw from the study at any point (DePoy & Gitlin, 2011). Although the recruitment pathway changed (outlined in Section 3.5.4.), efforts were made during both processes to prevent coercion and ensure an autonomous decision to participate was being made.

The choice to take part in the research was stated in the participant information leaflet, consent form and during meetings with the researcher. It was reiterated that participation or not in the research would not impact the individual's inclusion or participation in the "Kickstart to Recovery" programme. This differentiation between the programme and the research was important to insure one did not impact the other.

3.7.5. Nonmaleficence

Nonmaleficence, or "do no harm", is an important ethical principle in health-related research, which refers to making the greatest effort to minimize risk (Workman, Kielhofner & Taylor, 2017).

Although no harm was anticipated during this research, should a participant have become distressed during the filling out of the questionnaires, the occupational therapist from their service would be onsite to provide assistance.

In addition to the data collection process, in the unlikely event of a data breach, the participant may be subject to risk. Measures were taken to reduce this risk, which are outlined in the next section.

3.7.6. Data Protection

The General Data Protection Regulation (GDPR) aims to protect and regulate the movement of personal data (GDPR, 2018). Every health researcher is obliged to comply with the regulations and must complete data protection training (GDPR, 2018). This was completed by both the Principal Investigator and Lead Investigator in January 2019.

Requirements of GDPR were addressed throughout this research and every effort was made to ensure compliance. This included ensuring the principle of minimisation, which refers to gathering data that is "adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed" (GDPR, 2018, Article 5) is upheld. Questions posed in the questionnaire were chosen and limited to the areas relevant to the aims of the study. The questions posed in the demographics form were revised and selected on what was anticipated to be relevant demographic information for the study.

No unnecessary questions that did not have relevance to the programme or research were posed, such as date of birth or address.

Safeguards also were implemented to limit unauthorized access to personal information and protect against a data breach. These included the use of pseudonymising participants and sites (outlined in 3.7.2.), use of password protected computers and password protecting and encrypting all documents. A Data Protection Impact Assessment (DPIA), which outlines the risks and procedures for processing the data, was completed and sent to the Data Protection Officer (DPO) of Trinity College Dublin.

3.8 Research Trustworthiness

In order to provide a study of value, the threats that are posed against its trustworthiness must be acknowledged and methods put in place to attempt to combat these. Although it is not possible to control against all threats to the validity and reliability of the study, it is important that these threats are recognised when interpreting the results. In the below section, the threats posed to the validity and reliability of the study are outlined in addition to the methods put in place to combat these.

3.8.1. Threats to Internal Validity

The internal validity refers to the degree to which the results can be attributed to the independent variables as opposed to external factors (Brink, van der Walt & van Rensburg, 2012). Threats to internal validity are outlined below.

3.8.1.1. Maturation

Maturation refers to the natural development or change of the participant over time (Hissong, Lape & Bailey, 2015). With many mental health conditions, there is a possibility of symptoms fluctuating, which has a potential to impact the answers provided. Additionally, participants have a period of approximately eight weeks between pre-test and post-test, during which a range of life events may occur that can impact the results.

3.8.1.2. History

Historical contamination refers to the occurrence of an event or environmental change that was not anticipated in the planning of the study (Hissong, Lape & Bailey, 2015). This is relevant to this study as it is not possible to monitor the participants activities external to the study nor cannot know or impact input from other health professionals or interventions they are receiving which have similar aims as the 'Kickstart to Recovery' programme.

It must also be noted that during the time of this study, Football Association of Ireland (FAI) was a media focus due to queries of its governance. It is acknowledged that this negative political atmosphere may have influenced some participants and hence impacted the internal validity of the study.

3.8.1.3. Testing Effects

Testing effects refers to the influence exposure to the testing materials may have on repeated tests (Cunningham, Weathington & Pittenger, 2013). As this study utilises a pre-post design there is an increased risk that the participants will be familiar and have time to reflect on the questions asked, hence providing more insightful replies in the post-test questionnaires than the responses in the pre-test.

3.8.1.4. Study Mortality

The impact of participants dropping out of the study or disengaging from the football programme is referred to as mortality (Brink, van der Walt & van Rensburg, 2012). It can be predicted that in utilising a pre-post study design, a number of participants may disengage from the programme and/or the study. These individuals may be an important subset as there may be differences between them and those who remained engaged (Cunningham, Weathington & Pittenger, 2013). When analysing the groups as a whole, significant dropouts may also skew results when comparing the pre-test and post-test results (Brink, van der Walt & van Rensburg, 2012). Strategies to maintain participant inclusion and reduce the threat of mortality in this research are outlined in Section 3.8.4.5.

3.8.2. Threats to External Validity

The external validity is the degree to which the results can be generalised to people, settings, outcomes or treatments (Huebschmann, Leavitt & Glasgow, 2019). External validity and internal validity often impact one another. Controls put in place to combat threats to internal validity may reduce the relevance of the results to the programme's real-life execution (Hissong, Lape & Bailey, 2015). Threats to external validity are outlined below.

3.8.2.1. Replication

In the absence of sufficient records of the study's methods, including the process, context, settings and intervention, studies aiming to replicate the findings cannot be generalised as the results cannot be conclusively attributed to the same methods (Huebschmann, Leavitt & Glasgow, 2019). This threat was recognised and strategies

such as an audit trail, intervention fidelity documentation and a reflective diary were implemented to combat this threat (Sections 3.8.4.1, 3.8.4.2 and 3.8.4.3.).

3.8.2.2. Multiple Treatments

Like history contamination, participants may be receiving multiple interventions to aid in their mental health challenges, which reduces the ability to generalise the results to other services that may not provide multiple interventions, or the same interventions (Hissong, Lape & Bailey, 2015).

3.8.2.3. Reactive Effect

When a participant is aware that they are involved in an assessment, they may exhibit reactions, such as anxiety, which may hinder how they respond in the questionnaire (Brink, van der Walt & van Rensburg, 2012). As the target population of this study are individuals with existing mental health challenges, there is a high probability that such reactions may occur. Controlling external factors lead to these reactions is discussed in Section 3.8.4.4. as a means of combatting this.

3.8.3. Threats to Reliability

Like validity, reliability of a study impacts the trustworthiness of its results. Reliability refers to reproducibility of the study (Keen & Edmunds Otter, 2014)

3.8.3.1. Participant Concentration and Motivation

Individuals with mental health challenges often experience challenges with sustained concentration or motivation. Completing a questionnaire with an estimated fifteen to thirty-minute duration may be difficult for some individuals and answers may be affected if these challenges occur (Hissong, Lape & Bailey, 2015). Careful planning of the questionnaire layout and the researcher's observations outlined in Sections 3.8.4.3. and 3.8.4.4. aimed to reduce this threat to reliability.

3.8.3.2. Test Environment

As this study included multiple sites throughout the Republic of Ireland, it was not possible to use the same location for the data collection, which presented challenges in consistency. In order to compare the groups accurately, it was desirable that the environments were as similar as possible, especially the pre and post data collection conditions for each service. Measures to preserve reliability in different environments are discussed in Section 3.8.4.4.

3.8.3.3. *Social Desirability Responses*

As this study utilizes self-report measures, there is a potential for participants to attempt to appear “better” for the benefit of the researcher, rather than true self-reflection (Hissong, Lape & Bailey, 2015). This is more likely to occur if a relationship between the researcher and the participant already exists (Hissong, Lape & Bailey, 2015), hence the distant role of the researcher, outlined in Section 3.8.4.3., is important to combat this threat.

3.8.4. Combating Threats to Validity and Reliability

It is not possible to control for all factors outlined as threats above, such as maturation and multiple treatments. Every effort was made, however, to combat threats that were within the scope of this research to control or manage. These strategies are outlined below.

3.8.4.1. *Intervention Fidelity: Combatting Replication Bias*

One approach taken was recording of the intervention fidelity, which refers to the intervention being carried out as the developers intended (Carroll, et al., 2007; Slaughter, Hill & Snelgrove-Clarke, 2015; Breitenstein et al., 2010). When exploring the effectiveness of an intervention, it is important to explore, not only did the intervention make an impact, but how and why it did so (McGee et al., 2018). By exploring the fidelity of an intervention, the internal validity of the research increases as the findings can be attributable more to the intervention described (O’Shea, McCormack, Bradley & O’Neill, 2016). It also benefits the reproducibility of the study, hence improving the external validity (O’Shea, McCormack, Bradley & O’Neill, 2016). Monitoring of the intervention also benefits in improving its ability to be generalised to other settings as evidence-based practice.

Two documents to record the intervention fidelity were designed for the occupational therapy facilitators to complete. The first outlined the programme in their service, its aims and objectives, facilities and transport to the venue, the environment the football takes place in, expected number of participants and other factors about the overall programme (Appendix 17). The second was completed after each session by the occupational therapist facilitator and outlined anything that varied or changed from what was outlined in the first document (Appendix 18). This included the number of participations that attended, the weather, the length of the session and any other factors that may impact the programme and those participating in it. This allowed for but also monitored adaption

of the programme to the local site to accommodate the individual needs of the participants, the service and the environment (Huebschmann, Leavitt & Glasgow, 2019)

3.8.4.2. Audit Trail: Combatting Replication Bias

The audit trail is a detailed document that records research process (Akkerman, Admiraal, Brekelmans & Oost, 2006). An extract of the audit trail kept for this research can be found in Appendix 19. Use of an audit trail allows for the pathway taken by the study to be recorded, hence enhancing the reproducibility of the study. It also tracks when key decisions were made, which, with the aid of the reflective journal, allows for the researcher to reflect on the progress of the research and monitor threats to the validity and reliability. The extract of the audit trail below shows the researcher's efforts to maintain a balance between organising the practicalities of data collection, building awareness of researcher bias through regular supervision and updating her reflective journal and development of skills and knowledge relevant to the research, through courses, such as 'Engage National Men's Health Training Unit 6 – Connecting with Young Men'.

3.8.4.3. Role of the Researcher: Combatting Replication, Social Desirability Responses and Challenges with Participant Concentration and Motivation

The researcher's role in the study was an important aspect to consider to reduce the threats to the reliability and validity of the study. The same researcher was used for each site and was present during all the data collection process, which was advantageous in attempting to control the environment and to maintain standardisation throughout (Cunningham, Weathington & Pittenger, 2013). This researcher was impartial to the 'Kickstart to Recovery' programme as she did not have any prior association with the FAI or the mental health services providing the programme, hence reducing the risk of bias.

A distant researcher-participant relationship was maintained, with attempts to standardise interactions as best as possible (Hissong, Lape & Bailey, 2015). This approach was taken to reduce researcher bias (Section 3.8.2.1) and reduce any potential for socially desirable responses (Section 3.8.3.3). The researcher was not involved in the football or other aspects of the programme in order to draw a clear distinction between it and the research. In order to maintain this non-bias approach towards participants, a reflective journal was kept by the researcher. This allowed the researcher to reflect on her own experience of the research and was updated after each interaction with participants in order to maintain similar interactions throughout.

The use of the reflective journal also aided in documenting observations and environmental aspects when conducting the data collection. This became an important tool when completing the data analysis, as it prompted identification of the key environmental factors potentially impacting the study. An example of this was the identification of the two sites containing social aspects to the programme, which was not present in other sites. Appendix 20 provides one of these extracts, which highlights the sentence identified during the data analysis that prompted further investigation into the social environment of this site.

The researcher also used careful observation skills by offering appropriate breaks, adapting the environment or providing encouragement to manage participant fatigue, loss of motivation and/or loss of concentration while completing the questionnaire.

3.8.4.4. Standardisation of Testing Instrument and Context: Combatting Challenges with Participant Concentration and Motivation, Reactive Effect and Test Environment.

In addition to standardising the researcher's interactions, attempts were also made to standardise the instrument and context for the data collection.

For both the pre-test and post-test, the same outcome measures were used as part of the questionnaire. This aimed to reduce the threat to internal validity as standardisation was maintained (Brink, van der Walt & van Rensburg, 2012). The order of these outcome measures also remained the same, as the longer measure with the more complex, varied scales was presented first, while the shorter measure with consistent scales was presented at the end, to reduce participant fatigue or reduced concentration.

In addition to standardising the instrument, the data collection was conducted during the same stage of the programme for all sites. Accordingly, the pre-tests were conducted during the first week of the programme block, and the post-tests were conducted the last week of the programme block. All participants in each site completed the questionnaires on the same day, therefore the group for each site were experiencing the same external environment and time for assessment, increasing the internal validity of the study.

Although challenges were experienced in controlling the physical environment, the researcher made a conscious effort to manage external factors. To accommodate any reactive responses, a relaxed, quiet atmosphere was encouraged. Records were kept of

how pre-tests were conducted for each site and were replicated as best as possible for the post-tests.

3.8.4.5. Maintaining Participant Inclusion: Combatting Study Mortality.

In order to reduce the impact of mortality on the internal validity, participants were informed of the post-test aspect of the research prior to consenting to participate, as well as reiterating this after the pre-test was completed. Participation in the post-test was made convenient to the participant by the researcher utilising the same structure, location and time as the pre-test (Brink, van der Walt & van Rensburg, 2012).

3.8.4.6. Geographical Variation

Although this does not combat any specific threat to reliability or validity, the variance in the geographical recruitment sites for this study enhances the research trustworthiness and increases the generalizability of the study. This study recruited from seven sites in the north-east, south-east and mid-west regions of the Republic of Ireland. By utilising a sample from multiple sites in a wide geographical area, a greater number and range of individuals are represented in this study, and hence improves the external validity of the study.

3.9 Conclusion

This chapter has outlined the methods used to explore the aims and objectives of the study. A quantitative summative research approach using pre-test post-test design was used to answer the research question. The questionnaire included the valid and reliable outcome measures of the SF-36, RAS-DS and the EMAS adapted to focus on football. Data analysis was outlined, the results of which will be discussed in the following chapters.

Chapter Four: Results

4.1 Introduction

This chapter is presented in three main sections. The first section describes the demographics for each site, including location, environment, facilities available and accessibility of the programme delivered in each service. Following this, the demographics and results for the participants who took part in the study, including those who completed the pre-test only, will be recorded. Finally, the demographics and results for those who completed both the pre-test and post-test, in which inferential statistics will be used to compare these results, will be delivered.

Throughout this chapter, within tables and figures, the 'Kickstart to Recovery' programme may be referred to as 'KtoR' due to space constrictions. The Response Flow Chart (**Figure 5**) below outlines the research journey of recruitment and the number of participants in each site.

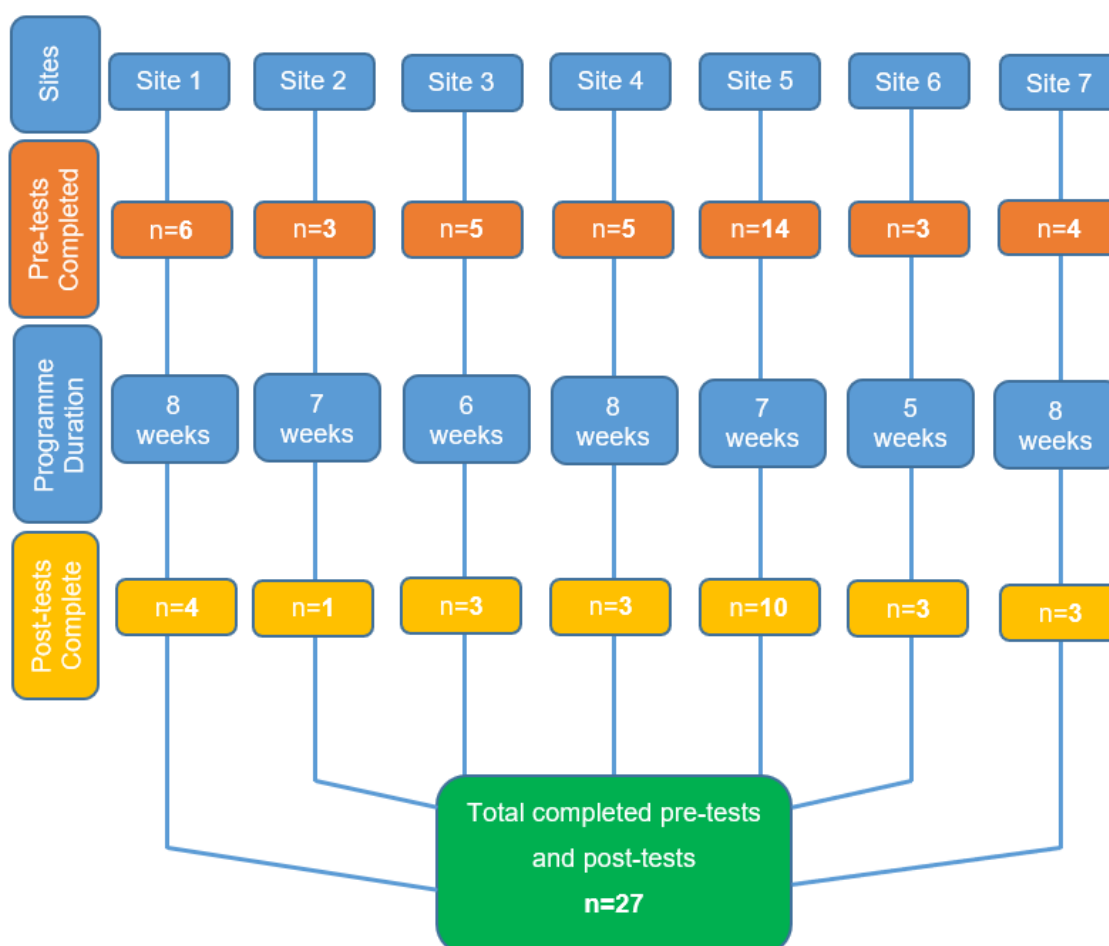


Figure 5 Response Flow Chart

4.2. Kickstart to Recovery Programme Sites and Services

Seven community mental health services that ran the 'Kickstart to Recovery' programme were utilised for recruitment of participants for this study. The environment of the programme, the components of the programme in each service and information on the intervention fidelity during the research period are outlined in this section.

All programmes were run in community-based facilities, which had no direct affiliation with the mental health service. **Table 3** outlines the environmental factors of each programme site.

<i>Table 3 Environment of the programme site</i>					
	Geographical Location	Type of Facility	Football Environment	Accessibility	Facilities available
S1	Leinster Town (central)	GAA club centre	Indoor Astroturf	Central to town Public transport	Free parking, changing rooms.
S2	Leinster Town (central)	Community Centre	Indoor hall	Cycle/walking distance to town centre	Free parking, changing rooms.
S3	Munster Town (central)	Sports and leisure facility	Indoor hall (outdoor Astroturf available for good weather)	Limited public transport.	Free parking, changing rooms, showers, kitchen area.
S4	Munster City (outskirts)	Youth Centre	Indoor hall	Public transport (on bus route)	Free parking, changing room.
S5	Leinster Town (outskirts)	Community Centre	Indoor hall (previously outdoors but moved due to resourcing issues)	HSE transport from Day Centre. 20-minute walk from town centre.	Free parking
S6	Munster City (outskirts)	Sports and leisure facility	Outdoor Astroturf (indoor hall available for very bad weather)	Public transport (on bus route)	Free parking, changing rooms & showers, café onsite, outdoor picnic tables
S7	Leinster City (outskirts)	Sports and leisure facility	Indoor hall or outdoor Astroturf (weather dependent)	Public transport	Free parking, café onsite,

Six of the seven services in this study have facilitated a 'Kickstart to Recovery' programme previously and have introduced additional features to their own service. All sites had at least one occupational therapist facilitating the group. One occupational therapist was male, and all others were female. **Table 4** outlines the programme history and structure in each site.

<i>Table 4 Kickstart to Recovery programmes in each service</i>			
	KtoR programmes run in the service to date	Occupational Therapist (OT) participate in the football	Additional element(s) to the programme
S1	Started April 2014	Y	-Participants set goals with OT before block and review after block is complete.
S2	First time run in the service	Y	-Participants set goals with OT before block and review after block is complete. -Some service users walk home together.
S3	4 blocks	Y (1 - 2 OTs)	-Tea and sandwiches after the session on site. -Ran a gym group before K2R block. -Often participate in matches against other service' KtoR groups.
S4	Started June 2016	Y (depending on numbers at session)	None
S5	3 blocks	Y (1 – 2 OTs)	-Continuous weekly football group without a FAI coach. -Many travel together on HSE bus. -Other continuous weekly physical activity groups in the service. -Often participate in matches against other service' KtoR groups.
S6	Approx. 12 blocks (Started summer 2016)	Y (2 -3 OTs)	-Occasionally service users attend local football games as spectators (not organised by the service). -Socialise together at picnic tables before and/or after the session. -A text reminder is sent by the OT the day before the session. -Often participate in matches against other service' KtoR groups.
S7	4 blocks	Y (2 OTs; at the end of the session, during a match)	-Participants set goals with OT before block and review after block is complete. -Post-Kickstart to Recovery programme gathering to present certificates.

Recording the intervention fidelity is important to ensure the intervention described in research is that that was carried out in practice.

Table 5 reports the information recorded before each programme started in order to understand what the expected structure and usual programme would be without the influence of external factors. For example, external factors may result in the number of participants attending the programme to fluctuate from session to session or some may dropout as the sessions progress. **Table 5** below records the number of participants each site expected to attend and outlines background of the FAI coach expected to facilitate each group and the expected number of service users to attend.

<i>Table 5 'Kickstart to Recovery' programmes run during the research</i>						
	Expected No. of sessions	Has the FAI Coach previously run a KtoR programme	Has the FAI Coach facilitated this group & if yes, no. of times	Expected no. of participants	First time service users participating in KtoR	Service users who previously participated in KtoR
S1	8	Y	N	10	7	3
S2	8	Y	N	8	8	0
S3	6	Y	Y (once)	9	4	5
S4	8	Y	Y (3 times)	11	0	11
S5	8	Y	Y (once)	15	2	13
S6	5	Y	Y (9 times)	8	0	8
S7	8	Y	Y (4 times)	5	2	3

Table 6 outlines the information gathered throughout the programme. This information was provided by the occupational therapist facilitating each programme. Changes that occurred to the structure or factors that could not be predicted in advance (attendance rates) were recorded.

Table 6 Intervention Fidelity of the 'Kickstart to Recovery' programmes during the study					
	Actual no. of sessions completed	Attendance per session			Changes to structure and/or additional elements to the football programme
		Mean	Mode	Range	
S1	8	4.12	3	3 – 6	No changes noted
S2	7	4	3	3 – 7	-Final session cancelled due to low numbers. -Change in OT for 2 sessions. -2 sessions OT did not participate in the football.
S3	6	5.5	5*	4 – 7	-Session rescheduled due to unavailability of OT. -Change in FAI coach for one session.
S4	8	5.13	6	3 – 7	No changes noted
S5	7	13.43	14	12 – 15	-Session cancelled due to unavailability of coach. -During the programme, travelled for a match against another service group.
S6	5	7.6	8	4 – 10	-Final session was a match against another service group.
S7	8	4.88	5	4 – 6	-Change of 1 OT facilitator. -Move to outdoor Astroturf from week 6 due to fine weather.

*there are 2 modes therefore the lower value is recorded

4.3. Results for Participants Who Completed Both Pre- and Post-Test Stages

A total of 27 out of 40 participants completed both the pre- and post-test stages of the research and their results will be recorded in this section.

4.3.1. Participant Demographics who Completed Both Pre- and Post-test

Table 7 illustrates the demographic information of participants who completed both the pre-test and post-test stages of the data collection.

<i>Table 7 Demographics of Participants who completed both Pre- and Post-test</i>								
Gender	Male				Female			
	n=27 (100%)				n=0 (0%)			
Age Range (years)	18-23	24-29	30-35	36-41	42-47	48-52	53-58	<58
	1	6	7	7	2	1	3	0
	3.7%	22.2%	25.9%	25.9%	7.4%	3.7%	11.1%	0%
Participating in other sports (excluding football)	Yes				No			
	15 (55.6%)				12 (44.4%)			
Community Activities	Yes				No			
	5 (18.5%)				22 (81.5%)			

As highlighted in **Table 7** above, those that remained in the programme (completed both the pre- and post-test; n=27) are closely divided between those that did (56%) and didn't (44%) participate in other sports. For those that did not remain in the study (completed pre-test only; n=13) there was a larger divide, with 77% already participating in sport and only 23% not participating in sport prior to commencing the 'Kickstart to Recovery' programme.

4.3.2. Connection with Football

In order to obtain information on the participant's connection with football, questions in relation to football routines were asked. These included watching football matches on TV and attending regular football matches. The questions posed in relation to football routines were asked in in two contexts; 'previously', which referred to prior to week one of the 'Kickstart to Recovery' programme, and 'currently', which referred to at the time

of completing the post-test questionnaire. Both sets of questions were asked at the post-test stage, therefore the 'previously' questions require a retrospective response.

Table 8 Participants Relationship with Football					
Previously played football	Yes			No	
	n=27 100%			n=0 0%	
Standard of football previously played	Club	School	Club & School	Other	Unanswered
	n=12 44.4%	n=6 22.2%	n=3 11.1%	n=5 18.5%	n=1 3.7%
Previously* watched football matches on TV	Yes			No	
	n=21 77.8%			n=6 22.2%	
Previously* attended football matches	Yes			No	
	n=7 25.9%			n=20 74.1%	
Currently** watches football matches on TV	Yes			No	
	n=21 77.8%			n=6 22.2%	
Currently** attended football matches	Yes			No	
	n=7 25.9%			n=20 74.1%	

* "Previously" refers to prior to week 1 of the 'Kickstart to Recovery' programme that participant completed.

** "Currently" refers to at time of the post-test.

All participants played football at some stage in their lives, with over half of them playing to a club standard (55.5%).

Furthermore, the same responses were given by each participant for both contexts (i.e. previously and currently). All those that answered 'Yes' to attending football matches also responded 'Yes' to watching football matches on TV (n=8). No participant reported attending matches without also watching matches on TV. This is documented in **Table 8** above.

The Engagement in Meaningful Activities Survey (EMAS) was the outcome measure used to measure the meaning of football to the participants. This was completed at both the pre-test and post-test stages of the study. In order to determine if there is relationship between those that have a connection with football as a sport (i.e. watch it on tv and/or attend matches) and their EMAS score, the Mann-Whitney U Test was used. The Mann-Whitney U Test tests for differences between two independent groups, which in this case

is those that watch football on tv and/or attend matches and those that do not identify as taking part in these football-related activities.

As seen in **Table 9**, the Mann-Whitney U Test revealed no statically significant difference in the EMAS percentage scores of those that have a connection with football (attend football matches and/or watch football on TV) ($Md = 94.15$, $n = 20$) and those that do not ($Md = 82.5$, $n = 4$), $U = 62$, $z = 1.711$, $p = .097$, $r = .349$.

Table 9 Impact of Connection with Football on the EMAS scores

Independent-Samples Mann-Whitney U Test Summary	
Total N	24
Mann-Whitney U	62.000
Wilcoxon W	272.000
Test Statistic	62.000
Standard Error	12.859
Standardized Test Statistic	1.711
Asymptotic Sig.(2-sided test)	.087
Exact Sig.(2-sided test)	.097

4.3.3. Attending the ‘Kickstart to Recovery’ Programme.

Although no statistical significance was found between those that have a connection with football and their EMAS score, their connection with football within the programme can be observed in their commitment to the ‘Kickstart to Recovery’ programme. Each programme required commitment from 5 to 8 weeks, of which 77.8% attended 75% or more of the sessions (**Table 10**).

<i>Table 10 Attendance of the ‘Kickstart to Recovery’ programme</i>				
No. of participants who attended each session block	5 or 6 session block (sites 3 & 6)		7 session block (sites 2 & 5)	
	n=6		n=11	
			n=10	
Exposure to programme (% of sessions attended)	Attended 0% - 24% of sessions	Attended 25%- 49% of sessions	Attended 50% - 74% of sessions	Attended 75%- 100% of sessions
	n = 1 3.7%	n = 2 7.4%	n = 3 11.1%	n = 21 77.8%

In relation to the number of sessions per block, we wanted to investigate if the amount of exposure to the 'Kickstart to Recovery' programme has an impact on quality of life, recovery-oriented change and the meaning of football to the person.

In order to determine if such relationships exist, the Kruskal-Wallis Test was used, as it allows for comparisons to be made for three or more groups. For these tests the three groups are '5 or 6 session block', '7 session block' and '8 session block'. The dependent variable are the total post-test scores and post-test domain scores of the three outcome measures used in this study.

4.3.3.1. RAS-DS and Exposure to the 'Kickstart to Recovery' Programme

As outlined in the Hypothesis Test Summary in **Table 11** below, the Kruskal-Wallis Tests conducted on the total recovery score and individual domains of the RAS-DS ('Doing Things I Value', 'Looking Forward', 'Mastering My Illness' and 'Connecting and Belonging') did not reveal statistically significant differences across the three different programme block durations.

Table 11 Impact of Exposure to the KtoR programme on the RAS-DS Post-test scores

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig.	Decision
1	The distribution of POST Total Score RAS-DS is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.655	Retain the null hypothesis.
2	The distribution of POST % Doing Things I Value RAS-DS is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.817	Retain the null hypothesis.
3	The distribution of POST % Looking Forward RAS-DS is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.579	Retain the null hypothesis.
4	The distribution of POST % Mastering My Illness RAS-DS is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.502	Retain the null hypothesis.
5	The distribution of POST % Connecting and Belonging RAS-DS is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.430	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is .050.

4.3.3.2. EMAS and Exposure to the 'Kickstart to Recovery' Programme

The Kruskal-Wallis Test (**Table 12**) revealed no statistically significant difference in the meaning of football across the three different programme block durations.

Table 12 Impact of Exposure to the KtoR programme on the EMAS Post-test scores

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig.	Decision
1	The distribution of POST EMAS Total Scores is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.257	Retain the null hypothesis.
2	The distribution of POST EMAS Percentage Score is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.259	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is .050.

4.3.3.3. SF-36 and Exposure to the 'Kickstart to Recovery' Programme

Outlined in the Hypothesis Test Summary in **Table 13** on the following page, the Kruskal-Wallis Tests conducted on the nine different domains of the SF-36 revealed two domains that have statistically significant differences across the three different programme block durations. These were the domains of Emotional Wellbeing and Social Functioning, which will be broken down further below. The other seven domains did not reveal statistically significant differences across the three different session block durations.

Table 13 Impact of Exposure to the KtoR programme on the SF-36 Post-test scores

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig.	Decision
1	The distribution of POST Physical Functioning is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.597	Retain the null hypothesis.
2	The distribution of POST Role limitations due to physical health is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.608	Retain the null hypothesis.
3	The distribution of POST Role limitations due to emotional problems is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.476	Retain the null hypothesis.
4	The distribution of POST Energy /Fatigue is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.164	Retain the null hypothesis.
5	The distribution of POST Emotional Well-being is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.016*	Reject the null hypothesis.*
6	The distribution of POST Social Functioning is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.020*	Reject the null hypothesis.*
7	The distribution of POST Pain is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.461	Retain the null hypothesis.
8	The distribution of POST General Health is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.104	Retain the null hypothesis.
9	The distribution of POST Health Change is the same across categories of Sessions per Block.	Independent-Samples Kruskal-Wallis Test	.384	Retain the null hypothesis.

Asymptotic significances are displayed. *The significance level is .050.

***Statistically Significant Result:** Emotional Wellbeing and Exposure to the 'Kickstart to Recovery' Programme

The Kruskal-Wallis Test (**Table 14**) showed a **statistically significant difference** in the post-test emotional wellbeing scores across the three different programme block duration (Gp1, n=6; 5 or 6 block programmes, Gp2, n=10; 7 block programmes, Gp3, n=9; 8 block programmes), $n = 25$, $p = .016$. The programme with the least sessions (5 or 6 sessions) recorded a higher median score ($Md = 80$) than the other two groups with more sessions per block (7 sessions and 8 sessions), which recorded median values of 74 and 52 respectively.

Table 14 KtoR programme Exposure on 'Emotional Wellbeing' Post Scores

Independent-Samples Kruskal-Wallis Test	
Summary	
Total N	25
Test Statistic	8.249 ^a
Degree Of Freedom	2
Asymptotic Sig.(2-sided test)	.016

a. The test statistic is adjusted for ties.

***Statistically Significant Result:** Social Functioning and Exposure to the 'Kickstart to Recovery' Programme

The Kruskal-Wallis Test (**Table 15**) showed a statistically significant difference in the post-test social functioning scores across the three different programme block duration (Gp1, n=5; 5 or 6 block programmes, Gp2, n=11; 7 block programmes, Gp3, n=10; 8 block programmes), $n=26$, $p = .020$. The programmes that had less sessions (5 or 6 sessions and 7 sessions) recorded a higher median score ($Md = 100$) than the other group which has the most sessions per block (8 sessions), which recorded median values of 43.75.

Table 15 KtoR programme Exposure on 'Social Functioning' Post Scores

Independent-Samples Kruskal-Wallis Test	
Summary	
Total N	26
Test Statistic	7.790 ^a
Degree Of Freedom	2
Asymptotic Sig.(2-sided test)	.020

a. The test statistic is adjusted for ties.

4.4. Change After Participation in the 'Kickstart to Recovery' Programme

The overall research question of this study; Do mental health service users experience a change after participation in the 'Kickstart to Recovery' programme. This section will focus on this through the objectives of the study;

1. Investigate if there is a change in **the quality of life** of mental health service users who participate in the 'Kickstart to Recovery' programme.
2. Investigate if there is a change in **self-reported mental health recovery** of mental health service users who participate in the 'Kickstart to Recovery' programme.
3. Investigate if participants experience a change in the **personal meaning of the occupation football** after participating in the 'Kickstart to Recovery' programme.
4. Investigate if participants experience **social gains** after participating in the 'Kickstart to Recovery' programme.

As data in this study is non-parametric in nature, the median and interquartile range of each domain are stated (Habibzadeh, 2013).

Unless otherwise stated, the sample used in this section are those that completed both the pre- and the post-test questionnaire of this research (n=27), who are described in Section 4.4. The significance level is equal to or less than .05. In determining the strength of an effect size, Cohen's criteria (1988) is used where .1 is a small effect, .3 is a medium effect and .5 is a large effect.

4.4.1. Quality of Life

This section is divided into the nine domains of the Short Form 36.

The Wilcoxon Signed Rank Test was carried out on each domain of the SF-36 to determine if there is a statistically significant difference in quality of life between the pre-test and the post-test score of the service users after participation in the 'Kickstart to Recovery' programme.

Following this, additional information was gathered on those participating in the 'Kickstart to Recovery' programme for the first time and those who were returning to the programme. Two separate Wilcoxon Signed Rank Tests were also carried out on each domain of the SF-35 to determine if there is a statistically significant difference in quality of life for these two groups.

4.4.1.1. Physical Functioning

Table 16 displays the descriptive statistics of the SF-36 domain 'Physical Functioning'

Table 16 Descriptive Statistics for 'Physical Functioning'

		Statistics	
		Pre-test Physical Functioning	Post-test Physical Functioning
N	Valid	36	23
	Missing	4	4
Median		85	85
Percentiles	25	70	80
	75	95	100

The median score of the physical functioning pre-test and post-test both 85 (pre-test Md = 85, pre-test IQR: 70, 95; post-test Md = 85, post-test IQR: 80,100)

A Wilcoxon Signed Rank Test (**Table 17**) revealed no statistically significant difference in the physical functioning of mental health service users following participation in 'Kickstart to Recovery' programme, N(Pre-test) = 23, N(Post-test) = 23, $z = -1.152$, $p = .249$.

Table 17 Total Sample KtoR programme Impact on 'Physical Functioning'

Test Statistics^a	
Post-test Physical Functioning - Pre-test Physical Functioning	
Z	-1.152 ^b
Asymp. Sig. (2-tailed)	.249

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 18**) revealed no statistically significant difference in the physical functioning pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, pre-test $n=6$, $N(\text{Post-test})=6$, $z = -.405$, $p = .686$

Table 18 First Time Sample KtoR programme Impact on 'Physical Functioning'

Test Statistics^a	
	Post-test Physical Functioning - Pre-test Physical Functioning
Z	-.405 ^b
Asymp. Sig. (2-tailed)	.686

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

A Wilcoxon Signed Rank Test (**Table 19**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the physical functioning of mental health service users following participation in the 'Kickstart to Recovery' programme, pre-test $n=17$, $N(\text{Post-test})=17$, $z = -1.546$, $p = .122$.

Table 19 Returners Sample KtoR programme Impact on 'Physical Functioning'

Test Statistics^a	
	Post-test Physical Functioning - Pre-test Physical Functioning
Z	-1.546 ^b
Asymp. Sig. (2-tailed)	.122

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

4.4.1.2. Role Limitations Due to Physical Functioning

Table 20 displays the descriptive statistics of the SF-36 domain 'Role Limitations Due to Physical Functioning'

Table 20 Descriptive Statistics of Role Limitation Due to Physical Functioning

		Statistics	
		Pre-test Role limitations due to physical health	Post-test Role limitations due to physical health
N	Valid	38	27
	Missing	2	0
Median		50	75
Percentiles	25	30	50
	75	100	100

The median score of the role limitation due to physical functioning pre-test is 50 and the post-test is 75 (pre-test Md = 50, pre-test IQR: 30,100; post-test Md = 75, post-test IQR: 50,100)

A Wilcoxon Signed Rank Test (**Table 21**) revealed no statistically significant difference in the role limitations due to physical functioning of mental health service users following participation in 'Kickstart to Recovery' programme, pre-test n= 27, N(Post-test) = 27, z = -.951, p = .342.

Table 21 Total Sample KtoR programme Impact on 'Role Limitations due to Physical Functioning'

Test Statistics^a	
Post-test Role limitations due to physical health – Pre-test Role limitations due to physical health	
Z	-.951 ^b
Asymp. Sig. (2-tailed)	.342

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 22**) revealed no statistically significant difference in the role limitation due to physical functioning pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, $N(\text{Pre-test}) = 6$, post-test $n = 6$, $z = .000$, $p = 1.000$

Table 22 First Time Sample KtoR programme Impact on 'Role Limitations due to Physical Functioning'

Test Statistics^a Post-test Role limitations due to physical health – Pre-test Role limitations due to physical health	
Z	.000 ^b
Asymp. Sig. (2-tailed)	1.000

a. Wilcoxon Signed Ranks Test

b. The sum of negative ranks equals the sum of positive ranks.

A Wilcoxon Signed Rank Test (**Table 23**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the role limitations due to physical health of mental health service users following participation in the 'Kickstart to Recovery' programme, pre-test $n = 21$, $N(\text{Post-test}) = 21$, $z = -1.041$, $p = .298$.

Table 23 Return Sample KtoR programme Impact on 'Role Limitations due to Physical Functioning'

Test Statistics^a Post-test Role limitations due to physical health – Pre-test Role limitations due to physical health	
Z	-1.041 ^b
Asymp. Sig. (2-tailed)	.298

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

4.4.1.3. Role Limitation Due to Emotional Problems

Table 24 displays the descriptive statistics of the SF-36 domain 'Role Limitations Due to Emotional Problems'

Table 24 Descriptive Statistics of Role Limitation Due to Emotional Problems

		Statistics	
		Pre-test Role limitations due to emotional problems	Post-test Role limitations due to emotional problems
N	Valid	40	27
	Missing	0	0
Median		66.6	100
Percentiles	25	33.3	66.6
	75	100	100

The median score of the role limitation due to emotional problems pre-test is 66.6 and the post-test is 100 (pre-test Md = 66.6, pre-test IQR: 33.3,100; post-test Md = 100, post-test IQR: 66.6,100).

A Wilcoxon Signed Rank Test (**Table 25**) revealed no statistically significant difference in role limitations due to emotional problems of mental health service users following participation in 'Kickstart to Recovery' programme, N(Pre-test) = 27, N(Post-test) =27, $z = -1.715$, $p = .086$.

Table 25 Total Sample KtoR programme Impact on 'Role Limitations due to Emotional Problems

Test Statistics^a	
Post-test Role limitations due to emotional problems – Pre-test Role limitations due to emotional problems	
Z	-1.715 ^b
Asymp. Sig. (2-tailed)	.086

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 26**) revealed no statistically significant difference in the role limitations due to emotional problems pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, $N(\text{Pre-test}) = 6$, $N(\text{Post-test}) = 6$, $z = -1.633$, $p = .102$

Table 26 First Time Sample KtoR programme Impact on 'Role Limitations due to Emotional Problems

Test Statistics^a	
Post-test Role limitations due to emotional problems – Pre-test Role limitations due to emotional problems	
Z	-1.633 ^b
Asymp. Sig. (2-tailed)	.102

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

A Wilcoxon Signed Rank Test (**Table 27**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the role limitation due to emotional problems of mental health service users following participation in the 'Kickstart to Recovery' programme, $N(\text{Pre-test}) = 21$, $N(\text{Post-test}) = 21$, $z = -1.056$, $p = .291$.

Table 27 Return Sample KtoR programme Impact on 'Role Limitations due to Emotional Problems'

Test Statistics^a	
Post-test Role limitations due to emotional problems – Pre-test Role limitations due to emotional problems	
Z	-1.056 ^b
Asymp. Sig. (2-tailed)	.291

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

4.4.1.4. Energy / Fatigue

Table 28 displays the descriptive statistics of the SF-36 domain 'Role Limitations Due to Emotional Problems'

Table 28 Descriptive Statistics of Energy/Fatigue

		Statistics	
		Pre-test Energy/Fatigue	Post-test Energy /Fatigue
N	Valid	39	26
	Missing	1	1
Median		45	57.5
Percentiles	25	35	43.75
	75	60	70

The median score of the energy/fatigue pre-test is 45 and the post-test is 57.5 (pre-test Md = 45, pre-test IQR: 35,60; post-test Md = 57.5, post-test IQR: 43.75,70).

A Wilcoxon Signed Rank Test (**Table 29**) revealed a **statistically significant difference** in the energy/fatigue levels of mental health service users following participation in 'Kickstart to Recovery' programme, $z = -2.542$, $p = .011$, with a medium effect size ($r = .35$) where $N(\text{pre-test}) = 26$ and $N(\text{post-test}) = 26$. The median score of the Energy/Fatigue domain of SF-36 increased from pre-programme ($Md = 47.5$) to post-programme ($Md = 57.5$).

Table 29 Total Sample KtoR programme Impact on 'Energy/Fatigue'

Test Statistics^a	
Post-test Energy /Fatigue – Pre-test Energy/Fatigue	
Z	-2.542 ^b
Asymp. Sig. (2-tailed)	.011*

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

* $p > .05$

Wilcoxon Signed Rank Test (**Table 30**) revealed no statistically significant difference in the energy/fatigue pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, N(pre-test) = 6 and N(post-test) = 6, $z = -1.802$, $p = .072$.

Table 30 First Time Sample KtoR programme Impact on 'Energy/Fatigue'

Test Statistics^a	
	Post-test Energy /Fatigue – Pre-test Energy/Fatigue
Z	-1.802 ^b
Asymp. Sig. (2-tailed)	.072

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

A Wilcoxon Signed Rank Test (**Table 31**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the energy/fatigue of mental health service users following participation in the 'Kickstart to Recovery' programme, N(pre-test) = 20 and N(post-test) = 20 $z = -1.902$, $p = .057$.

Table 31 Return Sample KtoR programme Impact on 'Energy/Fatigue'

Test Statistics^a	
	Post-test Energy /Fatigue – Pre-test Energy/Fatigue
Z	-1.902 ^b
Asymp. Sig. (2-tailed)	.057

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

4.4.1.5. Emotional Wellbeing

Table 32 displays the descriptive statistics of the SF-36 domain 'Emotional Wellbeing'.

Table 32 Descriptive Statistics of 'Emotional Wellbeing'

		Statistics	
		Pre-test Emotional Well-being	Post-test Emotional Well-being
N	Valid	38	25
	Missing	2	2
Median		52	64
Percentiles	25	40	52
	75	72	82

The median score of the emotional well-being pre-test is 52 and the post-test is 64 (pre-test Md = 52, pre-test IQR: 40,72; post-test Md = 64, post-test IQR: 52,82).

A Wilcoxon Signed Rank Test (**Table 33**) revealed no statistically significant difference in the emotional wellbeing of mental health service users following participation in 'Kickstart to Recovery' programme, N(pre-test) = 25 and N(post-test) =25 $z = -1.921$, $p = .055$.

Table 33 Total Sample KtoR programme Impact on 'Emotional Wellbeing'

Test Statistics^a	
Post-test Emotional Well-being – Pre-test Emotional Well-being	
Z	-1.921 ^b
Asymp. Sig. (2-tailed)	.055

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 34**) revealed no statistically significant difference in the emotional wellbeing pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, N(pre-test) = 5 and N(post-test) = 5 $z = -1.134$, $p = .257$.

Table 34 First Time Sample KtoR programme Impact on 'Emotional Wellbeing'

Test Statistics^a	
	Post-test Emotional Well-being – Pre-test Emotional Well-being
Z	-1.134 ^b
Asymp. Sig. (2-tailed)	.257

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

A Wilcoxon Signed Rank Test (**Table 35**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the emotional wellbeing of mental health service users following participation in the 'Kickstart to Recovery' programme, N(pre-test) = 20 and N(post-test) = 20 $z = -1.610$, $p = .107$.

Table 35 Return Sample KtoR programme Impact on 'Emotional Wellbeing'

Test Statistics^a	
	Post-test Emotional Well-being – Pre-test Emotional Well-being
Z	-1.610 ^b
Asymp. Sig. (2-tailed)	.107

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

4.4.1.6. Social functioning

Table 36 displays the descriptive statistics of the SF-36 domain 'Social Functioning'.

Table 36 Descriptive Statistics of 'Social Functioning'

		Statistics	
		Pre-test Social Functioning	Post-test Social Functioning
N	Valid	39	26
	Missing	1	1
Median		62.5	75
Percentiles	25	50	37.5
	75	87.5	100

The median score of the social functioning pre-test is 62.5 and the post-test is 75 (pre-test Md = 62.5, pre-test IQR: 50,87.5; post-test Md = 75, post-test IQR: 37.5,100).

A Wilcoxon Signed Rank Test (**Table 37**) revealed no statistically significant difference in the social functioning of mental health service users following participation in 'Kickstart to Recovery' programme, N(pre-test) = 26 and N(post-test) = 26 $z = -1.458$, $p = .145$.

Table 37 Total Sample KtoR programme Impact on 'Social Functioning'

Test Statistics^a	
Post-test Social functioning – Pre-test Social functioning	
Z	-1.458 ^b
Asymp. Sig. (2-tailed)	.145

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 38**) revealed no statistically significant difference in the social functioning pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, N(pre-test) = 6 and N(post-test) = 6 $z = -1.089$, $p = .256$.

Table 38 First Time Sample KtoR programme Impact on 'Social Functioning'

Test Statistics^a	
	Post-test Social Functioning – Pre-test Social Functioning
Z	-1.089 ^b
Asymp. Sig. (2-tailed)	.276

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

A Wilcoxon Signed Rank Test (**Table 39**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the social functioning of mental health service users following participation in the 'Kickstart to Recovery' programme, N(pre-test) = 20 and N(post-test) = 20 $z = -.978$, $p = .328$.

Table 39 Return Sample KtoR programme Impact on 'Social Functioning'

Test Statistics^a	
	Post-test Social Functioning – Pre-test Social Functioning
Z	-.978 ^b
Asymp. Sig. (2-tailed)	.328

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

4.4.1.7. Pain

Table 40 displays the descriptive statistics of the SF-36 domain 'Pain'.

Table 40 Descriptive Statistics of 'Pain'

Statistics		Pre-test Pain	Post-test Pain
N	Valid	40	27
	Missing	0	0
Median		77.5	90
Percentiles	25	57.5	57.5
	75	100	100

The median score of the pain pre-test is 77.5 and the post-test is 90 (pre-test Md = 77.5, pre-test IQR: 57.5,100; post-test Md = 90, post-test IQR: 57.5,100).

A Wilcoxon Signed Rank Test (**Table 41**) revealed no statistically significant difference in pain of mental health service users following participation in 'Kickstart to Recovery' programme, N(pre-test) = 27 and N(post-test) =27, $z = -1.109$, $p = .268$.

Table 41 Total Sample KtoR programme Impact on 'Pain'

Test Statistics ^a	
Post-test Pain – Pre-test Pain	
Z	-1.109 ^b
Asymp. Sig. (2-tailed)	.268

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

Wilcoxon Signed Rank Test (**Table 42**) revealed no statistically significant difference in the pain pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, $N(\text{pre-test}) = 6$ and $N(\text{post-test}) = 6$, $z = -1.604$, $p = .109$.

Table 42 First Time Sample KtoR programme Impact on 'Pain'

Test Statistics^a	
	Post-test Pain – Pre-test Pain
Z	-1.604 ^b
Asymp. Sig. (2-tailed)	.109

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

A Wilcoxon Signed Rank Test (**Table 43**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the pain of mental health service users following participation in the 'Kickstart to Recovery' programme, $N(\text{pre-test}) = 21$ and $N(\text{post-test}) = 21$, $z = -.179$, $p = .858$.

Table 43 Return Sample KtoR programme Impact on 'Pain'

Test Statistics^a	
	Post-test Pain – Pre-test Pain
Z	-.179 ^b
Asymp. Sig. (2-tailed)	.858

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

4.4.1.8. General Health

Table 44 displays the descriptive statistics of the SF-36 domain 'General Health'.

Table 44 Descriptive Statistics of 'General Health'

		Statistics	
		Pre-test General Health	Post-test General Health
N	Valid	39	26
	Missing	1	1
Median		50	52.5
Percentiles	25	45	38.75
	75	75	81.25

The median score of the general health pre-test is 50 and the post-test is 52.5 (pre-test Md = 50, pre-test IQR: 45, 75; post-test Md = 52.5, post-test IQR: 38.75, 81.25).

A Wilcoxon Signed Rank Test (**Table 45**) revealed no statistically significant difference in the general health of mental health service users following participation in 'Kickstart to Recovery' programme, N(pre-test) = 26 and N(post-test) = 26 $z = -.733$, $p = .464$.

Table 45 Total Sample KtoR programme Impact on 'General Health'

Test Statistics^a	
Post-test General Health – Pre-test General Health	
Z	-.733 ^b
Asymp. Sig. (2-tailed)	.464

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 46**) revealed no statistically significant difference in the general health pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, $N(\text{pre-test}) = 6$ and $N(\text{post-test}) = 6$ $z = -1.355$, $p = .176$.

Table 46 First Time Sample KtoR programme Impact on 'General Health'

Test Statistics^a	
	Post-test General Health – Pre-test General Health
Z	-1.355 ^b
Asymp. Sig. (2-tailed)	.176

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

A Wilcoxon Signed Rank Test (**Table 47**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the general health of mental health service users following participation in the 'Kickstart to Recovery' programme, $N(\text{pre-test}) = 20$ and $N(\text{post-test}) = 20$ $z = -.095$, $p = .924$.

Table 47 Return Sample KtoR programme Impact on 'General Health'

Test Statistics^a	
	Post-test General Health – Pre-test General Health
Z	-.095 ^b
Asymp. Sig. (2-tailed)	.924

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

4.4.1.9. Health Change

Table 48 displays the descriptive statistics of the SF-36 domain 'Health Change'.

Table 48 Descriptive Statistics of 'Health Change'

		Statistics	
		Pre-test Health Change	Post-test Health Change
N	Valid	40	27
	Missing	0	0
Median		75	75
Percentiles	25	50	50
	75	100	100

The median score of the health change pre-test and post-test are both 75 (pre-test Md = 75, pre-test IQR: 50, 100; post-test Md = 75, post-test IQR: 50, 100).

A Wilcoxon Signed Rank Test (**Table 49**) revealed no statistically significant difference in the health change of mental health service users following participation in 'Kickstart to Recovery' programme, N(pre-test) = 27 and N(post-test) = 27 $z = -1.490$, $p = .136$.

Table 49 Total Sample KtoR programme Impact on Health Change'

Test Statistics^a	
Post-test Health Change – Pre-test Health Change	
Z	-1.490 ^b
Asymp. Sig. (2-tailed)	.136

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

Wilcoxon Signed Rank Test (**Table 50**) revealed no statistically significant difference in the health change pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, $N(\text{pre-test}) = 6$ and $N(\text{post-test}) = 6$, $z = -1.000$, $p = .317$.

Table 50 First Time Sample KtoR programme Impact on 'Health Change'

Test Statistics^a	
	Post-test Health Change – Pre-test Health Change
Z	-1.000 ^b
Asymp. Sig. (2-tailed)	.317

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

A Wilcoxon Signed Rank Test (**Table 51**) conducted on those who had previously participated in the 'Kickstart to Recovery' programme revealed no statistically significant difference in the health change of mental health service users following participation in the 'Kickstart to Recovery' programme, $N(\text{pre-test}) = 21$ and $N(\text{post-test}) = 21$, $z = -1.155$, $p = .248$.

Table 51 First Time Sample KtoR programme Impact on 'Health Change'

Test Statistics^a	
	Post-test Health Change – Pre-test Health Change
Z	-1.155 ^b
Asymp. Sig. (2-tailed)	.248

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

To summarise this section on results related to the quality of life of mental health service users, a Wilcoxon Signed Rank Test found a statistically significant improvement in the energy levels of post-test compared to the pre-test of those who participated in the programme. This was the only statistically significant result found on quality of life measures.

Tests were carried out on all participant's pre and post SF-36 domain scores, as well on first timers and returners to the 'Kickstart to Recovery' programme. No statistically significant results emerged from these.

4.4.2. Recovery-Oriented Change

The median and interquartile ranges of the pre- and post-scores for each of the domains of the RAS-DS are stated at the beginning of each section.

The Wilcoxon Signed Rank Test was carried out on each domain of the four domains of the RAS-DS as well as on the total recovery score to determine if there is a statistically significant difference between the pre-test and the post-test scores of the service users after participation in the 'Kickstart to Recovery' programme.

Like with quality of life, an additional two Wilcoxon Signed Rank Test were conducted for both first-time participants of the programme and those who have previously participated in order to reveal if a statistically significant difference in recovery orientation following participation in the programme exists within these group.

4.4.2.1. Total Recovery Score

Table 52 displays the descriptive statistics of the RAS-DS Total Recovery Score.

Table 52 Descriptive Statistics of 'Total Recovery Score'

		Statistics	
		Pre-test Total Score RAS-DS	Post-test Total Score RAS-DS
N	Valid	37	25
	Missing	3	2
Median		116	120
Percentiles	25	101	105
	75	134.5	137

The median of the total recovery score pre-test is 116 and the post-test is 120 (pre-test Md = 116, pre-test IQR: 101, 134.5; post-test Md = 120, post-test IQR: 105, 137).

A Wilcoxon Signed Rank Test (**Table 53**) revealed no statistically significant difference in the total recovery score of mental health service users following participation in 'Kickstart to Recovery' programme, N(pre-test) = 25 and N(post-test) =25 $z = -.014$, $p = .989$.

Table 53 Total Sample KtoR programme Impact on the Total Recovery Score

Test Statistics^a	
	Post-test Total Score RAS-DS – Pre-test Total Score RAS-DS
Z	-.014 ^b
Asymp. Sig. (2-tailed)	.989

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 54**) revealed no statistically significant difference in the total recovery scores pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme, N(pre-test) = 6 and N(post-test) =6, $z = -1.782$, $p = .075$.

Table 54 First Time Sample KtoR programme Impact on the Total Recovery Score

Test Statistics^a	
	Post-test Total Score RAS-DS – Pre-test Total Score RAS-DS
Z	-1.782 ^b
Asymp. Sig. (2-tailed)	.075

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

An additional Wilcoxon Signed Rank Test (**Table 55**) also revealed no statistically significant difference in the recovery score for those who have previously participated in the 'Kickstart to Recovery' programme, N(pre-test) = 19 and N(post-test) = 19 $z = -.654$, $p = .513$.

Table 55 Return Sample KtoR programme Impact on the Total Recovery Score

Test Statistics ^a	
Post-test Total Score RAS-DS – Pre-test Total Score RAS-DS	
Z	-.654 ^b
Asymp. Sig. (2-tailed)	.513

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

4.4.2.2. Doing Things I Value

Table 56 displays the descriptive statistics of the RAS-DS domain 'Doing Things I Value'

Table 56 Descriptive Statistics of RAS-DS domain 'Doing Things I Value'

		Statistics	
		Pre-test % Doing Things I Value RAS-DS	Post-test % Doing Things I Value RAS-DS
N	Valid	40	27
	Missing	0	0
Median		79.165	87.5
Percentiles	25	66.67	75
	75	91.67	95.83

The median score of the 'Doing Things I Value' percentage pre-test is 79.165 and the percentage post-test is 87.5 (pre-test Md = 79.165, pre-test IQR: 66.67, 91.67; post-test Md = 87.5, post-test IQR: 75, 95.83).

A Wilcoxon Signed Rank Test (**Table 57**) revealed no statistically significant difference in the domain of 'doing things I value' for mental health service users following participation in 'Kickstart to Recovery' programme in neither the raw score nor percentage score, N(pre-test) = 27 and N(post-test) = 27, $z = -.158$, $p = .875$ and $z = -.143$, $p = .886$ respectively.

Table 57 Total Sample KtoR programme Impact on the RAS-DS domain 'Doing Things I Value'

Test Statistics^a		
	Post-test Doing Things I Value RAS-DS – Pre-test Doing things I Value RAS-DS	Post-test % Doing Things I Value RAS-DS – Pre-test % Doing Things I Value RAS-DS
Z	-.158 ^b	-.143 ^b
Asymp. Sig. (2-tailed)	.875	.886

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 58**) revealed no statistically significant difference in the domain of 'Doing Things I Value' pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme in neither the raw score nor percentage score, N(pre-test) = 6 and N(post-test) = 6 $z = -1.355$, $p = .176$ and $z = -1.625$, $p = .104$ respectively.

Table 58 First Time Sample KtoR programme Impact on the RAS-DS domain 'Doing Things I Value'

Test Statistics^a		
	Post-test Doing Things I Value RAS-DS – Pre-test Doing things I Value RAS-DS	Post-test % Doing Things I Value RAS-DS – Pre-test % Doing Things I Value RAS-DS
Z	-1.355 ^b	-1.625 ^b
Asymp. Sig. (2-tailed)	.176	.104

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

For those who have previously participated in the 'Kickstart to Recovery' programme, the Wilcoxon Signed Rank Test (**Table 59**) has shown no statistically significant difference in the domain of 'Doing Things I Value' following completing this the 'Kickstart to Recovery' programme in both the raw scores and percentage scores, N(pre-test) = 21 and N(post-test) = 21, $z = -.585$, $p = .559$ and $z = -.625$, $p = .532$ respectively.

Table 59 Return Sample KtoR programme Impact on the RAS-DS domain 'Doing Things I Value'

Test Statistics ^a		
	Post-test Doing Things I Value RAS-DS – Pre-test Doing things I Value RAS-DS	Post-test % Doing Things I Value RAS-DS – Pre-test % Doing Things I Value RAS-DS
Z	-.585 ^b	-.625 ^b
Asymp. Sig. (2-tailed)	.559	.532

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

4.4.2.3. Looking Forward

Table 60 displays the descriptive statistics of the RAS-DS domain 'Looking Forward'.

Table 60 Descriptive Statistics of RAS-DS domain 'Looking Forward'

		Statistics	
		Pre-test % Looking Forward RAS-DS	Post-test % Looking Forward RAS-DS
N	Valid	37	25
	Missing	3	2
Median		76.39	83.33
Percentiles	25	66.67	71.525
	75	88.185	92.365

The median score of the 'Looking Forward' pre-test is 76.39 and the post-test is 83.33 (pre-test Md = 76.39, pre-test IQR: 66.67, 88.185; post-test Md = 83.33, post-test IQR: 71.525, 92.365).

A Wilcoxon Signed Rank Test (**Table 61**) revealed no statistically significant difference in the domain of 'looking forward' for mental health service users following participation in 'Kickstart to Recovery' programme in neither the raw score nor percentage score, $N(\text{pre-test}) = 25$ and $N(\text{post-test}) = 25$, $z = -.606$, $p = .545$ and $z = .545$, $p = .667$ respectively.

Table 61 Total Sample KtoR programme Impact on the RAS-DS domain 'Looking Forward'

Test Statistics^a		
	Post-test Looking Forward RAS-DS – Pre-test Looking Forward RAS-DS	Post-test % Looking Forward RAS-DS – Pre-test % Looking Forward RAS-DS
Z	-.606 ^b	-.431 ^b
Asymp. Sig. (2-tailed)	.545	.667

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

Wilcoxon Signed Rank Test (**Table 62**) revealed no statistically significant difference in the domain 'Looking Forward' pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme in neither the raw score nor percentage score, $N(\text{pre-test}) = 6$ and $N(\text{post-test}) = 6$, $z = -.742$, $p = .458$ and $z = -.742$, $p = .458$ respectively.

Table 62 First Time Sample KtoR programme Impact on the RAS-DS domain 'Looking Forward'

Test Statistics^a		
	Post-test Looking Forward RAS-DS – Pre-test Looking Forward RAS-DS	Post-test % Looking Forward RAS-DS – Pre-test % Looking Forward RAS-DS
Z	-.742 ^b	-.742 ^b
Asymp. Sig. (2-tailed)	.458	.458

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

The Wilcoxon Signed Rank Test (**Table 63**) for participants who have previously participated in the 'Kickstart to Recovery' programme shows no statistically significant difference in the domain 'Looking Forward' for the mental health service users, in both the raw scores and percentage scores, N(pre-test) = 19 and N(post-test) = 19, $z = -.886$, $p = .376$ and $z = -.664$, $p = .506$ respectively.

Table 63 Return Sample KtoR programme Impact on the RAS-DS domain 'Looking Forward'

	Test Statistics ^a	
	Post-test Looking Forward RAS-DS – Pre-test Looking Forward RAS-DS	Post-test % Looking Forward RAS-DS – Pre-test % Looking Forward RAS-DS
Z	-.886 ^b	-.664 ^b
Asymp. Sig. (2-tailed)	.376	.506

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

4.4.2.4. Mastering My Illness

Table 64 displays the descriptive statistics of the RAS-DS domain 'Mastering My Illness'.

Table 64 Descriptive Statistics of RAS-DS domain 'Mastering My Illness'

		Statistics	
		Pre-test % Mastering My Illness RAS-DS	Post-test % Mastering My Illness RAS-DS
N	Valid	39	27
	Missing	1	13
Median		67.86	75
Percentiles	25	60.714	64.29
	75	82.143	91.66

The median score of the 'Mastering my Illness' pre-test is 67.86 and the post-test is 75 (pre-test Md = 67.86, pre-test IQR: 60.714, 82.143; post-test Md = 75, post-test IQR: 64.29, 91.66).

A Wilcoxon Signed Rank Test (**Table 65**) revealed no statistically significant difference in the domain of 'Mastering My Illness' for mental health service users following participation in 'Kickstart to Recovery' programme in neither the raw score nor percentage score, $N(\text{pre-test}) = 27$ and $N(\text{post-test}) = 27$, $z = -1.217$, $p = .224$ and $z = -.943$, $p = .346$ respectively.

Table 65 Total Sample KtoR programme Impact on the RAS-DS domain 'Mastering My Illness'

Test Statistics^a		
	Post-test Mastering My Illness RAS-DS – Pre-test Mastering My Illness RAS-DS	Post-test % Mastering My Illness RAS-DS – Pre-test % Mastering My Illness RAS-DS
Z	-1.217 ^b	-.943 ^b
Asymp. Sig. (2-tailed)	.224	.346

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Wilcoxon Signed Rank Test (**Table 66**) revealed **a statistically significant** difference in mastering my illness pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme in both the raw score and percentage score, $z = -2.032$, $p = .042$ and $z = -1.992$, $p = .046$ respectively. For the raw score, the effect size was large ($r = 0.58$) and the median score on the Mastering My Illness domain of the RAS-DS improved from pre-programme ($n=6$, $Md = 3$) to post-programme ($n=6$, $Md = 3.07$). For the percentage score, the effect size was also large ($r = .58$) and the median score on the Mastering My Illness domain also improved from pre-programme ($n=6$, $Md = 75$) to post-programme ($n=6$, $Md = 76.8$).

Table 66 First Time Sample KtoR programme Impact on the RAS-DS domain 'Mastering My Illness'

Test Statistics^a		
	Post-test Mastering My Illness RAS-DS – Pre-test Mastering My Illness RAS-DS	Post-test % Mastering My Illness RAS-DS – Pre-test % Mastering My Illness RAS-DS
Z	-2.032 ^b	-1.992 ^b
Asymp. Sig. (2-tailed)	.042	.046

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

In contrast to the previous result, the Wilcoxon Signed Rank Test (**Table 67**) for those that have previously participated in the 'Kickstart to Recovery' programme do not show a statistically significant difference in the domain of 'Mastering My Illness' for the sample in neither the raw score or the percentage score, $N(\text{pre-test}) = 21$ and $N(\text{post-test}) = 21$ $z = -.457$, $p = .647$ and $z = -.260$, $p = .795$, respectively.

Table 67 Return Sample KtoR programme Impact on the RAS-DS domain 'Mastering My Illness'

	Test Statistics ^a	
	Post-test Mastering My Illness RAS-DS – Pre-test Mastering My Illness RAS-DS	Post-test % Mastering My Illness RAS-DS – Pre-test % Mastering My Illness RAS-DS
Z	-.457 ^b	-.260 ^b
Asymp. Sig. (2-tailed)	.647	.795

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

4.4.2.5. Connecting and Belonging

Table 68 displays the descriptive statistics of the RAS-DS domain 'Connecting and Belonging'.

Table 68 Descriptive Statistics of RAS-DS domain 'Connecting and Belonging'

		Statistics	
		Pre-test % Connecting and Belonging RAS-DS	Post-test % Connecting and Belonging RAS-DS
N	Valid	39	27
	Missing	1	0
Median		82.14	85.71
Percentiles	25	71.43	75
	75	92.86	92.86

The median score of the 'Connecting and Belonging' pre-test is 82.14 and the post-test is 85.71 (pre-test Md = 82.14, pre-test IQR: 71.43, 92.86; post-test Md = 85.71, post-test IQR: 75, 92.86).

A Wilcoxon Signed Rank Test (**Table 69**) revealed no statistically significant difference in the domain of 'looking forward' for mental health service users following participation in 'Kickstart to Recovery' programme in neither the raw score nor percentage score, $N(\text{pre-test}) = 27$ and $N(\text{post-test}) = 27$, $z = -1.701$, $p = .089$ and $z = -1.399$, $p = .162$ respectively.

Table 69 Total Sample KtoR programme Impact on the RAS-DS domain 'Connecting and Belonging'

Test Statistics ^a		
	Post-test Connecting and Belonging RAS-DS – Pre-test Connecting and Belonging RAS-DS	Post-test % Connecting and Belonging RAS-DS – Pre-test % Connecting and Belonging RAS-DS
Z	-1.701 ^b	-1.399 ^b
Asymp. Sig. (2-tailed)	.089	.162

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

Wilcoxon Signed Rank Test (**Table 70**) revealed no statistically significant difference in connecting and belonging pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme in neither the raw score nor percentage score, $N(\text{pre-test}) = 6$ and $N(\text{post-test}) = 6$, $z = -.674$, $p = .500$ and $z = -.184$, $p = .854$ respectively.

Table 70 First Time Sample KtoR programme Impact on the RAS-DS domain 'Connecting and Belonging'

Test Statistics ^a		
	Post-test Connecting and Belonging RAS-DS – Pre-test Connecting and Belonging RAS-DS	Post-test % Connecting and Belonging RAS-DS – Pre-test % Connecting and Belonging RAS-DS
Z	-.674 ^b	-.184 ^b
Asymp. Sig. (2-tailed)	.500	.854

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

Wilcoxon Signed Rank Test (**Table 71**) revealed no statistically significant difference in the domain 'Connecting and Belonging' pre and post the programme for mental health service users who had previously participated in the 'Kickstart to Recovery' programme in neither the raw score nor percentage score, $N(\text{pre-test}) = 21$ and $N(\text{post-test}) = 21$, $z = -1.732$, $p = .083$ and $z = -1.462$, $p = .114$ respectively.

Table 71 Return Sample KtoR programme Impact on the RAS-DS domain 'Connecting and Belonging'

	Test Statistics^a	
	Post-test Connecting and Belonging RAS-DS – Pre-test Connecting and Belonging RAS-DS	Post-test % Connecting and Belonging RAS-DS – Pre-test % Connecting and Belonging RAS-DS
Z	-1.732 ^b	-1.462 ^b
Asymp. Sig. (2-tailed)	.083	.144

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

To summarise the recovery-oriented results presented in this section, the Wilcoxon Signed Rank Test showed a statistically significant improvement in the domain 'Mastering My Illness' for those participants who's first time it is participating in the 'Kickstart to Recovery' programme.

The participants who had previously partaken in the programme, and all other tests run for this section revealed no statistically significant difference. This includes all participants, first time participants and those who have participated previously.

4.4.3. Meaning of Football

The meaning of football for the participants was measured with the Engagement in Meaningful Activities Scale (EMAS). The median and interquartile range of the pre-scores and post-scores are stated.

As with the quality of life and recovery-orientation scores, the Wilcoxon Signed Rank Test was conducted with the total score and percentage score of the EMAS, as well as investigating significant difference for first time participants and those who have participated previously.

4.4.3.1. EMAS Total Scores

Table 72 displays the descriptive statistics of the EMAS total scores and percentage scores.

Table 72 Descriptive Statistics of the EMAS

		Statistics			
		Pre-test EMAS Total Scores	Pre-test EMAS Percentage Score	Post-test EMAS Total Scores	Post-test EMAS Percentage Score
N	Valid	38	38	24	24
	Missing	2	2	3	3
Median		48.5	80.835	55	90.665
Percentiles	25	43.75	72.8925	49	81.6175
	75	58	96.6	59.75	99.5825

The medians of the pre-test EMAS total score and percentage scores are 48.5 and 80.835% respectively (Total pre-test Md = 48.5, IQR: 43.75, 58; Percentage score pre-test Md = 80.835, IQR: 72.8925, 96.6). The medians of the post-test EMAS total score and percentage scores are 55 and 90.665% respectively (Total post-test Md = 55, IQR: 49,59.75; Percentage score post-test Md = 55, IQR: 81.6175, 99.5825).

A Wilcoxon Signed Rank Test (**Table 73**) revealed no statistically significant difference in the meaning of football for mental health service users following participation in 'Kickstart to Recovery' programme for neither the total score nor the percentage score, $N(\text{pre-test}) = 24$ and $N(\text{post-test}) = 24$, $z = -.209$, $p = .834$ and $z = -.174$, $p = .862$ respectively.

Table 73 Total Sample KtoR programme Impact on the EMAS

Test Statistics ^a		
	Post-test EMAS Total Scores – Pre-test EMAS Total Scores	Post-test EMAS Percentage Score – Pre-test EMAS Percentage Score
Z	-.209 ^b	-.174 ^b
Asymp. Sig. (2-tailed)	.834	.862

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

Wilcoxon Signed Rank Test (**Table 74**) revealed no statistically significant difference in the meaning of football pre and post the programme for mental health service users whose first time it was participating in the 'Kickstart to Recovery' programme in neither the raw score nor percentage score, $N(\text{pre-test}) = 4$ and $N(\text{post-test}) = 4$, $z = -.368$, $p = .713$ and $z = -.365$, $p = .715$ respectively.

Table 74 First Time Sample KtoR programme Impact on EMAS

Test Statistics^a		
	Post-test EMAS Total Scores – Pre-test EMAS Total Scores	Post-test EMAS Percentage Score – Pre-test EMAS Percentage Score
Z	-.368 ^b	-.365 ^b
Asymp. Sig. (2-tailed)	.713	.715

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

The Wilcoxon Signed Rank Test (**Table 75**) for participants who have previously participated in the 'Kickstart to Recovery' programme shows no statistically significant change in the meaning of football, in both the raw scores and percentage scores, $N(\text{pre-test}) = 20$ and $N(\text{post-test}) = 20$, $z = -.237$, $p = .813$ and $z = -.260$, $p = .795$ respectively.

Table 75 Return Sample KtoR programme Impact on the EMAS

Test Statistics^a		
	Post-test EMAS Total Scores – Pre-test EMAS Total Scores	Post-test EMAS Percentage Score – Pre-test EMAS Percentage Score
Z	-.237 ^b	-.260 ^b
Asymp. Sig. (2-tailed)	.813	.795

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

4.4.3.2. Breakdown of EMAS Individual Questions Scores

No statistically significant result was found for any test run for the EMAS. In order to rule out any individual question impacting the results, each participant's individual question scores from the pre-test were added together. Each question was scored on a Likert scale with 5 being the maximum score given, hence for the 38 participants (removing the two outliers), 190 was the maximum total score per question.

As seen in **Table 76** below, no question presented as an outlier, as each question's total score in percentage format ranged from between 77% - 93%. This however is high scoring for the pre-test stage and provides a small window of increased change to occur in the post-test stage, which may provide a reason for the insignificance of all EMAS results.

Table 76 Total Participants Pre-Test Scores for Each EMAS Question

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Total scores	155 /190	153 /190	156 /190	162 /190	155 /190	163 /190	162 /190	176 /190	151 /190	147 /190	164 /190	162 /190
%	82%	81%	82%	85%	82%	86%	85%	93%	79%	77%	86%	85%

4.4.4. Social Gains

As discussed in the Methodology chapter, when investigating the change in social gains an additional measure was not used. Instead, the social aspects of the current measures, which are the 'Social Functioning' domain the SF-36 and the 'Connecting and Belonging' domain of the RAS-DS, are isolated and explored in greater depth.

Numerous tests were run in order to determine if statistically significant differences exist for both domains. In Section 4.3.3.3., The Kruskal-Wallis Test showed a statistically significant difference in the social functioning scores across the three different programme block duration. There was not a statistically significant difference for this same test for the connecting and belonging domain.

For both domains, no Wilcoxon Signed Rank Test identified any significant difference, neither in total scores, nor first time participants nor for those who had previously participated in the 'Kickstart to Recovery' programme.

4.5. Additional Findings: Demographics of All Participants in the Study

This section will provide information on all participants in the study, including those who completed the pre-test stage of the research only. This is valuable findings as it provides demographic information of those who are referred to and join the 'Kickstart to Recovery' programme.

Table 77 displays the demographic information of all participants in this study.

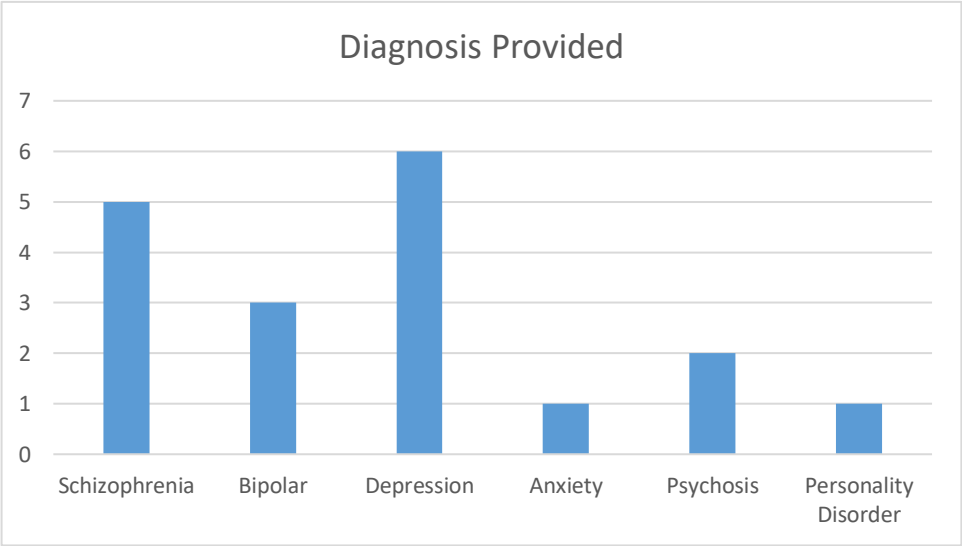
<i>Table 77 Demographics of All Participants</i>								
Gender	Male				Female			
	n=38 (95%)				n=2 (5%)			
Age Range (years)	18-23	24-29	30-35	36-41	42-47	48-52	53-58	<58
	1	6	13	10	5	2	3	0
	2.5%	15%	32.5%	25%	12.5%	5%	7.5%	0%
Previously played football	Yes				No			
	n=39 97.5%				n=1 2.5%			
Participating in other sports (excluding football)	Yes				No			
	n=27 67.5%				n=13 32.5%			
Community Activities	Yes				No			
	n=8 20%				n=32 80%			

4.5.1. Mental Health Challenges

The question posed to gather information on each participant's mental health was "how would you describe your mental health challenges?". There was variance in the answers provided to this question. Some participants (n=18) provided a diagnosis and others (n=20) provided a description of their perception of their personal mental health. Included in these are the 3 participants that provided a combination of a diagnosis and a description. 2 participants did not provide an answer to this question.

Figure 6 below displays the response of the 18 participants who provided an answer of a diagnosis in responding to how they would describe their mental health challenges.

Figure 6 Bar Chart of Diagnosis Provided



23 participants provided a description of their perception of their mental health challenges. In order to further understand the participant’s current perception of their mental health challenge, these descriptions were grouped. The language used by participants could be grouped into one of three categories; positive language, negative language and inconclusive language. Examples from each category are provided in **Table 78**. In 5 cases it was not possible to determine if the participant intended their response to be interpreted as positive or negative language, therefore they were categorised as “inconclusive language used”.

Table 78 Examples of Language Used to Describe Mental Health Challenges		
Positive Language (n=13)	Negative Language (n=5)	Inconclusive Language (n=5)
improving	annoying	it depends
stable	difficult	bit mixed up
very good at the moment	poor quality of life	medium

4.5.2. Participation in Other Sports

As recorded in **Table 77** above, 27 participants (67.5%) reported doing at least one sport other than football. The below table and pie chart (**Table 79** and **Figure 7**) illustrate the breakdown of this, with **Table 80** and **Figure 8** displaying the types of sports that were reported and the frequency of each.

Table 79 Frequency Table Other Current Sports

Number of other current sports per person	N	%
No other sports	13	32.5%
1 other sport	13	32.5%
2 other sports	9	22.5%
3 other sports	3	7.5%
More than 3 other sports	2	5%

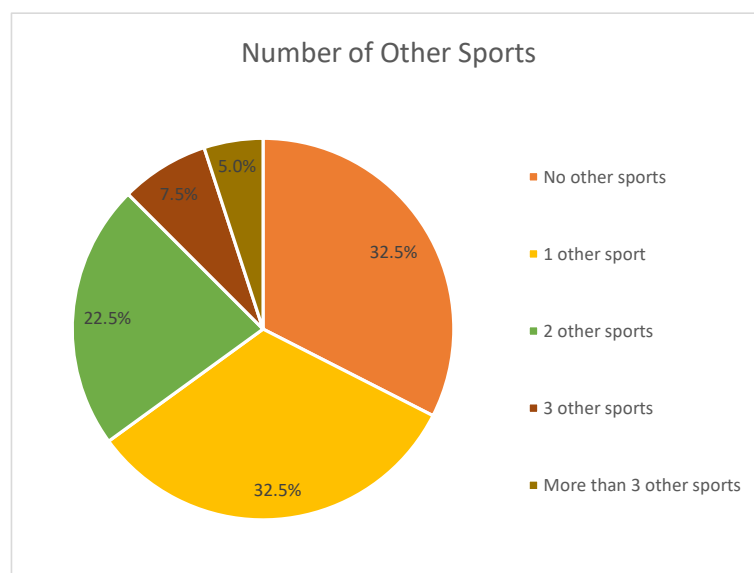


Figure 7 Pie Chart Representing Other Current Sports

Table 80 Frequency Table of Sports

Sports	N
Golf	8
Basketball	6
Swimming	6
GAA	5
Running	5
Other	5
Tennis	4
Cycling	3
Rugby	2
Gym	2

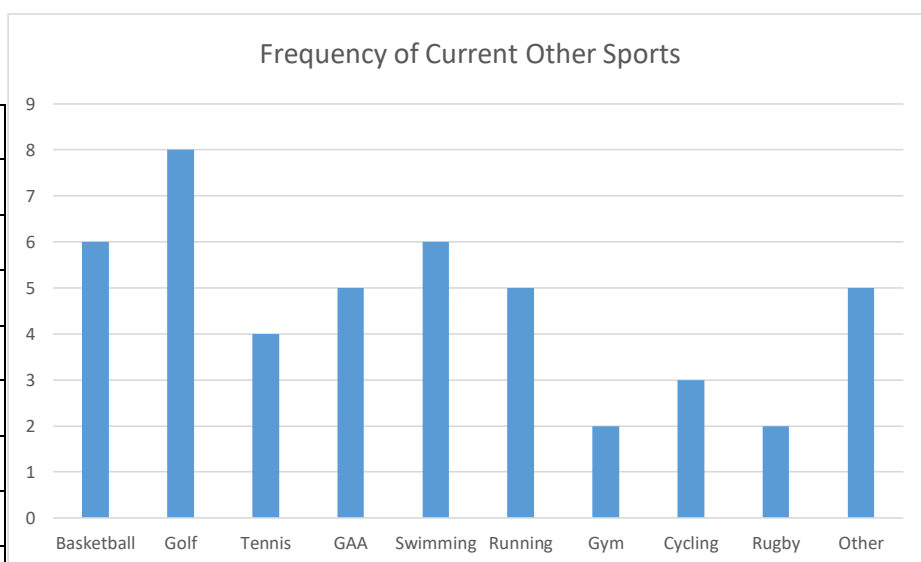


Figure 8 Bar Chart of Current Other Sports

To determine if geographical location impacts the participation in sport other than football for this sample of mental health service users, participants were grouped in their locations of Munster or Leinster and living in a town or a city. This enabled a comparison to be made between these groups, which is illustrated in **Table 81** and **Table 82** and in the stacked column charts in **Figure 10** below.

<i>Table 81 Participation in other sports by geographical region</i>		
	Yes	No
Munster (n=13) (Sites S3, S4, S6)	9 (62.2%)	4 (30.8%)
Leinster (n=27) (Sites S1, S2, S5, S7)	18 (66.7%)	9 (33.3%)

<i>Table 82 Participation in other sports by location</i>		
	Yes	No
Town (n=28)	19 (67.9%)	9 (32.1%)
City (n=12)	8 (66.7%)	4 (33.3%)

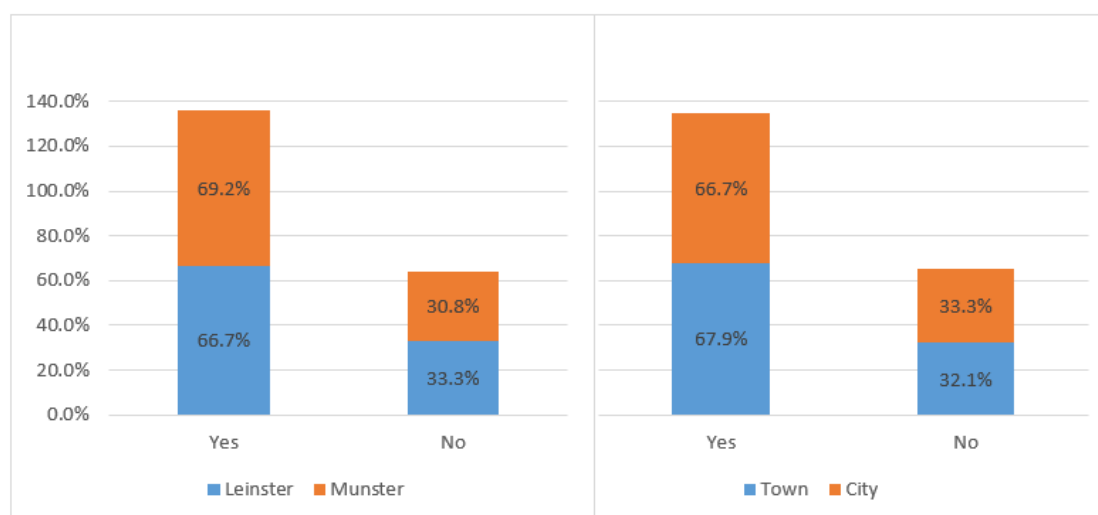


Figure 9 Stacked Column Chart Representing Environmental Location Differences for those that Participate in Other Sports (YES) vs those that do not (NO)

As the illustration above highlights, there is a small percentage difference (2.5%) for those that participate in other sports between those that live in Leinster compared to Munster. Similarly, the percentage difference is only 1.2% for those who participate in other sports living in towns compared to those living in cities.

4.5.3. Participation in Community Activities

A large percentage (80%) of those in this sample do not participate in community activities. Sports already mentioned were excluded to avoid repetition. The community activities reported (n=8) were “mass”, “men’s shed group”, “Special Olympics”, “parkrun”, “walking club”, “English classes”, “gardening” and “volunteering”.

When focusing on sports excluding football, participants were grouped in their locations of Munster or Leinster and living in a town or a city. This can be seen in **Table 83** and **Table 84** below.

<i>Table 83 Participation in community activities by geographical region</i>		
	Yes	No
Munster (n=13) (Sites S3, S4, S6)	5 (38.5%)	8 (61.5%)
Leinster (n=27) (Sites S1, S2, S5, S7)	3 (11.1%)	24 (88.9%)

<i>Table 84 Participation in community activities by location</i>		
	Yes	No
Town (n=28)	4 (14.3%)	24 (85.7%)
City (n=12)	4 (33.3%)	8 (66.7%)

<i>Table 85 Distribution of Sports/Community Activities between the Sites</i>	
	No. who participate in community activities and or sports excl. football / total in group
S1	5 / 6
S2	1 / 3
S3	4 / 5
S4	4 / 5
S5	13 / 14
S6	2 / 3
S7	3 / 4

When looking at community activities and engagement in sport together, it was found that 8 participants of the 40 did not participate in either a sport or community activities at the start of each of the ‘Kickstart to Recovery’ programmes. The distribution of those participating in community activities and/or sport excluding football between programme sites can be seen in **Table 85**.

4.6. Conclusion

This chapter has outlined the results of the data collected from seven services in the Republic of Ireland facilitating the football programme, 'Kickstart to Recovery', for mental health service users. Each programme, service and intervention conducted during the research is described in detail to improve reliability and transferability (see Chapter 3). The demographics of the participants is also described, both as individuals and as footballers. Inferential statistics were used to test the pre- and post-test results of the questionnaires to determine if statistically significant changes had occurred. The demographics of the groups as a whole, including those who did not complete the post-test, were included as additional information, as it provides valuable information about the group who are referred and participate in this programme.

The key findings identified in this chapter include:

- Statistically significant difference was found in comparing the total pre- and post-programme total sample scores of SF-36 domain of 'Energy Levels and Fatigue'.
- No other statistically significant results were found in comparing pre- and post-programme scores in any domain of the SF-36 in the total sample, first time participants only or participants who returned to the programme.
- There was no statistically significant change in the total recovery score measured by the RAS-DS when comparing pre- and post-programme scores in the total sample, first time participants only or participants who returned to the programme.
- A statistically significant change was found in comparing the RAS-DS sub-domain 'Mastering My Illness' for those whose first time it was to partake in the 'Kickstart to Recovery' programme.
- There was no statistically significant change found in any other domain of the RAS-DS for the total sample, first time participants of the programme, nor for those who returned to the programme.
- The Engagement in Meaningful Activities Survey (EMAS), adapted for football, found no statistically significant change in the total sample, first time participants only or participants who returned to the programme.
- No significant differences were found in comparing pre- and post-programme scores for social gains, which included the SF-36 domain of 'Connecting and Belonging' or for the RAS-DS domain of 'Social Functioning', for the total

sample, first time participants or return participants to the 'Kickstart to Recovery' programme.

- Statistically significant differences were found in post-programme scores in both domains of 'Social Functioning' and 'Emotional Wellbeing' for two groups with the shortest duration of sessions per block (S3 and S6) in comparison to the others.

These results will be discussed in the next chapter, drawing on current literature to enhance the discussion.

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Chapter Five: Discussion

5.1. Introduction

This research focused on investigating if change occurred after participation in the 'Kickstart to Recovery' programme in the following domains; quality of life, recovery-orientation, social gains and the meaning of football for mental health service users. In addition to these outcomes, this research also looked at the demographic information that may provide a perspective on who are the service users that avail of the 'Kickstart to Recovery' programme and how the programme can cater to these individuals. Finally, as an integral part of mental health service's goal, moving the programme from being community-based to community-integrated will be discussed.

5.2. Outcomes of the 'Kickstart to Recovery' Programme

As outlined in Chapter 3, this study does not contain a control group and therefore in comparing pre- and post-programme scores, any change found cannot be directly attributed to the 'Kickstart to Recovery' programme but can be considered a factor that may have influenced the change. This is also the case for comparisons between sites, as external factors may have impacted changes. Throughout the discussion of the results of this study, these factors will be taken into account.

Looking at the data collected as a whole, although only a few statistically significant results were identified, all median scores remained the same or increased from the pre-test to post-test. This is a positive finding to note, as the programme is not attributed to a negative impact on the elements of quality of life, social gains, recovery-orientation nor the meaning of football for the participants.

The following section will look in more detail at the outcomes for each measure used in this study. The social domain results of the quality of life and recovery-orientation will be discussed in its own section (Section 5.2.4) in order to reduce repetition.

5.2.1. Quality of Life

The Short Form 36 was utilised to investigate if a change was experienced in the quality of life of participants of the 'Kickstart to Recovery' programme.

No statistically significant results were found in comparing pre- and post-programme

scores in any domain of the SF-36, except that of the 'Energy Levels and Fatigue' domain. This domain, which captures the subjective well-being of the individual, has excellent empirical validity and is the only domain that has significant correlation with both mental health and physical health components of the SF-36 (Ware & Sherbourne, 1992; Ware, 2000). The median of the pre-test (Md= 45) was on the lower level of the scores, but the post-test median (Md= 57.5) moves towards the higher scores, which would indicate that participants experienced fatigue and had lower levels of energy prior to commencing the programme. However, given the short timeframe (between 5 - 8 weeks), they have demonstrated the potential for improvement (Ware & Sherbourne, 1992). This result includes first-time and return participants to the programme, and hence provides a positive indication that the 'Kickstart to Recovery' programme has the potential to improve energy levels and reduce fatigue, even on an ongoing basis. This is an important finding, as fatigue has been shown to be a barrier to physical activity for people with mental illness in Ireland (Matthews et al., 2018). The 'Kickstart to Recovery' programme not only has the potential to increase energy levels but may also aid the service user in overcoming fatigue as a barrier when participating in other physical activities.

This is a valuable quantitative result as it supports the qualitative findings of Butterly, Adams, Brown and Golby's (2006) MUSCSEL project and the 'Kickstart to Recovery' programme research findings of Moloney and Rodhe (2017). Both studies found participants reporting increased energy levels after participation in the football programmes. This benefit was found to have a positive impact their everyday lives, in addition to their performance during football sessions (Adams, Brown, Golby, 2006).

All other domains of quality of life as measured by the SF-36 did not present statistically significant differences in the pre-/ post-programme comparison. This included results for the total sample, first-time participants and return participants to the programme. These results differ from those found by Fredrick and Mason (2017), who, by using the WHOQOL-BREF, 16-item quality of life assessment, found statistically significant differences in the quality of life of participants of the *Coping Through Football* programme. This significance was found at the 6-month post-baseline, however was not evident at the 12-month post-baseline. Although it is not explicitly noted, this programme appears to run on an on-going basis, instead of in session blocks. This may be a possible attribute that may contribute to the differences between the studies' findings. This research has a minimum of 5-weeks and a maximum of 8-weeks between pre- and post-test follow up, while Fredrick and Mason

(2017) had 6-months from the pre-test to post-test period. While other structural elements of the programme or differences in the use of testing materials may impact this change, the limited exposure to the programme may reduce the opportunity for change in quality of life to occur.

5.2.2. Recovery-Oriented Change

Using the Recovery Assessment Survey; Scales and Domains (RAS-DS), the study's objective, to measure the recovery-oriented change of participants after the 'Kickstart to Recovery' programme, was achieved. Each domain of the RAS-DS will be discussed as each provides valuable findings from this study.

There was no statistically significant change in the total recovery score when comparing pre- and post-programme scores in the total sample, first time participants only or participants who returned to the programme. While recovery is an individual journey for each person, when looking at the sample as a whole, the median total recovery scores are high (pre-test Md = 114.51 / 152; post- test Md = 121.24 /152), which would indicate that the participants in this sample may be at a later stage in their recovery journey. No research on football as an intervention for mental health service users reviewed in this study brought forward similar findings or approached the topic of the stage of recovery an individual may be at when entering a similar football programme. This finding, therefore, provides a valuable contribution to the current body of literature and highlights the need for further research to enhance the understanding of football programme's impact on individuals at different stages of the recovery journey.

5.2.2.1 Hope; A Strong Element of Recovery

Hope is an essential ingredient in recovery and is often viewed as the essential motivator for personal growth (Tang, 2019). It is noted as both the trigger to start the recovery journey and the motivation to continue it (Bonney & Stickley, 2008).

The 'Looking Forward' domain of the RAS-DS was used in this study to measure hope. No statistically significant changes were noted from pre- to post-'Kickstart to Recovery' programme for the total sample, first time participants or those returning to the programme. The median score was noted to be high (pre-test Md = 76.39; post-test Md = 83.33), which would be indicative of individuals in the later stages of their recovery journey.

These results differ from other studies of a qualitative nature looking at football programmes for individuals with mental health challenges. However, as noted by Shrank, Bird, Rudnick and Slade (2012), hope is defined in a number of different ways in different literature, therefore it can be difficult to compare findings. The two most recent studies by Benkwitz and Healy (2019) and Hargreaves and Pringle (2019) both had themes of hope. Participants had something to look forward to weekly as well as fostering hope by making plans external to the group to enhance skill levels. The contradiction in results is interesting as two different methodologies were used. Further research is warranted to determine if it is a difference in methodology, definition of hope or programmes that brought forward these differences for findings of hope.

Hope is included in the '*Best Practice Guidelines for Mental Health Services*' (HSE Mental Health Services, 2017a) as part of each service user's recovery pathway. However, healthcare professionals are often faced with an uncertainty as to how to address this concept in practice. Although its importance is often referred to in literature and guidelines, hope is often a secondary outcome for interventions focused on recovery (Shrank, Bird, Rudnick & Slade, 2012). It is difficult to rely on non-specific interventions, as hope is not at the forefront of the input from health professionals. This may create difficulties in communicating hope, which has the potential to hinder a service user's recovery (Torrey, Rapp, van Tosh, McNabb & Ralph, 2005). Shrank, Bird, Rudnick and Slade's (2012) systematic review provided recommendations to improve interventions to foster hope, including developing collaborative strategies for mental health management (which is discussed further in the next section), setting achievable goals and providing opportunities for the service user to regain control. In the 'Kickstart to Recovery' programmes, goal setting was incorporated into the structure of three of the seven sites in this study, with the occupational therapist meeting with the participants before the programme to set goals related to attending the football and after the block is complete to review their progress.

In addition, Shrank, Bird, Rudnick and Slade's (2012) found that fostering relationships and utilising peer support to be strategies that can inspire hope. Individuals who have started their recovery journey are noted to have the potential to inspire hope for those about to take on their own journey, as they are a symbol of the future and can often provide advice that is relatable for the recipient (Repper & Perkins, 2003). As the 'Kickstart to Recovery' programme allows for individuals to return to the programme as well as new participants to enter, it is expected that this combination earlier and later stages of recovery would be present in the group. However ensuring structural

alterations to the programme are in place to facilitate this peer support opportunities is essential. This will be discussed in detail in Section 5.2.3. when discussing the social outcomes of the study.

5.2.2.2. 'Mastering My Illness'; Strategies and Skills for Management of Mental Health Illness

Recovery does not require the alleviation of mental health illness symptoms, but instead the concept that one can pursue a fulfilling and purposeful life 'as they are' (Davidson & Roe, 2007, p. 466). The domain of 'Mastering My Illness' in the RAS-DS focused on staying well, identifying warning signs of mental health symptoms and advanced planning for potential relapses (Hancock, Everett, Honey, & Scanlan, 2016). These concepts focus on management and control of the person's mental health, which aligns with Hitch and colleagues' (2014a) challenge of Wilcock's (1999) 'becoming' concept, which they state does not depend only on improvement and change, but also on maintaining and managing.

The results of this study found statistically significant improvement in 'Mastering My Illness' for those whose first time it was to partake in the 'Kickstart to Recovery' programme. It did not show significance for the overall sample nor those who had previously participated in the study. Those returning to the programme did not experience this improvement after the programme block. This perhaps signifies the initial impact of the programme on development of mental health symptom management, but not an ongoing and continuous development of these skills and coping mechanisms.

This is an important quantitative result as it supports a number of qualitative findings of other football interventions, including the qualitative study conducted on the 'Kickstart to Recovery' programme previously (Moloney & Rohde, 2017). Participant's found they could use the football as a distraction technique for mental health symptoms such as unhelpful thoughts (Moloney & Rohde, 2017). Fredrich and Mason's (2018b) participants developed new coping mechanisms, reducing their anxiety as a result of their participation in the football programme 'Coping Through Football'. Similarly, Darongkamas, Scott & Taylor (2011) found that the Park United programme helped their participants to manage mental health difficulties. Furthermore, Hargreaves and Pringle's (2019) quantitative work also identified self-control strategies developed as a result of self-talk and utilising social support. This study adds to the body of research, supporting the evidence that football programmes for mental health services have the potential to aid service users to take control of their symptoms and continue to live fulfilling lives.

These concepts of managing symptoms, developing coping mechanisms, learning to detect warning signs of becoming unwell and developing an action plan for potential relapse covers a broad range, all of which are important for recovery in and from mental illness. While the results indicate that first time participants of the 'Kickstart to Recovery' programme are developing these skills and strategies, the occupational therapists facilitating the sessions should be aware of these processes and be able to identify if a participant requires more support or guidance in mastering their illness.

5.2.2.3. Doing Things I Value

The 'Doing Things I Value' domain of the RAS-DS provides important information of recovery, with emphasis on doing things that are pleasurable, meaningful and benefit the individual's health (Hancock, Everett, Honey, & Scanlan, 2016). Activities that create this sense of value and personal meaning for an individual are considered occupations. Occupational engagement is a key component in health and well-being of all individuals, regardless of mental health challenges.

The domain of 'Doing Things I Value' of the RAS-DS identified no statistically significant change in scores after the 'Kickstart to Recovery' programme. This was the case for the total sample, those returning to the programme and those whose first time it was to participate. The median scores both before and after were also relatively high (pre-test Md = 79.165%; post- test Md = 87.5%). This information suggests participants in this study have high levels of engagement in valuable occupations, however not indicated to be as a result of participation in the 'Kickstart to Recovery' programme.

This lack of change was not unexpected as the demographic information indicates this sample of service users are a very active group prior to entering the 'Kickstart to Recovery' programme. With only 8 participants not currently partaking in sports other than football or community activities, many of these individuals may experience value and pleasure in participation in these other activities. Little difference was noted between the locations, with similar participation in sports excluding football in different parts of Ireland and in towns and cities. There was also little differences in the distribution of participations who participated in sport and/or community activities among the different sites.

5.2.3. Meaning of Football; Previous Experience Influences

Participation?

As outlined in the section above, engagement in activities that have personal meaning and value to the person is essential for recovery. As this study focuses on a football group, it was important to capture changes participants experienced in the meaning of this sport.

The Engagement in Meaningful Activities Survey (EMAS) adapted for football outcome measure found no statistically significant result neither pre- and post-programme, nor when looking at participants who's first time it was to participate in the programme. As it was expected participants would have a new experience of football, hence a change in the meaning it held for them. This lack of change was unexpected and warranted further investigation. As such, each question posed in the EMAS was investigated. This investigation identified that all scores for each question in the pre-test were very high (ranging from 77% to 93%). When scores are this high prior to commencing the programme, they create a ceiling effect, which allows for a smaller margin of improvement to be possible at post-programme stage (Cunningham, Weatherington & Pittenger, 2013).

This indicated that participants had deep meaning towards football prior to commencing or returning to the 'Kickstart to Recovery' programme. The demographic information suggests that all participants, with the exception of one, had previously played football at some stage in their life, many to club standard. In addition to this, a large percentage (77.8%) attend football matches as spectators and/or watch football on TV. This finding is supported by Hargreaves and Pringle (2019) who also found participants held a personal meaning and previous positive experience to football. This previous connection may facilitate reconnection with pre-illness identity, which would also support qualitative findings by Mason and Holt (2012) as a benefit of participating in a football programme.

Meaning and value are central to recovery in mental health (Repper & Perkins, 2003). Mason and Holt (2012) found that the service users who opted to join their football group did so as they experienced a pre-illness identity that they associated with football. This unique draw to the football intervention acted as a 'hook' which enticed the individual into initial attendance based on their previous positive experiences with the sport. It is, however, their experience during the programme that encouraged them to continue to attend.

5.2.4. The Importance of a Social Aspect

The duration of time participants in the 'Kickstart to Recovery' programme spend with other service users as a direct result of the programme is a maximum of 8 hours per block. Although it is acknowledged that social benefits, such as improving social confidence, building a social identity, reducing social isolation and increasing a feeling of belonging, can be gained from participation in a football group (Fredrich & Mason, 2018b; Butterly, Adams, Brown and Golby, 2006; Benkwitz & Healy, 2019; Darongkamas, Scott and Taylor, 2011; Brawn, Combes & Ellis, 2015), show that it is unlikely outcomes of friendships formed in continuous football programmes would be achieved in such a short timeframe of the 'Kickstart to Recovery' blocks.

Both the domains of 'Social Functioning' of the SF-36 and 'Connecting and Belonging' of the RAS-DS were isolated from their measures to investigate if social aspects change occurred as a result of participation in the 'Kickstart to Recovery' programme. As discussed in Chapter 3, 'Connecting and Belonging' focuses on friendship and community friendships (Hancock, Everett, Honey & Scanlan, 2016) while 'Social Functioning' domain of the quality of life measure reflects the degree the person's health impacts their normal social activities (Ware, 2000). As such, 'Connecting and Belonging' may reflect social growth, while 'Social Functioning' may reflect social maintenance. No significant differences were noted in comparing pre- and post-programme scores for either domain for the total sample, first time participants or return participants to the 'Kickstart to Recovery' programme.

This study found statistically significant differences in post-programme scores in both domains of 'Social Functioning' and 'Emotional Wellbeing' for two groups with the shortest duration of sessions per block (S3 and S6) in comparison to the others. Although this was the factor that allowed for the grouping of the sites for comparison, it is difficult to attribute the shorter duration of the blocks with the results found. When the demographics of these groups were examined closely, a common similarity identified was the presence of an additional social aspect to the programme. This was not present in the other groups in the study. Site 3 had tea and sandwiches after each football session, while Site 6 had picnic tables and a café onsite where the service users would often gather before and/or after the session to have a chat, especially when the weather was good. Although this was not a structured aspect for Site 6, the occupational therapist would often sit and chat with service users in an informal manner. This social aspect was previously incorporated into the programme, with Moloney and Rohde (2017) identifying

it as an important part of the social environment, however it has since faded as being activity incorporated into the programme structure.

It is appropriate that the domains to produce statistically significant results are 'Social Functioning' and 'Emotional Wellbeing' as Repper and Perkins (2003) describe these elements, in addition to mental and physical health as 'intimately interlinked' (p.136). While there is an importance in growing social connections in order to integrate into the community (as measured by 'Connecting and Belonging'), it would be difficult to maintain these new social activities if an individual's physical and mental health interfered significantly with their participation (as measured by 'Social Functioning'). In addition, the sessions provided a shared experience centred around the common entity of football. These experiences may provide inspiration for conversation between service users, which allows for relationships between individuals at different stages of recovery to occur. This would support the fostering of hope discussed above, as service users gain role models and peer support from each other. This is one of the most valuable findings of this study, as it provides strong justification for the implementation of a social aspect into the structure of the 'Kickstart to Recovery' programme, which has the potential to have a positive impact on the programme's service users.

5.3. Who are the Service Users of the 'Kickstart to Recovery' Programme

The outcomes of the study explored above bring to light questions on who the individuals are that avail of the 'Kickstart to Recovery' programmes, how they have come to be part of this programme and what structures are in place to provide them with a quality service. This may be impacted by those inviting and referring the service users to the group, by the expectations the service users have of the programme or a combination of both.

5.3.1. Assumptions and Expectations of the 'Kickstart to Recovery' programme

Participants of the 'Kickstart to Recovery' programme enter the programme by means of referral from health professionals in the mental health service they attend. With this pathway to enter the programme, it is important to investigate what the possible assumptions of the programme are and what is expected to be gained from participation, for both those that make the referrals and those that choose to attend.

The participants that took part in this study provided interesting responses to the question 'how would you describe your mental health difficulties?'. Half of participants opted to provide a description, rather than or in addition to a diagnosis in answering this question. Over half of these were framed with positive language, indicating that they felt their

mental health difficulties were improving or were at a stage they were satisfied with. This information, in addition to high pre-test scores in quality of life and recovery-orientation measure, indicate that the sample of participants in this study are at a later stage of recovery and possibly currently have positive attitudes towards their mental health situation, therefore possibly nearing discharge.

There may be an assumption that the programme is for individuals as they near discharge as community-integration, an aim of the programme, is desired at this stage. This assumption would contrast greatly with Davidson and Roe's (2007) argument that recovery, of which community integration is an important component, should not only be implemented as individuals near 'better' but be part of the process. In waiting to facilitate and support community-integration and active citizenship only as a person has overcome the disability they experience, the civil rights aspect of recovery *in* mental illness is undermined (Davidson & Roe, 2007). If the expectation of the programme is communicated in this manner to the service users, those in earlier stages in their recovery may be reluctant to join.

As discussed above, all participants had a personal connection to football, having played before and many still engaging in football activities such as attending and watching matches. This may be as a result of the football acting as the 'hook' to engage but must also be considered as the reason these individuals are invited to the group. In Moloney and Rohde's (2017) research on the programme, they stated that those who expressed an interest but did not have access to existing community groups were invited to the programme. If those making the referrals to the programme view it as an intervention only for those who express any interest in football, they may exclude a number of service users, thus preventing the opportunity for service users to participate for other reasons than the sport itself.

As with expressing a pre-existing interest in football, service users who express an interest in any sport or are known to already engage in sport(s) may be more likely to receive an invitation to the group. In the sample in this study, of those who already played sport, 77% dropped out of the programme prior to the end of the block. This may highlight a large number of service users who are referred due to their interest but cease to continue the programme as they feel they receive the benefits from sports they pre-engaged in. This may also be as a result of expectations of the programme by the service user, as they compare their current sporting engagements to the 'Kickstart to Recovery'

programme and it does not meet their expectations, or they already gain the benefits of occupational engagement in their current sport.

These assumptions outlined above may create a profile of service users who are viewed as suitable for the programme, hence influencing health professional's decision to discuss the 'Kickstart to Recovery' programme with certain service users or impacting how they communicate the purpose of the programme. Another particular assumption that may greatly impact the 'Kickstart to Recovery' programme is gender, which is discussed in detail in the next section.

5.3.2. Gender and 'Kickstart to Recovery' programme

Gender can be viewed as a characteristic that influences culture, such as high masculinity traits influence values in competition, achievement and success (Gupta, 2016). It can also provide an individual with social norms, role and expectations in society, that lead to different behaviours including those of health behaviours (Richardson, 2004).

There is evidence from a national policy level supporting the use of male-only approaches in enhancing the health and well-being of men in Ireland (HSE, 2016; National Women's Council of Ireland, 2012). The emphasis on gender-sensitive health service provision in Ireland has been acknowledged by the World Health Organisation (WHO) as a progressive move towards tackling inequalities in gender health (WHO, 2018). ENGAGE, a one-day programme that focuses on best practice for engaging men in health services, was accredited as "a key pillar of policy implementation" (WHO, 2018). The researcher of this study attended the *Engage National Men's Health Training Unit 6 – Connecting with Young Men*, where it was noted the 'Kickstart to Recovery' programme possesses a number of the desired qualities, such as peer-support and an activity that does not have mental health stigma attached (Richardson, Brennan, Carroll & Lambe, 2013), that would aid in helping men become active agents in their own healthcare.

Men are often described as a hard to reach population, as they are more likely not to seek help for mental health difficulties nor engage in the services provided than their female counterparts (WHO, 2018; Lee & Owens, 2002). A number of the pre-existing football programmes focus on recruitment and participation of male service users only (McGale, McArdle & Gaffney, 2011; McArdle, McGale & Gaffney, 2012; Darongkamas, Scott & Taylor, 2011), including Moloney and Rodhe's (2017) study on the early version of the 'Kickstart to Recovery' programme. The competitive nature of football provides

high levels of the cultural masculine traits, hence making the sport attractive and a culturally acceptable activity for men to participate in (Gupta, 2016; Fredrick & Mason, 2018a). With an almost all male sample ($n = 38/40$) in this study, it is clear that the 'Kickstart to Recovery' programme also experiences male-dominate participation.

The inclusion of leagues and other forms of competition is a highly debated topic for football mental health interventions, primarily due to the culturally high levels of masculine traits it can bring. Of the seven 'Kickstart to Recovery' programmes included in this study, three were found to currently organise matches against other 'Kickstart to Recovery' groups in different counties. Brawn, Combes and Ellis (2015) found a benefit of the league was that participants were motivated by the competitive aspect to improve their personal fitness and to do more in order to help their team achieve victory. With this, however, there is resistance to introducing such matches as Magee, Spaaij and Jeanes (2015) found the high competitive nature to lead to an exacerbation of mental health symptoms.

The majority presence of males in these programmes may be as a result of previous experiences, as participation in football and sports, in general, is higher for males than females. Only two participants in this study were female, one reporting she had not previously played football. It is expected that the 'hook' effect would be less effective for females, as a lower percentage of females will have ever had an experience of playing football, compared to that of their male peers. In England, it was found that for every female who plays football there is an equivalent of 12 male players (Women's Sport and Fitness Foundation, 2012). In addition, the drop-out age of participation in football for females is younger than that of males and continues to decline, unlike males of similar ages where the figures re-ascend as they enter their early 20s (Women's Sport and Fitness Foundation, 2012). In Ireland, the Football Association of Ireland's Women's Strategic Plan (FAI, 2015) is aimed at improving the quality and opportunities for female players to participate in football. This includes initiatives such as 'FAI Soccer Sisters', aimed at including young girls in the game. With such initiatives, it is expected that we will see a growth of females who have positive experiences with football and like males, will have past experiences that will influence their decision of engagement in football interventions if required.

Females have been a difficult population to recruit into football related mental health interventions (Fredrick & Mason, 2018a; Dyer & Mills, 2011) Both of the participants who participated in this study dropped out of the programme prior to its completion. When including females in such programmes it is important that their sole purpose isn't to positively benefit the males service users in the group by reducing traits of masculinity.

There is a potential for gender issues to arise, resulting in exclusion during sessions, as Fredrick and Mason (2018b) found females in the group would not be passed the ball. By including one female in the group, as was the case for all groups that had female presence in this study, there is a potential she is placed in a vulnerable position, where she may feel excluded, negatively impacting her self-esteem and social confidence.

While there are benefits and challenges to both investing in all-male groups and groups of mixed-genders, it is important that specific structural support is provided in both cases to insure all service users benefit equally, regardless of gender.

5.4. Community-Based; How Does This Become Community Integration?

The biggest progression for mental health services, both in Ireland and abroad, is the development of community-based services (Government of Ireland, 2006; WHO, 2005). All the 'Kickstart to Recovery' programmes in this study were located outside the clinical setting of the HSE mental health service sites and in community facilities within localities. This moves beyond the aim of services being situated in communities to services being intertwined in community resources.

An essential principle of being community-based is that locations are within accessible distance from service user's homes (Thornicroft, Szmukler & Mueser, 2011). While a positive finding was that all sites had free parking facilities, services should be cautious not to presume this provides an accessible environment. Lack of transport was identified by Butterly, Adams, Brown and Golby (2006) as a barrier to being active. Mental health challenges have the potential to impact driving (Buckley, Robinson & Stapleton, 2017) and the lower socio-economic class of those with mental health challenges (Perkins & Rinaldi, 2002) may prohibit having the means to purchase a vehicle, therefore access to public transport and alternative methods of transportation other than driving oneself to the sessions should be considered.

Four of the seven sites reported having public transport available. Of those remaining, one is in walking or cycling distance of the town centre and one has a bus provided from the Day Centre. Only one site reported having limited public transport to the football facility. In England, the Imagine Your Goal (IYG) football intervention also made links with local community resources including securing travel passes for service users to attend the sessions (Henderson, O'Hara, Thornicroft & Webber, 2014; Dyer & Mills, 2011). In Ireland, those who avail of Disability Allowance are entitled to a free travel pass

(Department of Employment Affairs and Social Protection, n.d.). With vast rural regions in Ireland, a likely barrier to attendance would be a means of transportation. The information in this study is limited to the seven regions included, hence would require further research to investigate if transport means are being met to facilitate attendance to the 'Kickstart to Recovery' programmes.

While community-based services are important, the physical presence of an individual in the community does not equate to community integration (Repper & Perkins, 2003). The service users in the 'Kickstart to Recovery' programme may play football surrounded by others outside of the service, however they remain disconnected from society as they remain as a segregated, exclusive group. The lack of significant changes in the domain of 'connecting and belonging' suggests that growth and development of social connections aren't facilitated as part of the football programme. Two key elements restricting community integration in the 'Kickstart to Recovery' structure is the fixed timeframe of the programme blocks and the lack of exit routes from the programme into the community.

5.4.1. Duration of the Programme Blocks

According to Miler and Rollnick (2013), there are six stages of change, comprising of precontemplation, contemplation, planning, action, maintenance and relapse. Time is required to facilitate moving through the stages and accommodating set-backs in this process. This is particularly relevant as it has been found that volition is a barrier to physical activity for individuals with mental health challenges (Matthews, et al., 2018). With football programmes, positive behavioural change towards physical activity is a desired outcome for participants, however restricted timeframes can limit this.

A reoccurring theme throughout this discussion is the participant's exposure to the programme being restricted due to the short duration of its session blocks. With a maximum of 8-weeks, hence maximum of 8 hours of exposure, it is difficult expect change to have occurred in such a short period. This is noted in outcomes found, where limited significant change in quality of life, recovery-orientation and social aspects have changed in the timeframe. Community integration is also expected to occur in this timeframe, despite the only aspect of facilitating this in the programme is the physical environment in the community.

'Kickstart to Recovery' is not an information providing programme, where the aim would be to develop knowledge about a certain subject. This programme focuses on

engagement in football, an occupation that is purposeful and meaningful to the participant. Although it may not be the case for every individual, the hope is that the participants build connections with the sport and make the decision to integrate it into their routine, identity and lifestyle. As such, in containing the sessions within a timeframe of 8-weeks blocks, the opportunity to build and maintain this relationship with the occupation is limited.

Of the studies outlining mental health football interventions, no programme stated that it was restricted to a timeframe of 8-weeks or less. Those that ran in blocks often met more than once a week, such as 'Back of the Net' (McArdle, McGale & Gaffney, 2012) and the groups in Magee, Spaaij and Jeanes' (2015) study, both which ran for 10-weeks with two sessions per week. Most programmes used a continuous format, where sessions were run all year round. This approach taken by other programmes highlights the possible pragmatic and structural reasons, such as availability of resources and finances, for the restricted timeframe (maximum 8-week blocks) for the 'Kickstart to Recovery' programme. If such limitations were not present, the more prolonged exposure to the occupation of football may allow the programme greater opportunity to meet its desired aims.

5.4.2. Exit Pathways into the Community

Football programmes, like that of the 'Kickstart to Recovery', can build safe environments for individuals to build their recovery journey. However, they should also offer a means of exiting the group, which allows the person to be supported, informed and to continue to build on the gains they achieved in their recovery journey. No exit pathway nor explicit on-going support to enter community was incorporated into the structure of the 'Kickstart to Recovery' programme.

43 of the 66 service users who attended the groups during the research period had previously participated in the 'Kickstart to Recovery' programme (as reported by the occupational therapist for each site). Without structured pathways into other social networks that provide similar levels of support and social connection, participants may not feel the need or want to leave the 'Kickstart to Recovery' programme, as was found by Lamont, Harris, McDonald, Kerin and Dickens (2017).

In containing the football sessions within the service, the occupational flow that may have been experienced is interrupted when a service user is discharged as they no longer

have place to experience it. Football has been shown to provide this flow, described in Hargreaves and Pringle's (2019) study as "being in the zone" (p.23).

Challenge is an important aspect of creating flow, however if this goes beyond the 'just right challenge' it may lead to failure, damaging gains in self-esteem (Fredrick & Mason, 2017; Dyer & Mills, 2011). As highlighted by Hargreaves and Pringle (2019) in investigating their football programme, "there is a need for challenge but not too great a challenge for those who were not ready" (p.24). If there is not a sufficient pathway for service users to move from a supported, controlled environment of the 'Kickstart to Recovery' programme into community football groups, which can be unpredictable and come with additional challenges, there is a risk of this failure occurring.

In the studies on football programmes identified and in the 'Kickstart to Recovery' programme, the football coach's role does not extend beyond the sessions. The coaches included in this study were highly experienced, with all having coached as part of the 'Kickstart to Recovery' programme previously. It is acknowledged that mental health professionals are limited in the relationship they can develop with the service user, simply due to the purpose and context the relationship formed (Repper & Perkins, 2003). On the other hand, the FAI coach does not have these same limitations as they are external to the mental health service. The coaches succeeded to make participants feel important in Hargreaves and Pringle's (2019) football intervention, which may also be the case with the FAI coaches in the 'Kickstart to Recovery' programme. They may even be viewed as role models due to their skills and association with the FAI, the national governing body for football in the Republic of Ireland. FAI coaches may have the potential to act as a valuable resource, integrating service users into the community by means of participation in teams they coach locally. By taking a graded exposure approach, the coach would act as a trusted, familiar person whose presence in a local football team would reduce the anxiety of attending (Repper & Perkins, 2003). The coach's knowledge of the service user from the 'Kickstart to Recovery' programme will provide them with an understanding of the individual's skill level, challenges faced in engaging and strengths both as a footballer and a person. Although further research would be required to determine the effectiveness, this may be an interesting and unique avenue for the 'Kickstart to Recovery' programme to take in promoting community-integration while utilising the resources available to them to provide a graded approach to maintaining football participation.

5.6. Study Conclusion

To conclude, the research successfully met the aim of this research by investigating if change occurred for community mental health service users after participation in the 'Kickstart to Recovery' football programme.

A pre-post study design was implemented. With ethical approval sought and obtained from four different research ethics committees, a total of 7 sites facilitating the 'Kickstart to Recovery' programme were used for recruitment in this study. 40 participants completed the pre-test questionnaire and 27 completed the post-test questionnaire.

This study had four objectives of measuring change for participants after the 'Kickstart to Recovery' programme in the four areas of quality of life, recovery-orientation, meaning of football and social gains. The results of this include;

1. In using the SF-36 to measure if a change occurred in the quality of life of mental health service users after participating in the 'Kickstart to Recovery' programme, a statistically significant difference in the domain of 'Energy/Fatigue' for the total sample was found. This was the only domain to find a statistically significant difference between the pre- and post-programme results.
2. In using the RAS-DS to measure if a change occurred in mental health recovery-orientation of mental health service users after participating in the 'Kickstart to Recovery' programme, a statistically significant difference in the domain of 'Mastering My Illness' was found for participants who's first time it was to the programme. No other domain found a statistically significant difference between the pre- and post-programme results. In addition to the objective, it was found that the total recovery scores were high.
3. In using EMAS adapted for football to measure if participants experienced change in the personal meaning of the football after participating in the 'Kickstart to Recovery' programme, no statistically significant result was found. In addition to the study objective, it was noted that the pre-tests scores were high for each question posed in this measure.
4. In using the domains of 'Connecting and Belonging' from the RAS-DS and 'Social Functioning' from the SF-36 to measure if participants experienced social gains after participating in the 'Kickstart to Recovery' programme, no statistically significant results were found. In addition to the study objective, S3 and S6 found statistically significant differences for inter-group post-test comparisons for both domains of 'Social Functioning' of the SF-36 and 'Connecting and Belonging' of the RAS-DS. It was identified that these two sites contain a social aspect in their sessions.

The occupational therapy facilitators for each site also provided information on the programme structure and any factors that may have impacted to the programme or participations throughout the study period programme block to insure intervention fidelity.

This insured the programme described was what was measured, while also identifying any environmental or structural differences that may have impacted the study results.

These results were analysed in depth and formed the discussion provided above.

5.7 Recommendations Drawn from this Study

5.7.1. Recommendations for Further Research

A number of findings of this study differ to those found in other similar studies on football programmes with similar aims and structures. It highlights the need for research on the 'Kickstart to Recovery' programme specifically was present, as the context and structure of the programme's design can have a significant impact on the outcomes.

This study has highlighted areas requiring further research. The following recommendations are made;

1. To conduct a study including a control. This research has indicated that the 'Kickstart to Recovery' programme may be a factor contributing to improved energy levels, symptoms management of first-time participants and social benefits for sites that include a structured social aspect. The attribution of these results to the programme, however, are limited due to the lack of a control. In order to validate this connection and determine if other significant results exist, it is recommended that a randomised control trial is conducted.
2. To further explore exit routes from the football programme for mental health service users to understand what is required to support community integration. This may be investigated by focusing on individuals who leave the group, both as a result of a successful exit route and those who drop out of the programme for other reasons. Both groups may provide information that would aid in understanding the supports required for successful exit from the programme.
3. In addition to the point above, investigate the possible resource and value the FAI coaches may bring to facilitate community integration for service users.
4. To conduct qualitative research focused on the recovery area of managing the mental health illness. A further understanding of the management strategies identified in this study is required to inform practice.
5. To conduct further research exploring the stage of recovery for individuals and their point of entry into the 'Kickstart to Recovery' programme. This would aid to determine if there differences between individuals who are in a mid or early

stage of recovery and their engagement with football. The RAS-DS used in this study is designed to identify an individual's stage of recovery.

5.7.2. Recommendations for Practice

Findings of this study have the potential to positively impact the structure of the 'Kickstart to Recovery' programme in order to provide a strong, evidence-based programme for mental health service users. It is acknowledged that resource and structural limitations may restrict the implementation of recommendations, however, are provided in the best interest of developing the programme. The main recommendations proposed are the following;

1. This study identified social gains in the 'Kickstart to Recovery' programmes that provided opportunities for social engagement. It is therefore recommended that a social aspect to the programme be developed and included as an integral part of the programme's structure.
2. In order to promote community integration further and enhance social gains, it is recommended that an exit pathway from the programme be developed. This may include using the FAI coaches as a resource for graded exposure to community football groups.
3. The literature identified gender, particularly the inclusion of females in football, as an area of concern. This study also noted the lack of female's participation in the programme, with individual's dropping out of the programme at early stages. It is therefore recommended that the programme organiser's support the entry and inclusion of females in the football programme.

With strong support for the use of all-male groups to target men's mental health (HSE, 2016; WHO, 2018), it is also recommended that the 'Kickstart to Recovery' programme be considered as an all-male group, when appropriate.

4. Change in quality of life, recovery orientation, community integration, social gains and meaningful participation take time to develop. It is therefore recommended that the structure of the programme is revisited and individuals are encouraged to partake for a longer duration in order to develop themselves.
5. It appears that individuals who partook in this study were at a later stage in the recovery journey. It is recommended in order to support recovery in mental illness, community integration support can be beneficial at earlier stages of the recovery journey (Davidson & Roe, 2007; Repper & Perkins, 2003).
6. Hope is an integral concept within the recovery approach, which is seldom specifically addressed by services (Shrank, Bird, Rudnick & Sade, 2012). This study also identified that there was no change in the participants 'hope' domain

as measured by the RAS-DS. It is therefore recommended that the development of hope for service users in the 'Kickstart to Recovery' programme is implemented by goal setting and fostering opportunities for control (Shrank, Bird, Rudnick & Slade, 2012).

7. This research has identified potential limitations in the current aims of the programme, in addition to identifying areas of improvement. These findings will be communicated back to the stakeholders of the programme. In order to enhance evidence based practice, it is recommended that the aims, objectives and structure of the 'Kickstart to Recovery' programme be reviewed and documented for future reference.

5.8. Study Limitations and Strengths

5.8.1. Study Strengths

The strengths of this study's design and results make it a valuable addition to the current body of literature. These strengths include geographical variation, use of standardised assessment, efforts to ensure intervention fidelity, the role of the researcher and the results themselves.

The key strength of this study was its geographical spread in the Republic of Ireland. Challenges with sourcing appropriate liaison persons and ethics committee boards for each site were overcome to attain seven appropriate sites to recruit participants from. These sites were spread across the north-east, south-east and mid-west of the country, providing a variance in environments and locations, which improves the generalisation of the findings.

These findings were obtained by means of three standardised assessments which were chosen as they have high levels of validity and reliability, in addition to their ability to provide information to answer the objectives of the study. Standardized assessments are regarded as effective in measuring subjective constructs and improve the reliability and external validity of the study (Schofield & Forrester-Knauss, 2015).

This research was strengthened by the measures taken to improve the intervention fidelity, in order to ensure that the programme discussed was that that was reported on. This became a critical aspect of the study, as different sites were shown to have adapted elements of the programme to meet the needs of the service users, environments and individual services. While the core principles of the Kickstart to Recovery programme

were maintained in all sites (FAI coach and OT present, community-based, football as the main activity), this information, in addition to the researcher's reflective diary, identified any factors that may have an impact on the research.

Consistent efforts were made by the researcher to reduce the impact of limitations on the study. A strength of this study was the presence of the researcher during the data collection, in order to be available for any questions and attempt to standardise the environment. Although the facilities for the completion of questionnaires varied between sites, the researcher documented the pre-test environment in order to attempt to replicate this for the post-test. In addition to this documentation, the researcher kept a research diary, which regular inputs allowed for reflection and highlighted areas of development, both for the research process and the researcher.

The final strength is of the results. Not only does the data contribute to the current body of literature for football programmes for mental health service users, but also provides suggested recommendations to improve the programme and further research in the area.

5.8.2. Limitations

This study fulfilled the aim and objectives of the research, however the limitations should be acknowledged. This includes limits of the research design, sample size and challenges with conducting research in real-life environments.

The lack of a control in this study poses the greatest limitation. The main impact this poses on the research is the results cannot be attributed to the 'Kickstart to Recovery' programme. The programme however, can be considered as a factor that contributed to the results.

The sample size, distribution and geographical locations sought were limited. A minimum of 30 participants is recommended provide strong sample size for statistical testing (Pallant, 2016). Although barriers were overcome and everything possible was done to increase the number of participants, the sample size achieved fell short of the recommendations, with 27 participants completing both pre-test and post-test stages of the data collection. In addition to the size of the sample, the distribution of the sample among each site was not equal. This was further limited by the geographical areas that were used to recruit participants from. While a good geographical variance was noted as a strength of the study, areas considered 'hotspots' for football, due to their strong football culture related to their association with popular international teams, such as

Dundalk F.C., Cork City F.C. and Shamrock Rovers F.C., were not included in this study. This was primarily due to a lack of active HSE research ethics committees. It is possible these areas may have provided important data and therefore is a limit of the study.

A further limitation of this study was the lack of documentation of participants leaving the study. The reason for dropping out of the programme was not known, therefore an understanding of unmet needs could not be gained. This was reflected on by the researcher during the data collection for the research, however it was not deemed appropriate to source this information at that stage.

The final limitation of this study related to the challenges of conducting research in real-life settings. A number of the groups made adaptations or added elements to the programme that catered to the specific needs of the service users and the service itself. Although attempts were made to document these changes with the facilitator documenting intervention fidelity, it was not possible to ensure all elements were known and controlled. This may also impact the aims of the programme, as altering the content, may subsequently alter the outcomes aimed to be achieved. While this presents as a limitation to controlling for validity and reliability of the study, the attempts to control this also strengthens this research as comparisons on different elements can be made.

This chapter has concluded this research by discussing the research findings in depth, outlining a summary of the research process, providing recommendations for practice and for future research and finally, highlighting the research's strengths and weaknesses.

References

- Abib, L.T., Fraga, A.B., Wachs, F., & de Paula Alves, C.T. (2010). The Body Practices Concerning Mental Health: A Football Workshop Capabilities and Possibilities in a Psychosocial Care Centre, *Pensar a Pratica*, 13(2), 1-14.
- Akkerman, S., Admiraal, W., Brekelmans, M., & Oost, H. (2006). Auditing quality of research in social sciences, *Quality & Quantity*, 42(2), 257-274.
- Alexandratos, K., Barnett, F., & Thomas, Y. (2012) *The impact of exercise on the mental health and quality of life of people with severe mental illness: a critical review*, *British Journal of Occupational Therapy*, 75(2), 48-60.
- American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.
- Anthony, W.A. (1993). Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s, *Psychosocial Rehabilitation Journal*, 16(4), 11–23.
- Benkwitza, A., & Healy, L. C., (2019). 'Think Football': Exploring a football for mental health initiative delivered in the community through the lens of personal and social recovery, *Mental Health and Physical Activity*, 17, 100292.
- Benson, A., & Sinnott, J. (2007). *Why are Brazil so good?* Retrieved 18th June 2020 from <http://news.bbc.co.uk/sport2/hi/football/internationals/6700897.stm>
- Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, 15(2), 140-153.
- Brangan, J. (2009). *Impact of the Introduction of an Occupational Therapy Service to an Irish Mental Health Setting Service Users and Staff Perspectives*. Dublin: Trinity College Dublin.
- Brawn, P., Combes, H., & Ellis, N.J. (2015). Football Narrative: Recovery and Mental Health, *Journal of New Writing in Health and Social Care*, 2(1), 30-46.
- Breitenstein, S., Gross, D., Garvey, C., Hill, C., Fogg, L. and Resnick, B. (2010). Implementation fidelity in community-based interventions, *Research in Nursing & Health*, 33(2), 164–173.
- Brennan, D. (2014). *Irish Insanity: 1800-2000 (Routledge Advances in Sociology)*. Dublin: Routledge.
- Brink, H., van der Walt, C., & van Rensburg, G. (2012). *Fundamentals of Research Methodology for Healthcare Professionals* (3rd ed). Capetown, South Africa; Juta and Company (Pty) Ltd.
- Buckley, S., Robinson, K., & Stapleton, T. (2017). Driving and depression: Health professional's perspectives in Ireland, *Journal of Transport and Health*, 7B, 235-246.
- Burns, P.B., Rohrich, R.J., & Chung, K.C. (2014). The Levels of Evidence and their role in Evidence-Based Medicine, *Plastic and Reconstructive Surgery*, 128(1), 305–310.

- Butterly, R., Adams, D., Brown, A., & Golby, J. (2006). Clients perceptions of MUSCSEL project: a community-based physical activity programme for patients with mental health problems, *Journal of Public Mental Health*, 5(4), 45-52.
- Carless, D., & Douglas, K. (2008). Narrative, Identity and Mental Health: How men with serious mental health illness re-story their lives through sport and exercise, *Psychology of Sport and Exercise*, 9(5), 576-594.
- Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J. and Balain, S. (2007). A conceptual framework for implementation fidelity, *Implementation Science*, 2(40), doi: 10.1186/1748-5908-2-40
- Chang, C.-K., Hayes, R. D., Perera, G., Broadbent, M. T. M., Fernandes, A. C., Lee, W. E., Hotopf, M., Stewart, R. (2011). Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. *PLoS ONE*, 6(5), e19590.
- Cohen, S., Mermelstein, R., Kamarck, T., & Hoberman, H.M. (1985). Measuring the functional components of social support. In I.G., Sarason, & B.R., Sarason (eds.), *Social support: theory, research, and applications* (pp.73–94). The Hague, Holland: Martinus Nijhoff.
- Cole, F. (2014). Physical Activity for Mental Health and Wellbeing. In W. Bryant, J., Fieldhouse, & K., Bannigan (eds.) *Creek's Occupational Therapy and Mental Health* (5th ed.) (pp. 205-220). Edinburgh: Churchill Livingstone Elsevier.
- Common Goal. (n.d.). Our Purpose: Common Goal. Retrieved August 15th, 2019, from <https://www.common-goal.org/About>
- Cordingley, K., & Pell, H. (2014). Living Skills. In W. Bryant, J., Fieldhouse, & K., Bannigan (eds.) *Creek's Occupational Therapy and Mental Health* (5th ed.) (pp. 294-308). Edinburgh: Churchill Livingstone Elsevier.
- Coyle, K., Lowry, S., & Saunders, J. (2016). See Change: The National Mental Health Stigma Reduction Partnership in Ireland. In G., Wolfgang, R., Wulf, & S., Norman (Eds.) *The Stigma of Mental Illness - End of the Story?* (pp.357-377). Switzerland: Springer International Publishing.
- Creek, J. (2014). The Knowledge Base of Occupational Therapy. In W. Bryant, J., Fieldhouse, & K., Bannigan (eds.), *Creek's Occupational Therapy and Mental Health* (5th ed.) (pp.27-48). Edinburgh: Churchill Livingstone Elsevier.
- Csikszentmihalyi, M. (2002). *Flow: The classic work on how to achieve happiness*. London: Rider.
- Csikszentmihalyi, M., & Rathunde, K. (1992). The measurement of flow in everyday life: toward a theory of emergent motivation. *Nebraska Symposium on Motivation*, 40, 57-97.
- Cullen, K., & McDaid, D. (2017). *Evidence Review to Inform the Parameters for a Refresh of A Vision for Change (AVFC)*. Dublin: Department of Health.
- Cummingham, C.J.L., Weathington, B.L., & Pittenger, D.J. (2013). *Understanding and Conducting Research in the Health Sciences*. New Jersey: US: John Wiley & Sons.

Cutrona, C.E. & Russell, D.W. (1983) The Provisions of Social Relationships and Adaptation to Stress. In W. H., Jones, & D., Perlman (eds.), *Advances in Personal Relationships* (pp.37-67). USA: JIA Press.

Darongkamas, J., Scott, H., & Taylor, E. (2011), "Kick-starting men's mental health: an evaluation of the effect of playing football on mental health service users' well-being", *International Journal of Mental Health Promotion*, 13(3), 14-21.

Davidson, L. (2016). The Recovery Movement: Implications for Mental Health Care and Enabling People To Participate Fully In Life, *Health Affairs*, 35(6), 1091-1097.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4), 459–470.

Davidson, L., Tondora, J., Pavlo, A.J., & Stanhop, V. (2017). Shared decision making within the context of recovery-oriented care. *Mental Health Review Journal*, 22(3), 179-190.

Deegan, P. (1988). Recovery: the lived experience of rehabilitation, *Psychosocial Rehabilitation Journal*, 11(4), 11-19.

Department of Employment Affairs and Social Protection (n.d.). Free Travel. Retrieved on August 2nd, 2019, from http://www.welfare.ie/en/Pages/204_Free-Travel.aspx

Department of Health. (2013). *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013 – 2025*. Dublin: Stationery Office.

DePoy, E., & Gitlin, L.N. (2011). *Introduction to Research: Understanding and Applying Multiple Strategies* (4th ed.). Missouri: Elsevier Mobsy.

Donskoy, A.L., Stevens, R., & Bryant, W. (2014). Perspectives on using and providing services. In J., Creek. (Ed.). *Creek's Occupational Therapy and Mental Health* (5th ed.) (pp.205-222). Edinburgh: Churchill Livingstone, Elsevier.

Drummond, A. (1996). *Research Methods for Therapists*. London, UK; Champman & Hall.

Dyer, L., & Mills, C. (2011). Service users are inspired to imagine their goals. *Mental Health Practice*, 14(5), 32-35.

Eakman, A. M. (2011). Convergent Validity of the Engagement in Meaningful Activities Survey in a College Sample, *OTJR: Occupation, Participation and Health*, 31(1), 23-32.

Eakman, A. M. (2012). Measurement characteristics of the Engagement in Meaningful Activities Survey in an age-diverse sample, *American Journal of Occupational Therapy*, 66(2), 20-29.

Eakman, A. M. (2014). A prospective longitudinal study testing relationships between meaningful activities, basic psychological needs fulfillment, and meaning in life. *OTJR: Occupation, Participation and Health*, 34, 93-105.

Eakman, A.M., Carlson, M.E., & Clark, F.A. (2010). Factor structure, reliability and convergent validity of the Engagement in Meaningful Activities Survey for older adults, *OTJR: Occupation, Participation and Health*, 30(1), 111-121.

Farrah, K., & Mierzwinski-Urban, M. (2019). Almost half of references in reports on new and emerging nondrug health technologies are grey literature, *Journal of the Medical Library Association*, 107(1), 43-48.

Faulkner, G.E.J., & Taylor, A.H. (2005). *Exercise, health, and mental health: emerging relationship*. London: Routledge.

Fenton, L., White, C., Gallant, K.A., Gilbert, R., Hutchinson, S., Hamilton-Hinch, B., & Lauckner, H. (2016). The Benefits of Recreation for the Recovery and Social Inclusion of Individuals with Mental Illness: An Integrative Review, *Leisure Sciences*, 39(1), 1-19.

Fetters, M.D., Curry, L.A., & Creswell, J.W. (2013). Achieving Integration in Mixed Methods Designs: Principles and Practices, *Health Service Research*, 48(6), 2134-2156

Firth, J., Cotter, J., Elliott, R., French, P., & Yung, A.R. (2015). A systemic review and meta-analysis of exercise interventions in schizophrenia patients, *Psychological Medicine*, 45(7), 1343-1361.

Firth, J., Stubbs, B., Rosenbaum, S., Vancampfort, D., Malchow, B., Schuch, F., Elliott, R., Nuechterlein, K.H., & Yung, A.R. (2017). Aerobic exercise improves cognitive functioning in people with schizophrenia: a systematic review and meta-analysis, *Schizophrenia Bulletin*, 43(3), 546-556.

Football Association of Ireland (FAI) (2015). *Women's Strategic Plan 2015-2018 Pointing the way forward for women's football*. Dublin: National Sports Campus Ireland.

Football Association of Ireland. (2009, June 5). FAI History: The Early Years. Retrieved on August 10th, 2019, from <https://www.fai.ie/domestic/news/fai-history-the-early-years>

Football Association of Ireland. (2016). *Strategic Plan 2016-2020*. Dublin: National Sports Campus.

Football Association of Ireland. (2017). *Football For All Strategy 2017-2020: Promoting Inclusion in Football*. Dublin: National Sports Campus.

Football Association of Ireland. (2018). *Club Management Guide (2nd ed.)*. Dublin: National Sports Campus.

Football Association of Ireland. (n.d.). *Football For All Programme*. Retrieved August 11th, 2019, from <https://www.fai.ie/domestic/football-for-all/football-for-all-programme>

Friedli, L. (2000). Mental health promotion - Rethinking the evidence base. *Mental Health Review Journal*, 5(3), 15-18

Friedrich, B., & Mason, O.J. (2017). Evaluation of the Coping Through Football Project: Physical Activity and Psychosocial Outcomes, *The Open Public Health Journal*, 10(1), 276-282.

Friedrich, B., & Mason, O.J. (2018a). Applying Positive Psychology Principles to Soccer Interventions for People with Mental Health Difficulties, *Psychology*, 9(3), 372-384.

Friedrich, B., & Mason, O.J. (2018b). Qualitative evaluation of a football intervention for people with mental health problems in the north-east of London, *Mental Health and Physical Activity*, 15, 132-138.

Gardner-Sood, P., Lally, J., Smith, S., Atakan, Z., Ismail, K., Greenwood, K. E., O'Brien, C., Onagbesan, O., Fung, C., Papanastasiou, E., Eberherd, J., Patel, A., Ohlsen, R., Stahl, D., David, A., Hopkins, D., Murray, R.M., & Gaughran, F. (2015). Cardiovascular risk factors and metabolic syndrome in people with established psychotic illnesses: baseline data from the IMPaCT RCT study-Corrigendum, *Psychological Medicine*, 45(12), 2631–2631.

General Data Protection Regulation (GDPR) (2016). *Regulation (EU) 2016/679 of the European Parliament and of the council of 27 April 2016*. 2016/679.

Goldberg, B., Brintnell, E. S., & Goldberg, J. (2002). The relationship between engagement in meaningful activities and quality of life in persons disabled by mental illness. *Occupational Therapy in Mental Health*, 18(2), 17-44.

Government of Ireland. (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office.

Green, J., & Thorogood, N. (2004). *Qualitative methods for health research*. London: Sage Publications.

Gupta, J. (2016). Exploring Culture. In S.A., Wells, R.M., Black, & J. Gupta (Eds.). *Culture and Occupation: Effectiveness for Occupational Therapy Practice, Education and Research* (3rd ed.)(pp. 3-21). Bethesda MD: AOTA Press.

Habibzadeh, F. (2013). Common statistical mistakes in manuscripts submitted to biomedical journals. *European Science Editing*, 39(4), 92-94.

Hancock, N., Bundy, A., Honey, A., James, G., & Tamsett, S. (2017). Improving Measurement Properties of the Recovery Assessment Scale with Rasch Analysis. *American Journal of Occupational Therapy*, 65(6), 77-85.

Hancock, N., Everett, G., Honey, A., & Scanlan, J. N. (2016). *Recovery Assessment Scale – Domains and Stages: Workbook. Version 1*. Sydney: The University of Sydney.

Hancock, N., Scanlan, J., Honey, A., Bundy, A., & O'Shea, K. (2015). Recovery Assessment Scale – Domains & Stages (RAS-DS): Its Feasibility and Outcome Measurement Capacity. *Australian and New Zealand Journal of Psychiatry*, 49(7), 624-633.

Hancock, N., Scanlan, J.N., Bundy, A.C., & Honey, A. (2016). *Recovery Assessment Scale – Domains & Stages (RAS-DS) Manual- Version 2*. Sydney; University of Sydney.

Harding, K. (2019). *The Rabbit Effect; Live Longer, Happier, and Healthier with the Groundbreaking Science of Kindness*. New York: Atria.

Hargreaves, J., & Pringle, A., (2019) "Football is pure enjoyment": An exploration of the behaviour change processes which facilitate engagement in football for people with mental health problems, *Mental Health and Physical Activity*, 16, 19-30

Health Service Executive (HSE). (2016). *National Men's Health Action Plan Healthy Ireland 2017-2021*. Dublin: The Stationery Office.

Health Service Executive (HSE); Mental Health Services (2018) *Let's Get Active; for improved health and wellbeing!* Dublin: The Stationery Office.

- Health Service Executive (HSE); Mental Health Services. (2017a). *Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement*. Dublin: The Stationery Office.
- Health Service Executive (HSE); Mental Health Services. (2017b). *A National Framework for Recovery in Mental Health 2018-2020*. Dublin: The Stationery Office.
- Health Service Executive. (HSE). (2018). *National Service Plan 2019*. Dublin: The Stationery Office.
- Henderson, C., O'Hara, S., Thronicroft, G., & Webber, M. (2014). Corporate social responsibility and mental health: The Premier League football Imagine Your Goals programme. *International Review of Psychiatry*, 26(4), 460-466.
- Heun, R., & Pringle, A. (2018). Football does not improve mental health: a systematic review on football and mental health disorders, *Global Psychiatry*, 1(1), 25-37.
- Hissong, A.N., Lape, J.E., & Bailey, D.M. (2015). *Bailey's Research for the Health Professional* (3rd ed). Philadelphia: F.A. Davis Company.
- Hitch, D., Pépin, G., & Stagnitti K. (2014a). In the Footsteps of Wilcock, Part One: The Evolution of Doing, Being, Becoming, and Belonging. *Occupational Therapy In Health Care*, 28(3), 231-224.
- Hitch, D., Pépin, G., & Stagnitti K. (2014b). In the Footsteps of Wilcock, Part Two: The Interdependent Nature of Doing, Being, Becoming, and Belonging. *Occupational Therapy in Health Care*, 28(3), 247-263.
- Holmens, M. (2007). Symbols of national identity and sport: The case of the Irish football team. *Journal Irish Political Studies*, 9(1), 81-98.
- Huebschmann, A.G., Leavitt, I.M., & Glasgow, R.E. (2019). Making Health Research Matter: A Call to Increase Attention to External Validity, *Annual Review Public Health*, 40(1), 45-63.
- Hulteen, R.M., Smith, J.J., Morgan, P.J., Barnett, L.M., Hallal, P.C., Colyvas, K., & Lubans, D.R. (2017). Global participation in sport and leisure-time physical activities: a systematic review and meta-analysis. *Preventive Medicine*, 95, 14-25.
- Hynes, J. (2008), "The Positive Mental Attitude (PMA) Football League", *A Life in the Day*, 12(3), 6-10.
- Irish Sports Monitor (2018). *Irish Sports Monitor Annual Report 2017*. Sport Ireland. <https://assets.gov.ie/16014/3abf58a4a5af41b9ab66065de65e15a3.pdf>
- Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives, *Psychiatric Rehabilitation Journal*, 24(3), 248-256.
- Jarvie, G. (2012). *Sport, Culture and Society; An Introduction* (2nd ed.). New York, Routledge.
- Jenkinson, C., Layte, R., Wright, L., & Coulter, A. (1996). *The U.K. SF-36: An Analysis and Interpretation Manual; A guide to health status measurement with particular reference to the Short Form 36 Health Survey*. Oxford UK; University Oxford.
- Johnston, H. (2014). *All Vision but No Change? Determinants of Implementation: The Case of Ireland and Mental Health Policy*. Dublin: Institute of Public Administration (IPA).

- Johnston, J. (2018). *Kickstart to Recovery Outcomes of a National Survey*. Unpublished personal communication.
- Johnston, J., Moloney, L., & Jordan O. (2015). *Powerpoint Presentation entitled: Kickstart to Recovery Presentation*. Unpublished personal communication.
- Jordan, O., & Johnston, J. (2014). *Powerpoint Presentation entitled: Kickstart 2 Recovery Football Programme*. Unpublished personal communication.
- Katz, J. (2015). A Theory of Qualitative Methodology: The Social System of Analytic Fieldwork, *Méthod(e)s: African Review of Social Sciences Methodology*, 1(1-2), 131-146
- Keen, C. & Otter, M.E. (2014). Critical Appraisal. In D. Walker, (Ed), *An Introduction to Health Services Research* (pp. 35-50). London; UK: Sage Publications Ltd.
- Kelly, B. (2017). *Mental Health in Ireland: The Complete Guide for Patients, Families, Health Care Professional and Everyone Who Wants To Be Well*. Dublin: The Liffey Press.
- Kelly, B.D. (2007). Penrose's Law in Ireland: An ecological analysis of psychiatric inpatients and prisoners'. *Irish Medical Journal*, 100, 373-374.
- Kielhofner, G. (2008). *A model of human occupation theory and application*. Baltimore: Lippincott Williams & Wilkins.
- Lamont, E., Harris, J., McDonald, G., Kerin, T., & Dickens, G.L. (2017). Qualitative investigation of the role of collaborative football and walking football groups in mental health recovery, *Mental Health and Physical Activity*, 12, 116-123.
- Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers, *Bmj*, 346:f2539.
- Lee, C., & Owens, R.G. (2002). Issue for a psychology of men's health. *Journal of Health Psychology*, 7(3), 209-217.
- Llyod, C., & Williams, P.L. (2009). The Future of Occupational Therapy in Mental Health in Ireland, *British Journal of Occupational Therapy*, 72(12), 539-542.
- Llyod, C., & Williams, P.L. (2009). The Future of Occupational Therapy in Mental Health in Ireland. *British Journal of Occupational Therapy*, 72(12), 539-542.
- Louth/Meath Mental Health Service (2017). *The Kickstart to Recovery Model Booklet*. Unpublished personal communication.
- Magee, J., Spaaij, R., & Jeanes, R. (2015). "Its Recovery United for Me": Promises and Pitfalls of Football as Part of Mental Health Recovery. *Sociology of Sport Journey*, 32(4), 357-376.
- Moloney, L., & Rohde, D. (2017). Experiences with psychosis participating in a community-based football programme, *Irish Journal of Occupational Therapy*, 45(2), 100-111.
- Mason, O.J., & Holt, R. (2012). A role for football in mental health: The Coping Through Football project. *The Psychiatrist*, 36(8), 290- 293.

- Matthews, E., Cowman, M., Brannigan, M., Dloan, D., Ward, P.B., & Denieffe, S. (2018). Examining the barriers to physical activity between active and inactive people with severe mental illness in Ireland, *Mental Health and Physical Activity*, 15, 139-144.
- McArdle, S., McGale, N., & Gaffney, P. (2012). A qualitative exploration of men's experiences of an integrated exercise/CBT mental health promotion programme, *International Journal of Men's Health*, 11(3), 240-257.
- McDowell, I. (2006). *Measuring health: a guide to rating scales and questionnaires* (3rd ed.). New York, US: Oxford University Press.
- McGale, N., McArdle, S., & Gaffney, P. (2011). Exploring the effectiveness of an integrated exercise/CBT intervention for young men's mental health, *British Journal of Health Psychology*, 16(3), 457-471.
- McGee, D., Lorencatto, F., Matvienko-Sikar, K., & Toomey, E. (2018). Surveying knowledge, practice and attitudes towards intervention fidelity within trials of complex healthcare interventions. *Trials*, 19(504), doi: 10.1186/s13063-018-2838-6
- Mental Health Reform (2019, 24 January). Lessons must be learned from shortcomings in implementing mental health policy. Retrieved on August 20th, 2019, from <https://www.mentalhealthreform.ie/news/lessons-must-be-learned-from-shortcomings-in-implementing-mental-health-policy/>
- Mental Health Reform. (2015). *A Vision for Change Nine Years On: A coalition analysis of progress*. Dublin: Stationery Office.
- Miller, R., & Rollnick, S. (2013). *Motivational Interviewing: Preparing people for change* (2nd ed.). New York, NY: The Guilford Press.
- Morton, E., Michalak, E.E., Murray, G. (2017). What does quality of life refer to in bipolar disorders research? A systematic review of the construct's definition, usage and measurement. *Journal of Affective Disorders*, 212, 218-137.
- Morton, E., Michalak, E.E., Murray, G. (2017). What does quality of life refer to in bipolar disorders research? A systematic review of the construct's definition, usage and measurement. *Journal of Affective Disorders*, 212, 218-137.
- National Women's Council of Ireland (2012). *Equal but Different A framework for integrating gender equality in Health Service Executive Policy, Planning and Service Delivery*. Dublin: Women's Health Council.
- O'Toole, G. (2011). Analyzing the occupation components of self-care. In L., Mackenzie, & G., O'Toole (Eds.), *Occupation analysis in practice* (pp 99 - 144). West Sussex: Wiley-Blackwell.
- Oldknow, H., & Grant, G. (2008). Does joining a football academy help mental health recovery?, *Mental Health Nursing*, 28(2), 8-11.
- Osborne, J.W., & Overbay, A. (2008). The power of outliers (and why researchers should ALWAYS check for them). *Practical Assessment, Research & Evaluation*, 9(6). 1-8.
- O'Shea, O., McCormack, R., Bradley, J. M., & O'Neill, B. (2016). Fidelity Review: A scoping review of the methods used to evaluate treatment fidelity in behavioural change interventions, *Physical Therapy Reviews*, 21(3-6), 207-214

Pallant, J. (2016). *SPSS survival manual: a step by step guide to data analysis using SPSS*. Maidenhead: Open University Press.

Parkinson, S. (2014). *Recovery through activity: increasing participation in daily life*. London: Speechmark Publishing.

“Pep”, (2015). In Oxford English Dictionary online (3rd ed). Retrieved March 10th, 2019, from <https://en.oxforddictionaries.com/definition/pep>

Pepin, G. (2017). Occupational Engagement: How Clients Achieve Change. In R.R., Taylor (Ed.), *Kielhofner’s Model of Human Occupation* (5th ed.)(pp.187-194). Philadelphia: Wolters Kluwer

Perkins, P. & Rinaldi, M. (2002) Unemployment rates among patients with long-term mental health problems, *Psychiatric Bulletin*, 26(8), 295-298.

Pierce, D. E. (2003). *Occupation by design: building therapeutic power*. Philadelphia: F.A. Davis Co.

Pizur-Barnekow, K., & Davel Pickens, N. (2019). Introduction to Occupation and Co-Occupation. In C. Brown, V.C., Stoffel, & J.P., Munoz (Eds) *Occupational therapy in mental health: a vision for participation* (2nd ed.)(pp.759-771). Philadelphia: F.A. Davis Company.

Polatajko, H.J., Backman, C., Basptiste, S., Davis, J., Efehar, P., Havrvey, A., Jarman, J., Krupa, T., Lin, N., Pentland, W., Rudman, D.L., Shaw, L., Amoroso, B., & Connor-Schisler, A. (2007). Human occupation in context. In E.A., Townsend, & J.P., Helene (Eds.), *Enabling Occupation II: Advancing an occupational therapy vision for health well-being & justice through occupation* (pp.37-62). Ottawa: CAOT.

Poulsen, S. (June 9th 2018). Football as a powerful tool for social change, THINK. Retrieved August 12th, 2019, from <https://www.thnk.org/blog/football-as-a-powerful-tool-for-social-change/>

Powell, R. (2014). Surveys. In D. Walker, (Eds). *An Introduction to Health Services Research* (pp.145-155). London; UK: Sage Publications Ltd.

Premier League (July 16th, 2019). *Premier League global audience on the rise*. Retrieved 18th June 2020 from <https://www.premierleague.com/news/1280062>

Pringle, A. (2009). The growing role of football as a vehicle for interventions in mental health care, *Journal of Psychiatric and Mental Health Nursing*, 16(6), 553-557.

Pringle, A., & Sayers, P. (2004). It’s a Goal!: basing a community psychiatric nursing service in a local football stadium, *Journal of the Royal Society for the Promotion of Health*, 124(5), 234-238.

Read, H., & Stoffel, V.C. (2019). Recovery. In C. Brown, V.C., Stoffel, & J.P., Munoz (Eds.), *Occupational therapy in mental health: a vision for participation* (2nd ed.) (pp. 3-13). Philadelphia: F.A. Davis Company.

Rebar, A.L. & Taylor, A. (2017). Physical activity and mental health: its more than just a prescription, *Mental Health and Physical Activity*, 13, 77-82.

- Rebeiro, K., Day, D., Semeniuk, B., O'Brien, M., & Wilson, B. (2001). Northern Initiative for Social Action: An occupation-based mental health program, *American Journal of Occupational Therapy*, 55(5), 493–500.
- Repper, J., & Perkins, S. (Eds.) (2003). *Social Inclusion and Recovery; A Model for Mental Health Practice*. London: Baillière Tindall.
- Rice, M. S., Stein, F., & Tomlin, G. (2019). *Clinical research in occupational therapy*. Thorofare, NJ: Slack Incorporated.
- Richardson, N. (2004). *Getting Inside Men's Health*. Health Promotion Department, South Eastern Health Board.
- Richardson, N., Brennan, L., Lambe, B., & Carroll, P. (2013) *ENGAGE. National Men's Health Training Programme. A men's health training resource pack for health professionals*. Ireland: National Men's Health Training.
- Ross, T. (2012). *A Survival Guide for Health Research Methods*. Berkshire, UK; Open University Press.
- Scanlan, J.N., Hancock, N., & Honey, A. (2018). The Recovery Assessment Scale - Domains and Stages (RAS-DS): Sensitivity to change over time and convergent validity with level of unmet need. *Psychiatry Research*, 216, 560-564.
- Schofield, M.J., & Forrester-Knauss, C. (2015). Surveys and Questionnaires in Health Research. In P., Liangputtong (ed.) *Research Methods in Health* (pp. 199-218). Oxford: Oxford University Press.
- See Change. (2017). The Green Ribbon Impact Report 2017. Retrieved August 20th, 2019, from <https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/green-ribbon-impact-report-2017.pdf>
- Shiely, J.-C. (1995). *SF-36 health survey annotated bibliography: first edition (1988-1995)*. Boston: Health Institute, New England Medical Center.
- Shrank, B., Bird, V., Rudnick, A., & Slade, M. (2012). Determinants, self-management strategies and interventions for hope in people with mental disorders: systematic search and narrative review, *Social Science and Medicine*, 74(4), 554-564.
- Slaughter, S. E., Hill, J. N., & Snelgrove-Clarke, E. (2015). What is the extent and quality of documentation and reporting of fidelity to implementation strategies: a scoping review, *Implementation Science*, 10(1), doi: 10.1186/s13012-015-0320-3
- Spandler, H., McKeown, M., Roy, A., & Hurley, M. (2013). Football metaphor and mental well-being: An evaluation of the It's a Goal! Programme, *Journal of Mental Health*, 22(6), 544-554.
- Sports Ireland. (2017). Irish Sports Monitor Annual Report 2017. Retrieved August 19th, 2019, from <https://www.sportireland.ie/Research/Irish%20Sports%20Monitor%202017%20-%20Half%20Year%20Report/Irish%20Sports%20Monitor%202017.pdf>
- Standnyk, R.L., Townsend, E.A., & Wilcock, A.A. (2010). Occupational Justice. In C.H., Christiansen, & E.A., Townsend, E.A. (eds). *Introduction to Occupation: The Art and Science of Living* (2nd ed.) (pp. 329-355). New Jersey: Pearson Education Ltd.

Study Group on the Development of the Psychiatric Services (1984). *The Psychiatric Services; Planning For the Future*. Dublin: The Stationery Office.

Su, C.-T., Ng, H.-S., Yang, A.-L., & Lin, C.-Y. (2014). Psychometric evaluation of the Short Form 36 Health Survey (SF-36) and the World Health Organization Quality of Life Scale Brief Version (WHOQOL-BREF) for patients with schizophrenia. *Psychological Assessment*, 26(3), 980-989.

Tang, L. (2019). The double hazard in recovery journey: The experiences of UK Chinese users of mental health services. *International Journal of Social Psychiatry*, 65(4), 271-278.

Taylor R.R., & Kielhofner, G. (2017). *Kielhofner's model of human occupation: theory and application*. Philadelphia: Wolters Kluwer.

Taylor, R.R., Kielhofner, G., & Fossey, E. (2017). Classification of Aims of Research. In R.R. Taylor (ed.) *Kielhofner's Research in Occupational Therapy: Methods of Inquiry for Enhancing Practice* (2nd ed.)(pp. 11-24). Philadelphia: F.A. Davis Company.

The Nielsen Company. (2018). World Football Report 2018. Retrieved on August 15th, 2019, from <https://www.nielsen.com/wp-content/uploads/sites/3/2019/04/world-football-report-2018.pdf>

Thorincroft, G., Semrau, M., Alem, A., Drake, R.E., Hiroto, I., Mari, J., McGeorge, P., & Thara, R. (2011). *Community Mental Health: Putting policy into practice globally*. Sussex: John Wiley & Sons.

Thornicroft, G., Szumukler, G., and K. T. Mueser (Eds.), 2011. *Oxford textbook of community mental health*. USA: Oxford University Press.

Tondora, J., Miller, R., Slade, M., & Davidson, L. (2014). *Partnering for recovery in mental health*. New Jersey: John Wiley & Sons.

Torrey, W. C., Rapp, C. A., Tosh, L. V., McNabb, C. R. A., & Ralph, R. O. (2005). Recovery Principles and Evidence-Based Practice: Essential Ingredients of Service Improvement. *Community Mental Health Journal*, 41(1), 91–100.

Vancampfort, D., Firth, J., Schuch, F. B., Rosenbaum, S., Mugisha, J., Hallgren, M., Probst, M., Ward, P.B., Gaughran, F., Hert, M., Carvalho, A.F., & Stubbs, B. (2017). Sedentary behavior and physical activity levels in people with schizophrenia, bipolar disorder and major depressive disorder: a global systematic review and meta-analysis, *World Psychiatry*, 16(3), 308–315.

Ware, J.E. (2000) SF-36 Health Survey Update. *SPINE*, 25(24), 3130–3139.

Ware, J.E., & Sherbourne, C.D. (1992). The MOS 36-Item Short-Form Health Survey (SF-36). *Medical Care*, 30(6), 473-483.

Webber, M.P., & Huxley, P.J. (2007). Measuring access to social capital: The validity and reliability of the The Resource Generator-UK and its association with common mental health disorder. *Social Science and Medicine*, 65(3), 481-492.

WHO (2005). *Mental Health Declaration for Europe: Facing Challenges, Building Solutions*. Copenhagen: WHO Regional Office for Europe.

WHO (2009). *Track 1: Community empowerment*. Retrieved August 10th, 2019, from <https://www.who.int/healthpromotion/conferences/7gchp/track1/en/>

WHO (2018, 12th September). *Ireland builds capacity to improve men's health*. World Health Organisation. Retrieved on July 31st, 2019, from <http://www.euro.who.int/en/countries/ireland/news2/news/2018/9/ireland-builds-capacity-to-improve-mens-health>

WHO (2005). *Mental Health Declaration for Europe: Facing Challenges, Building Solutions*. Copenhagen: WHO Regional Office for Europe.

WHO; The WHOQOL Group. (1995). The World Health Organization quality of life assessment (WHOQOL): Position paper from the World Health Organization. *Social Science & Medicine*, 41(10), 1403–1409.

WHOQOL Group. (1998). Development of the World Health Organisation WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28(3), 551-558.

Wilcock, A.A. (1999). Reflections on doing, being and becoming, *Australian Occupational Therapy Journal*, 46(5), 1-11.

Women's Sport and Fitness Foundation. (2012). *Changing the Game for Girls*. Retrieved on August 9th, 2019, from <https://www.womeninsport.org/wp-content/uploads/2015/04/Changing-the-Game-for-Girls-Policy-Report.pdf>

Wood, S., Harrison, L. K., & Kucharska, J. (2017). Male professional footballers' experiences of mental health difficulties and help-seeking, *The Physician and Sports Medicine*, 45(2), 120-128.

Workman, D.E., Kielhofner, G., & Taylor, R.R. (2017). Ensuring Ethical Research. In R.R. Taylor (ed.) *Kielhofner's Research in Occupational Therapy: Methods of Inquiry for Enhancing Practice* (2nd ed.) (pp. 114-161). Philadelphia: F.A. Davis Company.

World Federation of Occupational Therapy (WFOT) (2012). *Definition of Occupation*. Retrieved July 18th, 2019, from <https://www.wfot.org/about-occupational-therapy>

World Health Organisation (2018). *Fact Sheet 220: Mental health: strengthening our response*. Retrieved on August 5th, 2019, from <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>

Wright, J. (2004). Occupational Flow. In M., Molineux (Ed.), *Occupation for Occupational Therapists* (pp. 66-77). Oxford: Blackwell Publishing Ltd.

Appendices

Appendix 1: Current Literature on Football Programme for Service Users.

Study Title	Study Design	Intervention /Programme
Mason, O.J., & Holt, R. (2012). A role for football in mental health: The Coping Through Football project, <i>The Psychiatrist</i> , 36(8), 290- 293.	Qualitative: individual interviews with service users, referrers and coaches involved in the football group	'Coping Through Football' (CTF) project (Study 1) (England)
Friedrich, B., & Mason, O.J. (2017). Evaluation of the Coping Through Football Project: Physical Activity and Psychosocial Outcomes, <i>The Open Public Health Journal</i> , 10(1), 276-282.	Quantitative: Pre-post design, with an additional 6 and 12 month follow-up. Measured quality of life, self-esteem and physical activity.	'Coping Through Football' project. (Study 2) (England)
Friedrich, B., & Mason, O.J. (2018a). Applying Positive Psychology Principles to Soccer Interventions for People with Mental Health Difficulties, <i>Psychology</i> , 9(3), 372-384.	Qualitative: Participants were asked at 6-month reviews to describe changes as a result of attending the programme. A content analysis was performed on the statements to classify them according to PERMA elements.	'Coping Through Football' project (Study 3) (England)
Friedrich, B., & Mason, O.J. (2018b). Qualitative evaluation of a football intervention for people with mental health problems in the north-east of London, <i>Mental Health and Physical Activity</i> , 15, 132-138.	Qualitative individual interviews with participants and stakeholders of the football programme.	'Coping Through Football' project (Study 4) (England)
Dyer, L., & Mills, C. (2011). Service users are inspired to imagine their goals, <i>Mental Health Practice</i> , 14(5), 32-35.	Service user evaluation of the programme. Focus groups and surveys conducted by Mersey Care NHS Trust Service User Research and Evaluation (SURE) group.	Imagine Your Goals (IYG) (Study 1) (England)

Henderson, C., O'Hara, S., Thronicroft, G., & Webber, M. (2014). Corporate social responsibility and mental health: The Premier League football Imagine Your Goals programme, <i>International Review of Psychiatry</i> , 26(4), 460-466.	Mixed methods: pretest/posttest questionnaire, end of programme questionnaire for coaches and focus group for participants to assess their views of the programme. Participant questionnaire included the Warwick-Edinburgh Mental Well-Being Scale to evaluate well-being, the Resource Generator-UK, to measure access to social capital. Coaches questionnaire included questions regarding their experience of running the programme.	Imagine Your Goals (IYG) (Study 2) (England)
Benkwitz, A., & Healy, L. C., (2019). 'Think Football': Exploring a football for mental health initiative delivered in the community through the lens of personal and social recovery. <i>Mental Health and Physical Activity</i> , 17, 100292	Qualitative individual interviews with mental health service users who attended the football group and staff who delivering the group.	Think Football project (England)
Brawn, P., Combes, H., & Ellis, N.J. (2015). Football Narrative: Recovery and Mental Health, <i>Journal of New Writing in Health and Social Care</i> , 2(1), 30-46.	Qualitative: Individual interviews with participants of the football group.	Mental Health and Well-being Football League. (England)
Hynes, J. (2008), "The Positive Mental Attitude (PMA) Football League", <i>A Life in the Day</i> , 12(3), 6-10.	Description of the programme. No research conducted.	The Positive Mental Attitude (PMA) Football League (England)
Darongkamas, J., Scott, H., & Taylor, E. (2011), "Kick-starting men's mental health: an evaluation of the effect of playing football on mental health service users' well-being", <i>International Journal of Mental Health Promotion</i> , 13(3), 14-21.	Quantitative: Short questionnaire using a Likert scale. Questions based on previous report evaluating change in well-being after participation in the football, how enjoyable and supportive it was, and other questions related to everyday life. Qualitative:	Park House United (name provided in in-house report by Rietzschel & Darongkamas, 2008) (England)

	Individual interviews providing a more in-depth exploration of the quantitative factors.	
Oldknow, H., & Grant, G. (2008). Does joining a football academy help mental health recovery? <i>Mental Health Nursing</i> , 28(2), 8-11	Annual evaluation of the course. Methodology not described.	REACT (Recreational enterprise assisted client training) Football Training Academy. (England)
Butterly, R., Adams, D., Brown, A., & Golby, J. (2006). Clients perceptions of MUSCSEL project: a community-based physical activity programme for patients with mental health problems, <i>Journal of Public Mental Health</i> , 5 (4), 45-52.	Quantitative: Questionnaire for new participants over a 5-month period. Questions included demographic information, personal perception of fitness, details of current or previous participation in sport, difficulty levels of daily living activities and improvements in these. Qualitative: Individual interviews with participants.	MUSCSEL (Meeting Up for Social Contact, Sport, Exercise and Leisure) project. (England)
Hargreaves, J., & Pringle, A., (2019) "Football is pure enjoyment": An exploration of the behaviour change processes which facilitate engagement in football for people with mental health problems, <i>Mental Health and Physical Activity</i> , 16, 19-30	Qualitative individual interviews with mental health service users who attended the football group	No programme name stated. (England)
Magee, J., Spaaij, R., & Jeanes, R. (2015). "Its Recovery United for Me": Promises and Pitfalls of Football as Part of Mental Health Recovery, <i>Sociology of Sport Journey</i> , 32(4), 357-376.	Qualitative: Individual interviews with participants, coaches, assistant coaches, project directors and staff	No programme names stated. (England)
Lamont, E., Harris, J., McDonald, G., Kerin, T., & Dickens, G.L. (2017). Qualitative investigation of the role of collaborative	Qualitative: Focus groups with mental health service users and staff.	No programme names stated. (Scotland)

football and walking football groups in mental health recovery, <i>Mental Health and Physical Activity</i> , 12, 116-123.		
Abib, L.T., Fraga, A.B., Wachs, F., & de Paula Alves, C.T. (2010). The Body Practices Concerning Mental Health: A Football Workshop Capabilities and Possibilities in a Psychosocial Care Centre, <i>Pensar a Pratica</i> , 13(2), 1-14.	Qualitative and ethnography: Field diaries and observation records.	No programme name stated. (Brazil)
McGale, N., McArdle, S., & Gaffney, P. (2011). Exploring the effectiveness of an integrated exercise/CBT intervention for young men's mental health, <i>British Journal of Health Psychology</i> , 16(3), 457-471.	Randomised Control Trial: 10-week RCT with an 8-week post-intervention follow-up. The control group refrained from exercise. Participants completed Beck Depression Inventory, the Social Provision Scale (SPS) and a short qualitative questionnaire at pre-intervention, week 5, post-test and 8 week post-test.	Back of the Net (BTN) (Study 1) (Ireland)
McArdle, S., McGale, N., & Gaffney, P. (2012). A qualitative exploration of men's experiences of an integrated exercise/CBT mental health promotion programme, <i>International Journal of Men's Health</i> , 11(3), 240-257.	Qualitative: Both individual interviews and focus groups.	Back of the Net (BTN) (Study 2) (Ireland)
Moloney, L., & Rohde, D. (2017) "Experiences of men with psychosis participating in a community-based football programme", <i>Irish Journal of Occupational Therapy</i> , 45(2), 100-111.	Qualitative individual interviews with mental health service users who attended the football group	Kickstart to Recovery programme (previously known as 'Kickstarting Recovery Programme (KSRP)') (Ireland)

Appendix 2: Questionnaire and Background Information

Standardised assessments:

Part 1) Short Form 36 (SF-36)

Part 2) Recovery Assessment Survey – Scales and Domains (RAS-DS)

Part 3) Engagement in Meaningful Activities Survey adapted for football (EMAS)

(Pre 'Kickstart to Recovery' programme)

Background Information

In order to keep your information safe please do not put your name or other details that would identify you on this form.

Tell us a little bit about you:

1. Is this the first time you have participated in the 'Kickstart to Recovery' Programme? Yes ☐ No ☐

2. Have you ever played football? Yes ☐ No ☐

If yes, to what standard?

School ☐ Club ☐ ☐ Other: please specify _____

Do you do other sports? Yes ☐ No ☐
If yes, what are they?

3. What age are you?

18-23 ☐ 24-29 ☐ 30-35 ☐ 36-41 ☐ 42-47 ☐ 48-52 ☐

53-58 ☐ 59-64 ☐ 65+ ☐

4. Are you:

Male ☐ Female ☐ Other; Please define: _____

5. How would you describe your mental health difficulties?

6. Do you currently attend any activities in your local area? Yes ☐ No ☐
If yes, please list:

(Post 'Kickstart to Recovery' programme)

1. How many sessions of the 'Kickstart to Recovery' programme did you attend?

Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
DATES	DATES	DATES	DATES	DATES	DATES	DATES	DATES

2. How many sessions of 'Kickstart to Recovery' have you participated in total?

- This is my first time session ☐
- This is my second session ☐
- This is my third session ☐
- I have attended more than three sessions ☐ Write the number of sessions here

If you are not sure how many sessions you have attended, roughly how long have you been attending the football in this service (months or years)

3. Before attending the 'Kickstart to Recovery' Programme (before week 1), did you;

	Yes	No
Regularly watch football on tv		
Regularly attend football matches		

4. Since attending the 'Kickstart to Recovery' Programme (now), do you;

	Yes	No
Regularly watch football on tv		
Regularly attend football matches		

Questionnaire

There are 3 parts to this questionnaire.

Choose one option for each questionnaire item by placing an **X** in the box.

Part 1:

The following questions are about you and your quality of life.

In general, would you say your health is:

Excellent	1 ☐
Very good	2 ☐
Good	3 ☐
Fair	4 ☐
Poor	5 ☐

Compared to one year ago, how would you rate your health in general **now**?

Much better now than one year ago	1 ☐
Somewhat better now than one year ago	2 ☐
About the same	3 ☐
Somewhat worse now than one year ago	4 ☐
Much worse now than one year ago	5 ☐

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	1 ☐	2 ☐	3 ☐
Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1 ☐	2 ☐	3 ☐
Lifting or carrying groceries	1 ☐	2 ☐	3 ☐
Climbing several flights of stairs	1 ☐	2 ☐	3 ☐
Climbing one flight of stairs	1 ☐	2 ☐	3 ☐
Bending, kneeling, or stooping	1 ☐	2 ☐	3 ☐
Walking more than a mile	1 ☐	2 ☐	3 ☐
Walking several blocks	1 ☐	2 ☐	3 ☐
Walking one block	1 ☐	2 ☐	3 ☐
Bathing or dressing yourself	1 ☐	2 ☐	3 ☐

During the **past 4 weeks**, have you had any of the following problems with your work or other regular activities as a **result of your physical health**?

	YES	NO
Cut down the amount of time you spent on work or other activities	1 ☐	2 ☐
Accomplished less than you would like	1 ☐	2 ☐
Were limited in the kind of work or other activities	1 ☐	2 ☐
Had difficulty performing the work or other activities (for example, it took extra effort)	1 ☐	2 ☐

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a **result of any emotional problems** (such as feeling depressed or anxious)?

	YES	NO
Cut down the amount of time you spent on work or other activities	1 ☐	2 ☐
Accomplished less than you would like	1 ☐	2 ☐
Didn't do work or other activities as carefully as usual	1 ☐	2 ☐

During **the past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups?

Not at all	1 ☐
Slightly	2 ☐
Moderately	3 ☐
Quite a bit	4 ☐
Extremely	5 ☐

How much **bodily** pain have you had during the **past 4 weeks**?

None	1	☐
Very mild	2	☐
Mild	3	☐
Moderate	4	☐
Severe	5	☐
Very severe	6	☐

During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

Not at all	1	☐
A little bit	2	☐
Moderately	3	☐
Quite a bit	4	☐
Extremely	5	☐

These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes close to the way you have been feeling.

How much of the time **during the past 4 weeks...**

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of pep?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Have you been a very nervous person?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Have you felt so down in the dumps that nothing could cheer you up?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Have you felt calm and peaceful?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Did you have a lot of energy?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Have you felt downhearted and blue?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Did you feel worn out?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Have you been a happy person?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Did you feel tired?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	1 ☐
Most of the time	2 ☐
Some of the time	3 ☐
A little of the time	4 ☐
None of the time	5 ☐

How TRUE or FALSE is **each** of the following statements for you:

	Definitel y true	Mostl y true	Don' t kno w	Mostl y false	Definitel y false
I seem to get sick a little easier than other people	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
I am as healthy as anybody I know	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
I expect my health to get worse	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
My health is excellent	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Part 2:

Instructions: Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and X the box of the number that best describes you at the moment. Put an X in only one box for each statement and do not skip any items.

	Untrue	A bit true	Mostly true	Completely true
It is important to have fun	1 ☐	2 ☐	3 ☐	4 ☐
It is important to have healthy habits	1 ☐	2 ☐	3 ☐	4 ☐
I do things that are meaningful to me	1 ☐	2 ☐	3 ☐	4 ☐
I continue to have new interests	1 ☐	2 ☐	3 ☐	4 ☐
I do things that are valuable and helpful to others	1 ☐	2 ☐	3 ☐	4 ☐
I do things that give me a feeling of great pleasure	1 ☐	2 ☐	3 ☐	4 ☐
I can handle it if I get unwell again	1 ☐	2 ☐	3 ☐	4 ☐
I can help myself become better	1 ☐	2 ☐	3 ☐	4 ☐
I have the desire to succeed	1 ☐	2 ☐	3 ☐	4 ☐
I have goals in life that I want to reach	1 ☐	2 ☐	3 ☐	4 ☐
I believe that I can reach my current personal goals	1 ☐	2 ☐	3 ☐	4 ☐
I can handle what happens in my life	1 ☐	2 ☐	3 ☐	4 ☐
I like myself	1 ☐	2 ☐	3 ☐	4 ☐
I have a purpose in life	1 ☐	2 ☐	3 ☐	4 ☐

If people really knew me they would like me	1 ☐	2 ☐	3 ☐	4 ☐
	Untrue	A bit true	Mostly true	Completely true
If I keep trying, I will continue to get better	1 ☐	2 ☐	3 ☐	4 ☐
I have an idea of who I want to become	1 ☐	2 ☐	3 ☐	4 ☐
Something good will eventually happen	1 ☐	2 ☐	3 ☐	4 ☐
I am the person most responsible for my own improvement	1 ☐	2 ☐	3 ☐	4 ☐
I am hopeful about my own future	1 ☐	2 ☐	3 ☐	4 ☐
I know when to ask for help	1 ☐	2 ☐	3 ☐	4 ☐
I ask for help, when I need it	1 ☐	2 ☐	3 ☐	4 ☐
I know what helps me get better	1 ☐	2 ☐	3 ☐	4 ☐
I can learn from my mistakes	1 ☐	2 ☐	3 ☐	4 ☐
I can identify the early warning signs of becoming unwell	1 ☐	2 ☐	3 ☐	4 ☐
I have my own plan for how to stay or become well	1 ☐	2 ☐	3 ☐	4 ☐
There are things that I can do that help me deal with unwanted symptoms	1 ☐	2 ☐	3 ☐	4 ☐
I know that there are mental health services that help me	1 ☐	2 ☐	3 ☐	4 ☐
Although my symptoms may get worse, I know I can handle it	1 ☐	2 ☐	3 ☐	4 ☐
My symptoms interfere less and less with my life	1 ☐	2 ☐	3 ☐	4 ☐

My symptoms seem to be a problem for shorter periods of time each time they occur	1 ☐	2 ☐	3 ☐	4 ☐
	Untrue	A bit true	Mostly true	Completely true
I have people that I can count on	1 ☐	2 ☐	3 ☐	4 ☐
Even when I don't believe in myself, other people do	1 ☐	2 ☐	3 ☐	4 ☐
It is important to have a variety of friends	1 ☐	2 ☐	3 ☐	4 ☐
I have friends who have also experienced mental illness	1 ☐	2 ☐	3 ☐	4 ☐
I have friends without mental illness	1 ☐	2 ☐	3 ☐	4 ☐
I have friends that can depend on me	1 ☐	2 ☐	3 ☐	4 ☐
I feel OK about my family situation	1 ☐	2 ☐	3 ☐	4 ☐

Part 3:

Below is a list of statements about football. Please read each one carefully and choose the answer that best describes to what extent each statement is true for you. Take your time and try to be as accurate as possible.

	Never	Rarely	Sometimes	Usually	Always
Football helps me take care of myself.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football reflects the kind of person I am.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football expresses my creativity.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football helps me achieve something which gives me a sense of accomplishment.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football contributes to my feeling competent.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football is valued by other people.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football helps other people.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football gives me pleasure.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football gives me a feeling of control.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Football helps me express my personal values.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
	Never	Rarely	Sometimes	Usually	Always
Football gives me a sense of satisfaction.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Football has just the right amount of challenge.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Thank you for taking the time to complete this questionnaire. We hope you enjoy the 'Kickstart to Recovery' Programme.

Appendix 3: Terms and Conditions for the Use of the SF-36

Terms and Conditions for Using the 36-Item Short Form Survey (SF-36)

RAND hereby grants permission to use RAND 36-Item Short Form Health Survey in accordance with the following conditions, which shall be assumed by all to have been agreed to as a consequence of accepting and using this document:

1. Changes to the Health Survey may be made without the written permission of RAND. However, all such changes shall be clearly identified as having been made by the recipient.
2. The user of this Health Survey accepts full responsibility, and agrees to indemnify and hold RAND harmless, for the accuracy of any translations of the Health Survey into another language and for any errors, omissions, misinterpretations, or consequences thereof.
3. The user of this Health Survey accepts full responsibility, and agrees to indemnify and hold RAND harmless, for any consequences resulting from the use of the Health Survey.
4. The user of the 36-Item Health Survey will provide a credit line when printing and distributing this document acknowledging that it was developed at RAND as part of the Medical Outcomes Study.
5. No further written permission is needed for use of this Health Survey.

Appendix 4: Email Permission for the use of the RAS-DS



Nicola Hancock nicola.hancock@sydney.edu.au via unisyd.onmicrosoft.com

Fri, 2 Nov 2018, 22:01



to RAS-DS, me ▾

Hi Hannah

What a fantastic sounding study! You are very welcome to use the RAS-DS. Please can you just make sure you are using the most recent version: www.ras-ds.net.au

For you interest – there are a few services/researchers already using RAS-DS in Ireland.

Look forward to hearing how you study goes. Do get in touch if you have any further questions.

Warm regards

Nicola

Nicola Hancock PhD

Senior Lecturer | Post-Graduate Coordinator Disability and Mental Health Research

Appendix 5: Email Permission to Use and Adapt the EMAS for football only.

Permission to use the EMAS:



Eakman, Aaron <Aaron.Eakman@colostate.edu>

to me ▾

Hello Hannah,

This should be what you need. You are welcome to use the EMAS for your research purposes.

Best,

Aaron

Aaron M. Eakman, PhD, OTR/L, FAOTA
Associate Professor

Permission to adapt the EMAS to measure the activity of football only:

Eakman, Aaron <Aaron.Eakman@colostate.edu>

Mon, 12 Nov 2018, 18:03



to me ▾

Hello Hannah,

I think it is a wonderful idea, and this approach is being used more and more when researchers/clinicians wish to target change in meanings for specific types of activities. I do recommend that you use the original 5-point scaling on the EMAS if addressing only one type of activity, i.e., football (1-never, 2-rarely, 3-sometimes, 4-usually, and 5-always).

Appendix 6: Letter of Invitation for Sites 1 and Site 2

Letter of Invitation

To whom it may concern,

You are being invited to take part in a research study in relation to the Kickstart to Recovery programme that you will be involved with.

Attached you will find the Participant Information Leaflet and a consent form, which will give you full details of the study and what is involved if you decide to participate.

I (Hannah) will be available on _____ (DATE) at
_____ (TIME) in _____ (LOCATION) _____
to answer any questions you may have on the study and what would be involved for you.

At the end of this letter and the Participant Information Leaflet you will find the contact details of the researchers. Please feel free to contact us with any questions you may have.

Thank you for taking the time to read this information and we hope you will consider taking part in this study.

Best wishes,

Hannah Casey and Dr. Clodagh Nolan

Contact details:

Hannah Casey

Phone: **089 490 1947**
8963218

Email: kickstarttorecoveryresearch@gmail.com

Dr Clodagh Nolan

Phone: **(01)**

Email: nolancl@tcd.ie

Appendix 7: Participant Information Leaflet



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

Participant Information Leaflet

Study title: A quantitative investigation of quality of life, social gains, recovery orientation and meaning associated with football pre and post involvement in the 'Kickstart to Recovery programme' for mental health service users.

Researcher's name: Hannah Casey

Researcher's title: Occupational Therapy Postgraduate Student

Contact details of researcher: (089) 4651245 /
kickstarttorecoveryresearch@gmail.com

Research supervisor's name: Dr. Clodagh Nolan

Research supervisor's title: Occupational Therapy Assistant Professor,
Trinity College Dublin

You are being invited to take part in a research study to be carried out in the
[*service area*] Health Services.

Before you decide whether or not you wish to take part, you should read the information provided below carefully and, if you wish, discuss it with your family, friends or GP (doctor). Take time to ask questions – 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'.

Why is this study being done?

This research aims to find out if by partaking in the "Kickstart to Recovery" football programme whether or not there is a change for individuals in their quality of life, their recovery journey, their social connections and the meaning football has for them. The outcomes of this study may enable the programme facilitators to improve the programme to meet the needs of mental health users.

Who is organising and funding this study?

This study is being organised by the Football Association of Ireland (FAI), the Health Service Executive (HSE) and Trinity College Dublin.

This study has received ethical approval from Trinity College Dublin Faculty of Health Sciences, the Research Ethics Committee, HSE, South East, the Research Ethics Committee, HSE, North West and Research Ethics Committee, HSE, UL Hospital Group.

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. You cannot take part in this study if you have not been approved to participate in the Kickstart to Recovery Programme.

How will the study be carried out?

If you are interested in taking part in this study you will meet with a researcher (Hannah Casey) twice, once at the start of the programme for 15-30 minutes maximum and again at the end of the programme for 15-30 minutes maximum.

At the first meeting Hannah will discuss the study with you and ask you to sign a consent form if you wish to be involved. She will then ask you to fill out a questionnaire which should take about 15 to 30 minutes maximum which will contain questions related to:

1. Your Quality of life.
2. A Measure of Recovery.
3. The Meaning Football has for you.

The researchers will compare your results from the start to those at the end of the programme to see if there is a difference.

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 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 when filling out the questionnaires you will be put in contact with your mental health team within the [*service area*] Mental Health Service and you can withdraw from the study anytime without incurring any penalties or benefits you had before entering the study.

The researchers may withdraw your participation in the study at any time without your consent if it you should become unwell and unable to participate.

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 researchers. You will be assigned a number which will replace your name on all results of the questionnaires you complete, thus keeping it confidential.

Please note, should you disclose any allegation of professional misconduct, I am duty-bound to report this to the authorities.

Your research questionnaire will be kept in a locked cabinet for 5 years in line with Trinity College Dublin Procedures after which it will be destroyed.

It is anticipated that the results of this research may be published in academic journals. It may also be shared back to the Mental Health teams involved and the Football Association of Ireland (FAI) in order to improve the Kickstart to Recovery programme.

Data Protection

<i>Data Controller:</i>	Trinity College Dublin
<i>Data Controller's Contact Details:</i>	(Hannah Casey, researcher) phone: (089)4651245 or email: kickstarttorecoveryresearch@gmail.com

<i>Data Protection Officer's Identity:</i>	Jennifer Ryan (Trinity College Dublin)
<i>Data Protection Officer's Contact Details:</i>	phone: 01 896 8486 or email: dataprotection@tcd.ie

- We will be using your data as part of this study to investigate if by partaking in the "Kickstart to Recovery" football programme there is a change for individuals in their quality of life, their recovery journey, their social connections and the meaning football has for them.

- Your data is being processed for the purpose of legitimate interest (Article 6;1(f), General Data Protection Regulation, 2016) and for the purpose of scientific research purposes (Article 9;2(j), General Data Protection Regulation, 2016).

- Researchers Hannah Casey and Dr. Clodagh Nolan will have access to your data.

- The data will be stored in a locked cupboard in Dr. Clodagh Nolan's office in Trinity Centre of Health Science for 5 years in line with Trinity College Dublin Policy.

- Measures will be taken to reduce risk when processing the data, however should a data breach occur, this may cause you harm. This harm will be significantly reduced as your data will not have any identifiable information on it. Instead of your name, a research number will be used. This number will be put on your questionnaires. A document (called the "key") will link your name to the number. This document will be kept separate from the questionnaires to protect your identity. This is called pseudonymisation.

- If necessary, you have the right to lodge a complaint with the Data Protection Commissioner. Their contact details can be found at the top of this section.

- Until data is analysed by the researchers (May 2019), you have the right to the following;

- request access to your data and a copy of it
- to have any inaccurate information about you corrected or deleted

- to have personal data deleted

Once the data is analysed, the “key” will be destroyed. This will make your data anonymous as it will not be possible to match your name with your research number on the questionnaires. Before this stage, you can contact the researchers for any of the above.

- It would be impossible to conduct this research without processing of your data, therefore data processing is necessary.

Data processing is any operation which is performed on personal data, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction (Act 4(2), General Data Protection Regulation, 2016).

- Your data will be used for this research only and will not be used for any other research without your explicit consent.

Where can I get further information?

If you have any further questions about the study or if you want to opt out of the study, you can rest assured it won't affect the quality of treatment you get in the future.

If you need any further information now or at any time in the future, please contact us on the details below.

Name: Hannah Casey

Qualifications: B.Sc Hons. (Curr.Occ.)

Position: Postgraduate Student

Dept: Occupational Therapy

Organisation: Trinity College Dublin

Address: Trinity Centre for Health Sciences, James St., Dublin 8

Tel: (089) 4651245

Email:

kickstarttorecoveryresearch@gmail.com

Or

Name: Dr. Clodagh Nolan

Qualifications: Ph.D., M.Sc., M.A., Pg. Dip. Stats, Dip. C.O.T.

Position: Assist. Professor

Dept: Occupational Therapy

Organisation: Trinity College Dublin

Address: Trinity Centre for Health Sciences, James St., Dublin 8

Tel: (01) 8963218

Email: nolancl@tcd.ie

Teiripe Ceirde
Ionad Choláiste Tríonóide do
na hEolaíochtaí Sláinte,
Ospidéal San Séamas,
Sráid San Séamas,
Baile Atha Cliath 8, Éire.

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

T: +353 1 896 3210
email: occupthe@tcd.ie
Web: www.medicine.tcd.ie/occupational-therapy/

Appendix 8: Consent Form



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

Consent Form

I have read and understood the Information Leaflet about this research project.	Yes ☐	No ☐
The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	Yes ☐	No ☐
I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I don't have to give a reason for opting out and I understand that opting out won't affect my future services in the Louth/Meath Mental Health Services or place on the Kickstart to Recovery Programme.	Yes ☐	No ☐
I have been assured that information about me will be kept private and confidential/anonymous.	Yes ☐	No ☐
I have been given a copy of the Information Leaflet and this completed consent form for my records.	Yes ☐	No ☐
Storage and future use of information: I give my permission for information collected about me to be stored or electronically processed for the purpose of <u>this</u> research.	Yes ☐	No ☐

Participant Name (Block Capitals) | Participant Signature | Date

To be completed by the Researcher:

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

Name (Block Capitals) | Qualifications | Signature | Date

Teiripe Ceirde
Ionad Choláiste Tríonóide do
na hEolaíochtaí Sláinte,
Ospidéal San Séamas,
Sráid San Séamas,
Baile Átha Cliath 8, Éire.

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

T: +353 1 896 3210
email: occupthe@tcd.ie
Web: www.medicine.tcd.ie/occupational-therapy/

Appendix 9: Extract of Codebook

Demographics File

Full variable name	SPSS variable name	SPSS variable label	Coding instructions
Participant Number	ID	Participant Number	Include Participant Number (eg P1)
Completed stage(s) of the study	PrePost	Pre/post or Pre Only	1=Pre and Post completed 2=Pre only
Gender	Gender	Gender	1=male, 2=female
Age bracket	Age	Age bracket	1=18-23 2=24-29 3=30-35 4=36-41 5=42-47 6=48-52 7=53-58 8=59-64 9=65+
Mental Health Difficulties	MentalHealth	Mental Health Difficulties	1= Schizophrenia 2=Bipolar 3=Depression 4=Anxiety 5=Psychosis 6=Personality disorder 7=Other Diagnosis 8=Other Description 9=Unanswered
Mental health difficulties description provided	MenHeaDes	Mental health difficulties description provided	0=no description 1=yes, described positively 2=yes, described negatively 3=yes described in inconclusive manner
Do you do other sports?	OtherSports	Other Sports	0=No 1=Yes
Basketball	Basketball	Basketball	0=No 1=Yes
Golf	Golf	Golf	0=No 1=Yes
Tennis	Tennis	Tennis	0=No 1=Yes
GAA (include "hurling" and "gaelic football")	GAA	GAA	0=No 1=Yes
Swimming	Swimming	Swimming	0=No 1=Yes
Running (include "10k runs")	Running	Running	0=No 1=Yes
Gym (include "weights")	Gym	Gym	0=No 1=Yes
Cycling	Cycling	Cycling	0=No 1=Yes
Rugby	Rugby	Rugby	0=No 1=Yes
Other	Other	Other	0=No 1=Yes

Number of sports listed	NoSports	No of different sports per person	1=1, 2=2, 3=3, 4=more than 3
Do you attend activities in your area?	CommAct	Community Activities	0=No 1=Yes
If yes, list these activities	ListAct	List Community Activities in grouped categories	1= Physical activity related 2=Volunteering related 3=Leisure-based (not including physical activity) 4=Other

EMAS File

Full variable name	SPSS variable name	SPSS variable label	Coding instructions
Pre-test Total Score EMAS	EMASSts1	PRE EMAS Total Scores	Total Raw Score
Post-test Total Score EMAS	EMASSts2	POST EMAS Total Scores	Total Raw Score
Pre-test Percentage Score EMAS	EMASpc1	PRE EMAS Percentage Score	Percentage Score
Post-test Percentage Score EMAS	EMASpc2	POST EMAS Percentage Score	Percentage Score

RAS-DS File

Full variable name	SPSS variable name	SPSS variable label	Coding instructions
Pre-test Total Score RAS-DS	tsRASDS1	PRE Total Score RAS-DS	Total Scores
Post-test Total Score for RAS-DS	tsRASDS2	POST Total Score RAS-DS	Total Scores
Pre-test Doing Things I Value average score RAS-DS	dtvRASDS1	PRE Doing things I Value RAS-DS	Average Score
Post-test Doing Things I Value average score RAS-DS	dtvRASDS2	POST Doing Things I Value	Average Score
Pre-test Doing Things I Value percentage score RAS-DS	dtvRASDSpc1	PRE % Doing Things I Value RAS-DS	Percentage Score
Post-test Doing Things I Value percentage score RAS-DS	dtvRASDSpc2	POST % Doing Things I Value RAS-DS	Percentage Score

Pre-test Looking Forward average score RAS-DS	IfRASDS1	PRE Looking Forward RAS-DS	Average Score
Post-test Looking Forward average score RAS-DS	IfRASDS2	POST Looking Forward RAS-DS	Average Score
Pre-test Looking Forward percentage score RAS-DS	IfRASDSpc1	PRE % Looking Forward RAS-DS	Percentage Score
Post-test Looking Forward percentage score RAS-DS	IfRASDSpc2	POST % Looking Forward RAS-DS	Percentage Score
Pre-test Mastering My Illness average score RAS-DS	mmiRASDS1	PRE Mastering My Illness RAS-DS	Average Score
Post-test Mastering My Illness average score RAS-DS	mmiRASDS2	POST Mastering My Illness RAS-DS	Average Score
Pre-test Mastering My Illness percentage score RAS-DS	mmiRASDSpc1	PRE % Mastering My Illness RAS-DS	Percentage Score
Post-test Mastering My Illness percentage score RAS-DS	mmiRASDSpc2	POST % Mastering My Illness RAS-DS	Percentage Score
Pre-test Connecting and Belonging average score RAS-DS	cbRASDS1	PRE Connecting and Belonging RAS-DS	Average Score
Post-test Connecting and Belonging average score RAS-DS	cbRASDS2	POST Connecting and Belonging RAS-DS	Average Score
Pre-test Connecting and Belonging percentage score RAS-DS	cbRASDSpc1	PRE % Connecting and Belonging RAS-DS	Percentage Score
Post-test Connecting and Belonging percentage score RAS-DS	cbRASDSpc2	POST % Connecting and Belonging RAS-DS	Percentage Score

Appendix 10: Missing Values and Outliers Logbook

All Missing Values

Domain	Participant No	Pre or Post	Impact to Study
SF-36 PF	P11	Pre	None, didn't complete Post test
SF-36 RLPF	P11	Pre	None, didn't complete Post test
SF-36 RLPF	P37	Pre	None, didn't complete Post test
SF-36 E/F	P36	Pre	Post-test P36 E/F removed for comparison balance.
SF-36 EWB	P17	Pre	Post-test P17 EWB removed for comparison balance.
SF-36 EWB	P27	Pre	Post-test P27 EWB Removed for comparison balance.
SF-36 SF	P36	Pre	Post-test P36 SF removed for comparison balance.
SF-36 GH	P35	Pre	Post-test P35 GH removed for comparison balance.
RAS-DS T.S.	P18	Pre	None, didn't complete Post test
RAS-DS L.F.	P18	Pre	None, didn't complete Post test
RAS-DS M.M.I.	P18	Pre	None, didn't complete Post test
RAS-DS C.B.	P18	Pre	None, didn't complete Post test
RAS-DS T.S.	P36	Pre	Post-test TS P36 removed for comparison balance.
RAS-DS T.S	P40	Pre	Post-test AV and PS P40 removed for comparison balance.
RAS-DS L.F.	P36	Pre	Post-test AV and PS P36 removed for comparison balance.
RAS-DS L.F	P40	Pre	Post-test AV and PS P40 removed for comparison balance.

Changes Made for Missing Values

Reason For Removed Value	Participant No	Pre or Post	Removed Domain	Removed Value
Missing value for Energy/Fatigue Pre-test score P36, hence corresponding Post-test removed for comparison balance.	P36	Post	SF-36 E/F	85
Missing value for Emotional Wellbeing Pre-test score P17, hence corresponding Post-test removed for comparison balance.	P17	Post	SF-36 EWB	80
Missing value for Emotional Wellbeing Pre-test score P27, hence corresponding Post-test removed for comparison balance.	P27	Post	SF-36 EWB	96
Missing value for Social Functioning Pre-test score P36, hence corresponding Post-test removed for comparison balance.	P36	Post	SF-36 SF	100
Missing value for General Health Pre-test score P35, hence corresponding Post-test removed for comparison balance.	P35	Post	SF-36 GH	55
Missing value for RAS-DS Total Score Pre-test score P36, hence corresponding	P36	Post	RAS-DS TS	145

Post-test removed for comparison balance.				
Missing value for RAS-DS Total Score Pre-test score P40, hence corresponding Post-test removed for comparison balance	P40	Post	RAS-DS TS	122
Missing value for RAS-DS Looking Forward Pre Average Score and Pre Percentage Score Pre-test score P36, hence corresponding Post-test removed for comparison balance.	P36	Post	RAS-DS LF average score and % score	3.778 and 94.44%
Missing value for RAS-DS Looking Forward Pre Average Score and Pre Percentage Score Pre-test score P40, hence corresponding Post-test removed for comparison balance.	P40	Post	RAS-DS LF average score and % score	3 and 75%

Outliers Identified

Domain	Participant No	Pre or Post	Impact to Study (in addition to removing outlier)
SF-36 P.F.	P12	Pre	Post-test P12 P.F. removed as also an outlier.
SF-36 P.F.	P36	Pre	Post-test P36 P.F. removed as also an outlier.
SF-36 P.F.	P12	Post	Pre-test P12 P.F. removed as also an outlier.
SF-36 P.F.	P22	Post	Pre-test P22 removed for comparison balance.
SF-36 P.F.	P15	Post	Pre-test P15 removed for comparison balance.
SF-36 P.F.	P36	Post	Pre-test P36 P.F. removed as also an outlier.
SF-36 P.F.	P33	Pre	None, did not complete post-test.

Changes Made for Outliers

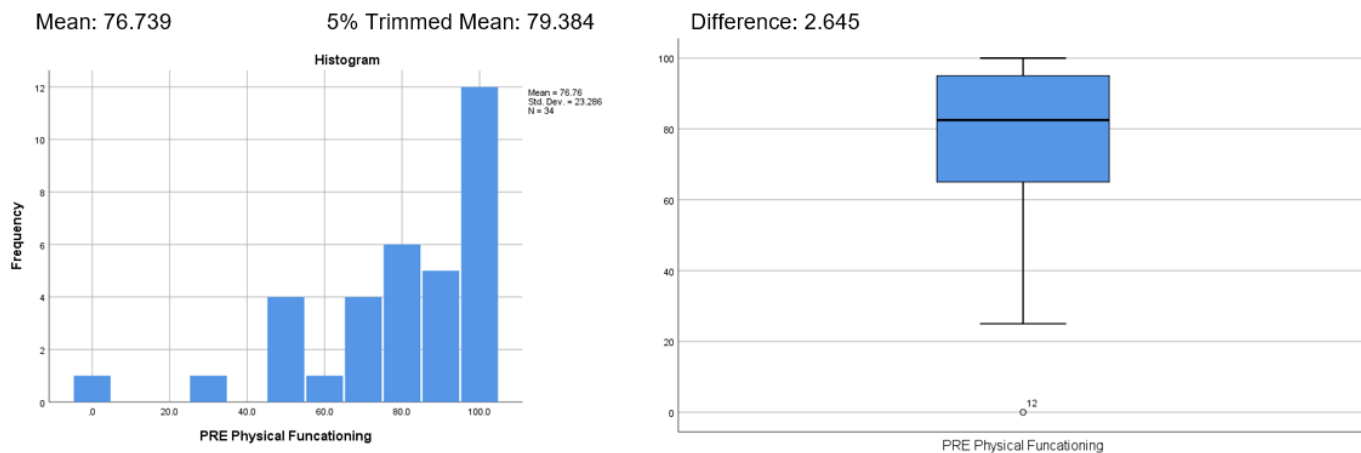
Reason For Removed Value	Participant No	Pre or Post	Removed Domain	Removed Value
Identified Pre Physical Functioning Score for P12 as an outlier.	P12	Pre	SF-36 PF	0
Identified Post Physical Functioning Score for P12 as an outlier (also corresponding pre score is an outlier)	P12	Post	SF-36 PF	0
Identified Post Physical Functioning Score for P22 as an outlier	P22	Post	SF-36 PF	15
Remains when examining Pre-test only Corresponding Physical Functioning Post-test score for P22 is an outlier, hence Pre score removed for comparison balance.	P22	Pre	SF-36 PF	100
Identified Pre Physical Functioning Score for P36 as an outlier	P36	Pre	SF-36 PF	5
Corresponding Physical Functioning Pre-test score for P36 is an outlier, hence	P36	Post	SF-36 PF	40

Post score removed for comparison balance.				
Identified Post Physical Functioning Score for P15 as an outlier	P15	Post	SF-36 PF	30
Remains when examining Pre-test only Corresponding Physical Functioning Post-test score for P15 is an outlier, hence Pre score removed for comparison balance.	P15	Pre	SF-36 PF	95
Identified Pre Physical Functioning Score for P33 as an outlier	P33	Pre	SF-36 PF	25
Identified Pre EMAS Total Average Score & Percentage Score for P4 as an outlier	P4	Pre	EMAS	19 (31.67%)
Corresponding EMAS average score & percentage score pre-test score for P4 is an outlier, hence post score removed for comparison balance.	P4	Post	EMAS	52 (86.67%)
Identified Pre EMAS Total Average Score & Percentage Score for P5 as an outlier	P5	Pre	EMAS	20 (33.33%)
Identified Post EMAS Total Average Score & Percentage Score for P5 as an outlier (also corresponding pre score is an outlier)	P5	Post	EMAS	16 (26.67%)
Identified Post EMAS Total Average Score & Percentage Score for P23 as an outlier	P23	Post	EMAS	24 (40%)
Remains when examining Pre-test only Corresponding EMAS average score & percentage score post-test score for P23 is an outlier, hence pre score removed for comparison balance.	P23	Pre	EMAS	36 63.3%)

Appendix 11: Identifying Outliers

SF-36 Domains

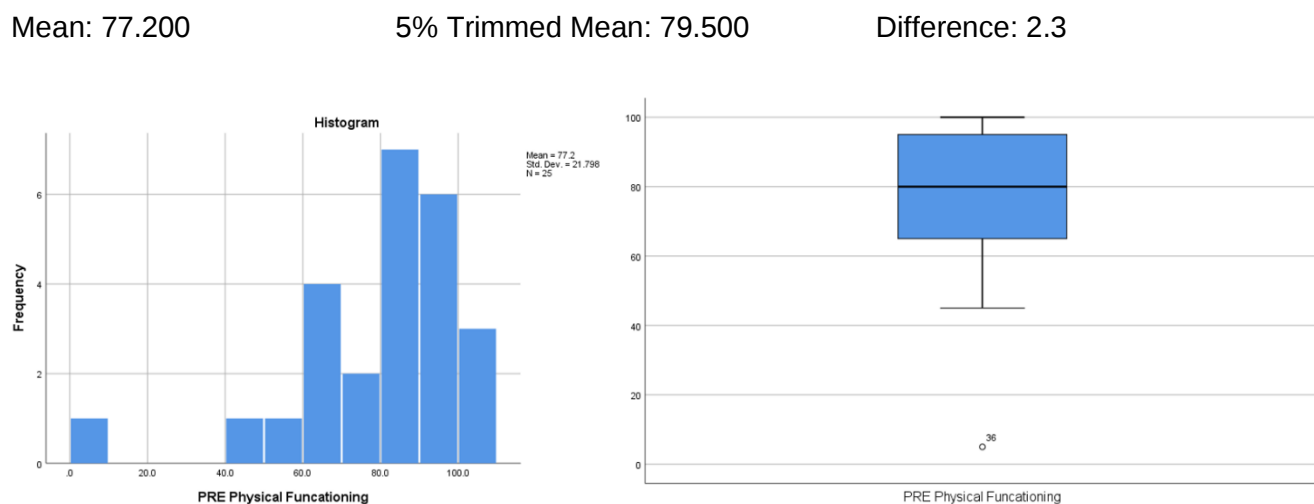
Pre-test Physical Functioning (Original Results)



Outcome: Outlier Identified (P12)

When the outliers were removed from pre-test SF-36 domain 'Physical Functioning', further large differences between the mean and the 5%Trimmed mean were identified. These were investigated further.

Pre-test Physical Functioning (Re-run Descriptives with outliers above removed)



Outcome: Outlier identified (P36)

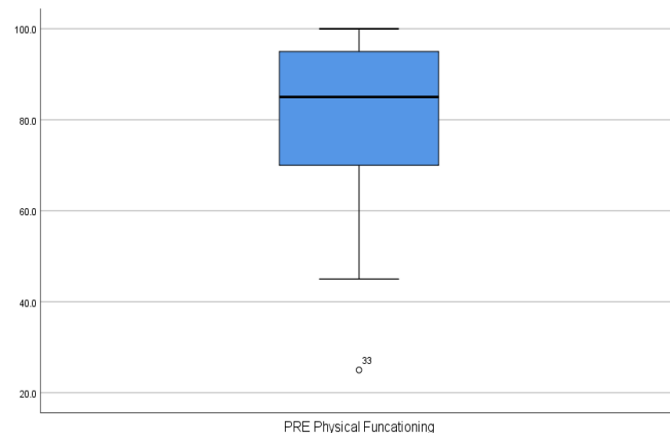
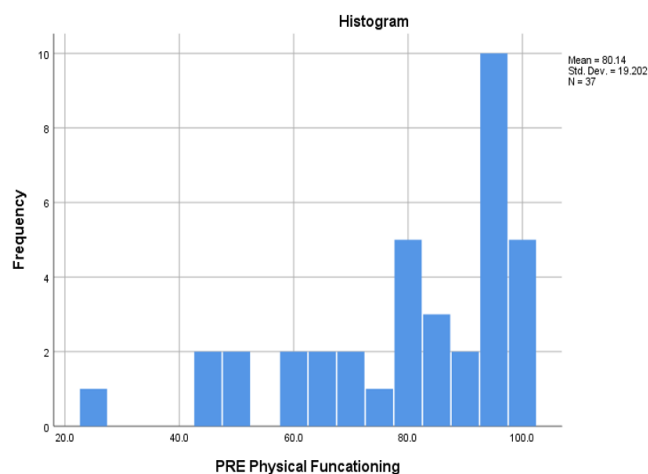
When the outliers were removed from pre-test SF-36 domain 'Physical Functioning', further large differences between the mean and the 5%Trimmed mean were identified. These were investigated further.

Pre-test Physical Functioning (Second re-run Descriptives with outliers above removed)

Mean: 80.135

5% Trimmed Mean: 81.584

Difference: 1.449



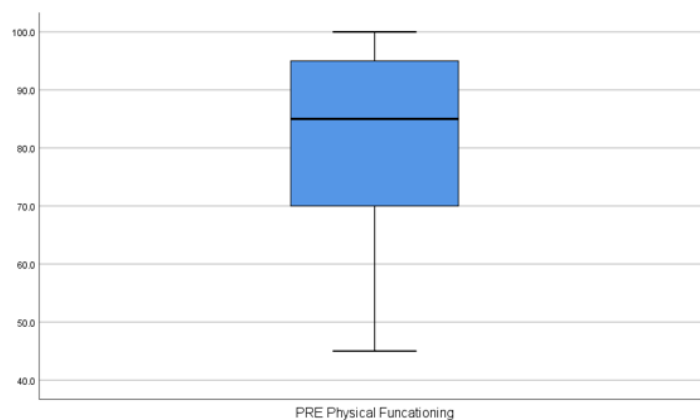
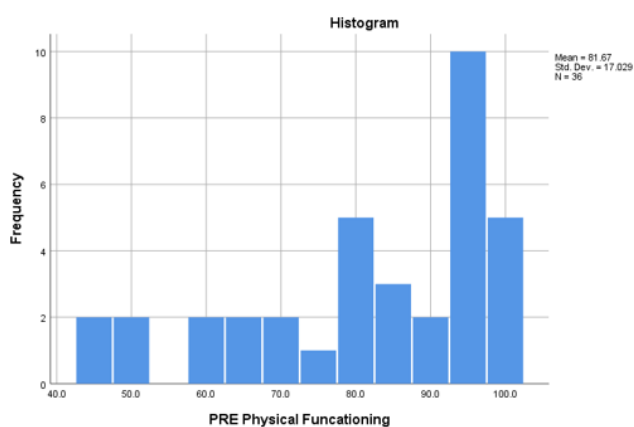
Outcome: Outlier identified (P33)

Final Pre-test Physical Functioning (Third set of Descriptives with all outliers removed)

Mean: 81.667

5% Trimmed Mean: 82.685

Difference: 1.018



Outcome: No further outliers identified.

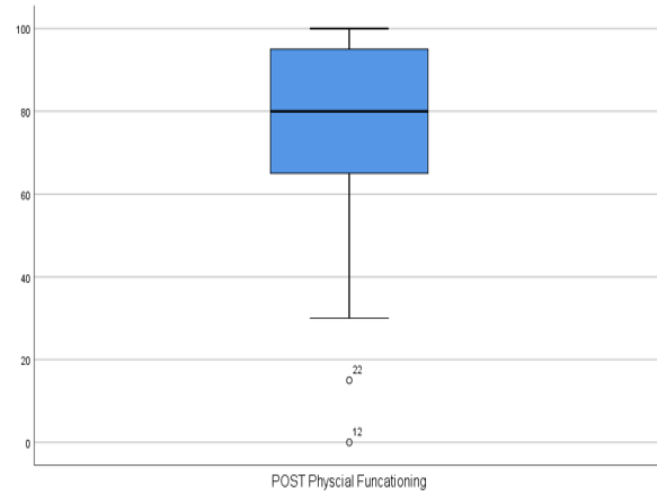
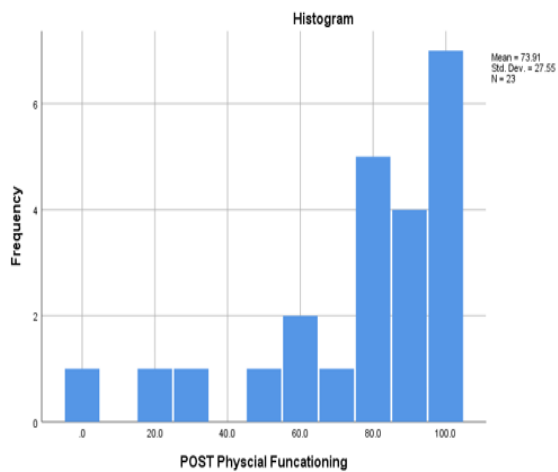
Total outliers identified from pre-test SF-36 domain 'Physical Functioning': 3 (P12, P33 & P36)

Post-test Physical Functioning (Original Results)

Mean: 73.913

5% Trimmed Mean: 76.461

Difference: 2.548



Outcome: Outliers (2) Identified (P12 & P22)

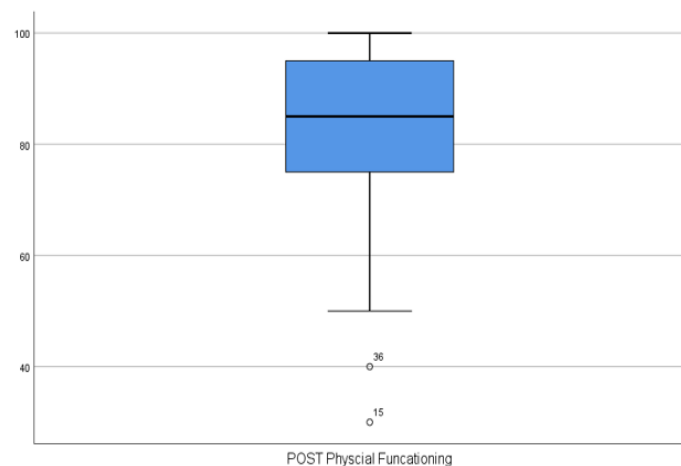
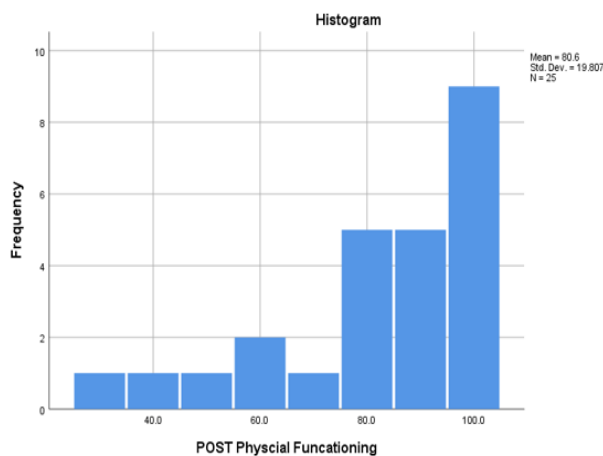
When the outliers were removed from post-test SF-36 domain 'Physical Functioning', further large differences between the mean and the 5%Trimmed mean were identified. These were investigated further.

Post-test Physical Functioning (Re-run Descriptives with outliers above removed)

Mean: 80.600

5% Trimmed Mean: 82.222

Difference: 1.622



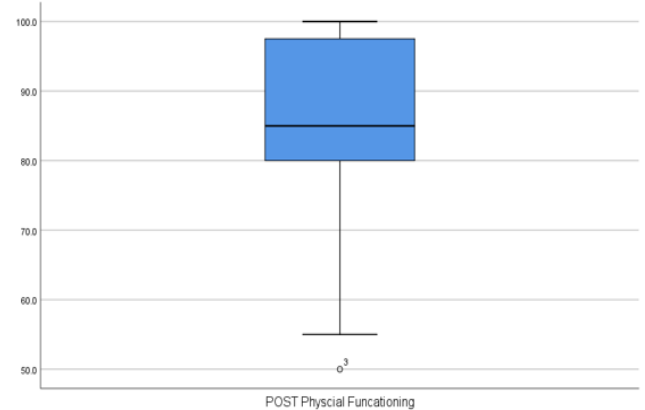
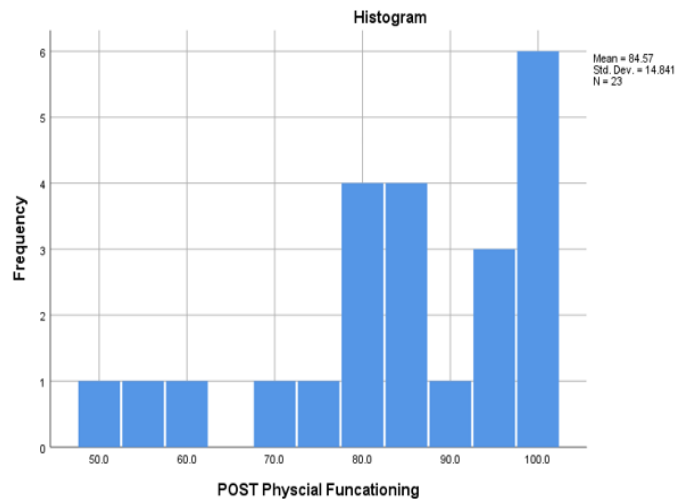
Outcome: Outliers (2) identified (P15 & P36)

Final Post-test Physical Functioning (Third set of Descriptives with all outliers removed)

Mean: 84.565

5% Trimmed Mean: 85.592

Difference: 1.027



P3 identified as external to the whiskers in the box plot, is a value of 50. The next lowest value is 55. P3 is therefore not an outlier from the data set.

Outcome: No further outliers are identified.

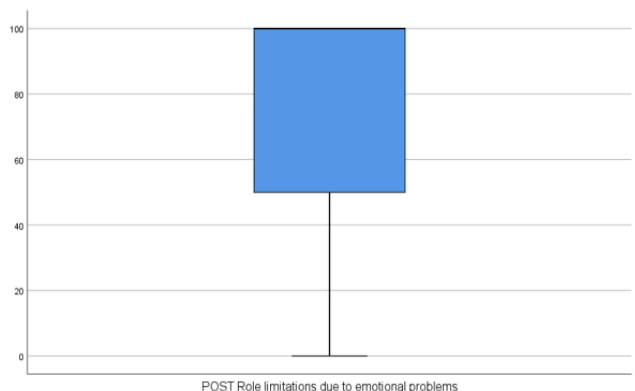
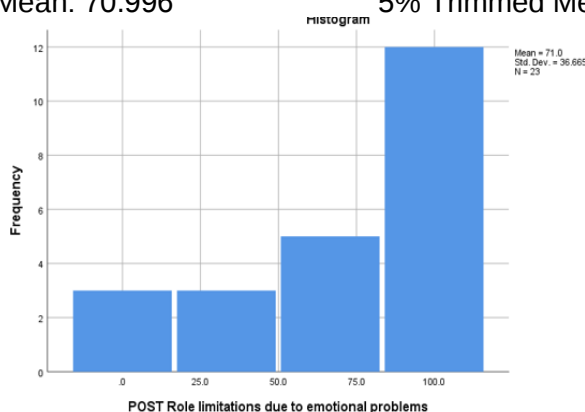
Total outliers identified from post-test SF-36 domain 'Physical Functioning': 4
(P12, P15, P22 & P36)

Post-test Role Limitations Due to Emotional Problems (Original Results)

Mean: 70.996

5% Trimmed Mean: 73.329

Difference: 2.333



Although a difference was noted between the mean and 5% trimmed mean, no value was observed to be isolated from the data set.

Outcome: No outlier identified

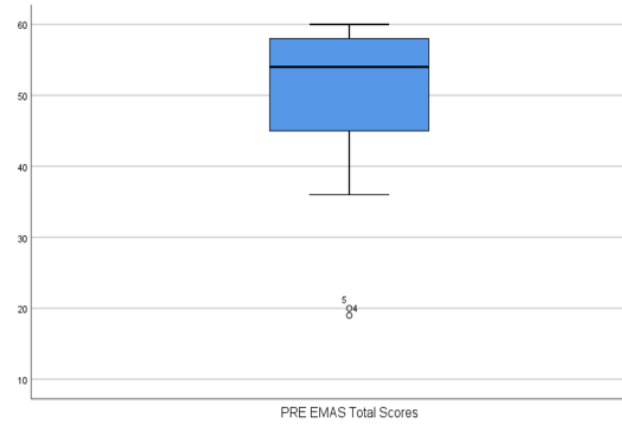
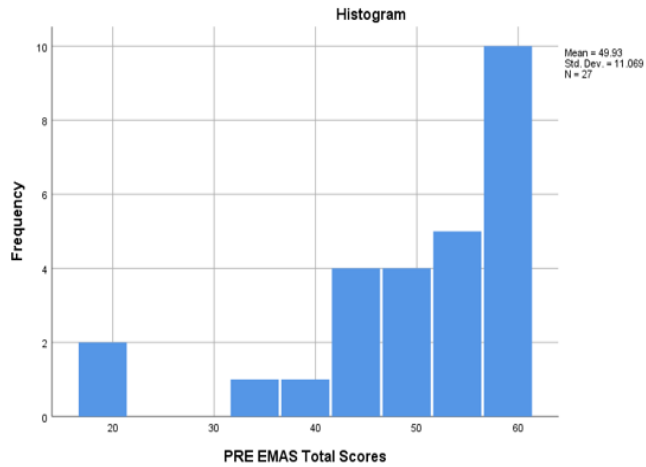
EMAS

Total EMAS Average Score Pre-test (Original Results)

Mean: 49.93

5% Trimmed Mean: 51.07

Difference: 1.14

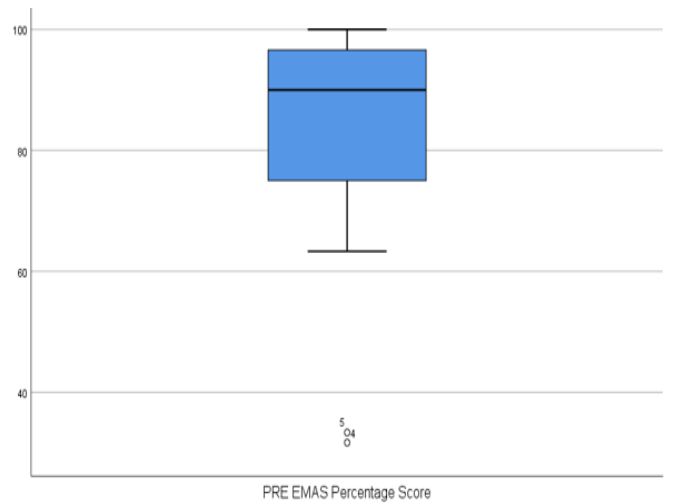
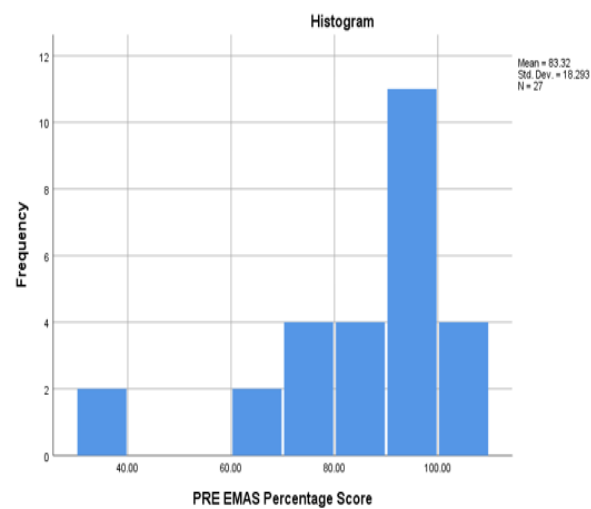


Total EMAS Percentage Score Pre-Test (Original Results)

Mean: 83.3196

5% Trimmed Mean: 85.2385

Difference: 1.9189



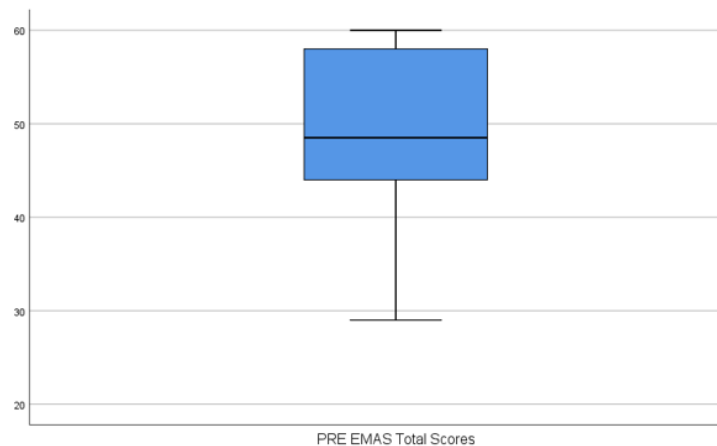
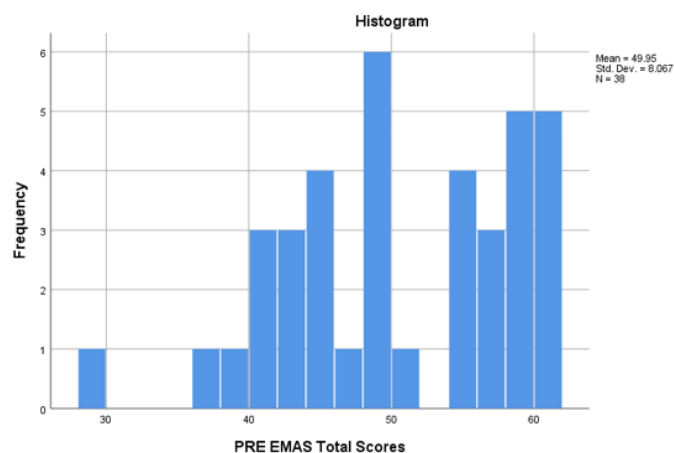
Outcome: Outliers (2) identified (P4 & P5)

Total EMAS Average Score Pre-test (Re-run Descriptives with outliers above removed)

Mean: 49.95

5% Trimmed Mean: 50.37

Difference: 0.45

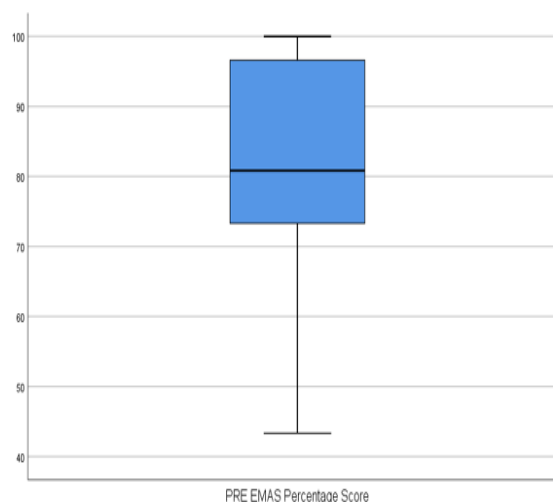
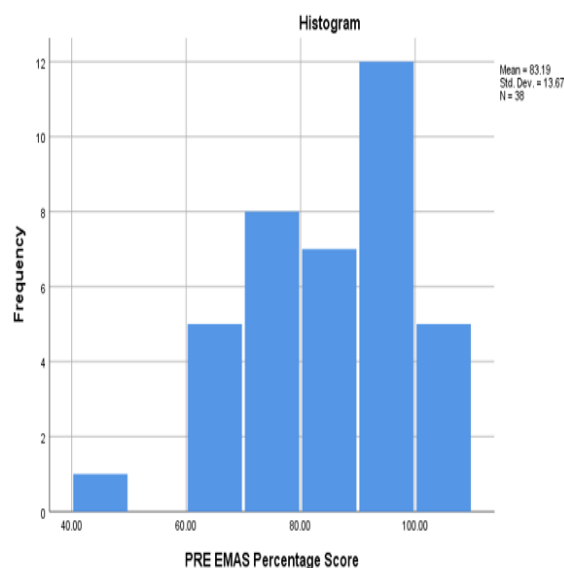


Total EMAS Percentage Score Pre-test (Re-run Descriptives with outliers above removed)

Mean: 83.1918

5% Trimmed Mean: 83.9471

Difference: 0.7553



The value observed in both histograms as detached from the data set was investigated. This is P9 with the values 29 and 43.33 for the average score and percentage score respectively. It was not identified as an outlier on the box plot and there is not a large difference between the mean and the 5% trimmed mean. These values are not determined as outliers as they do not have a great impact on the data set.

Outcome: No further outliers identified.

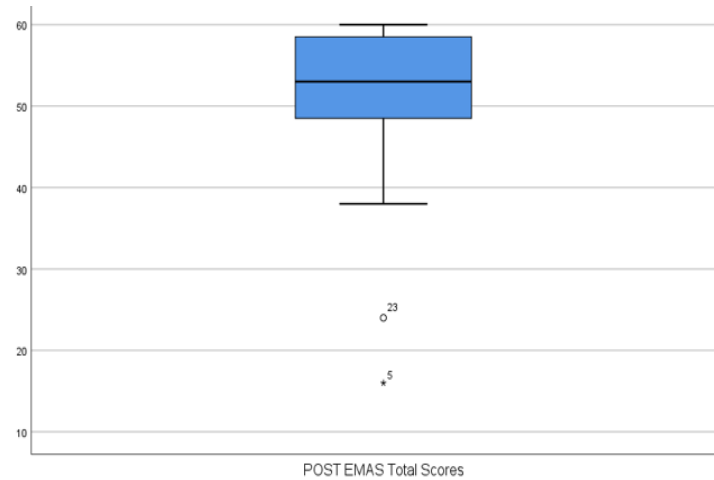
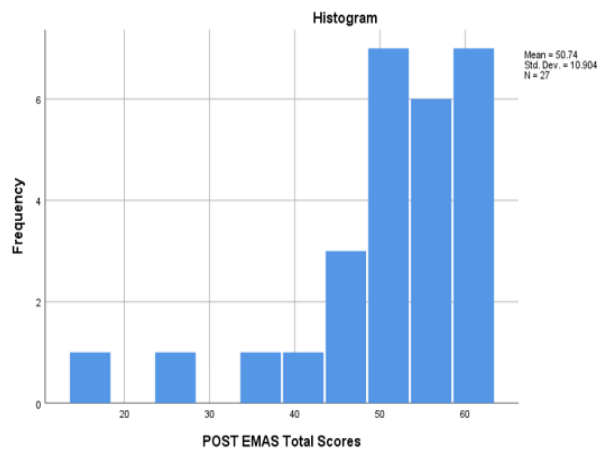
Total outliers identified from pre-test EMAS: 2 (P4 & P5)

Total EMAS Average Score Post-test (Original Results)

Mean: :50.74

5% Trimmed Mean: 52.04

Difference: 1.3

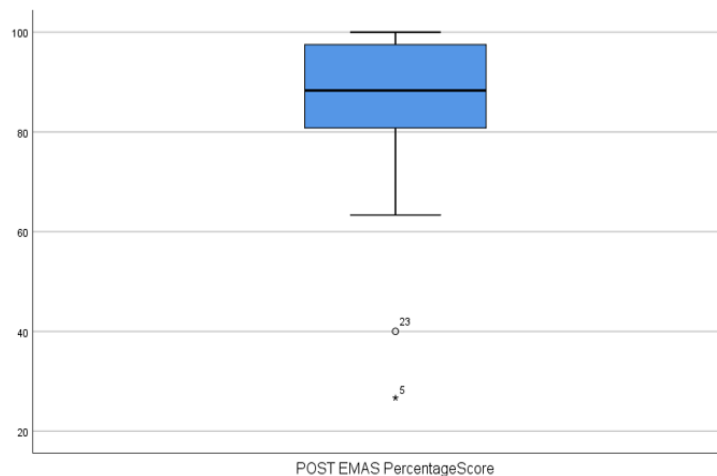
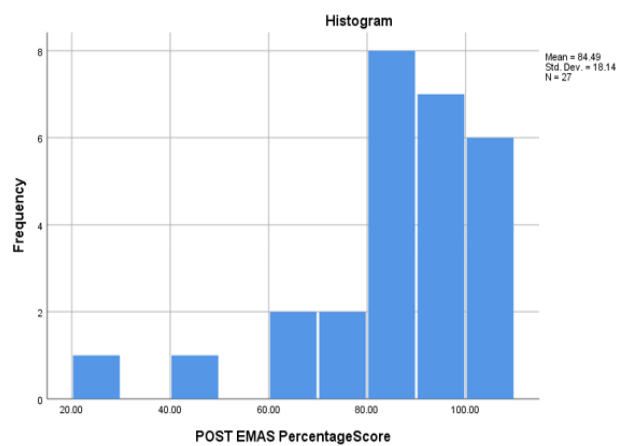


Total EMAS Percentage Score Post-Test (Original Results)

Mean: 84.4856

5% Trimmed Mean: 86.6436

Difference: 2.158



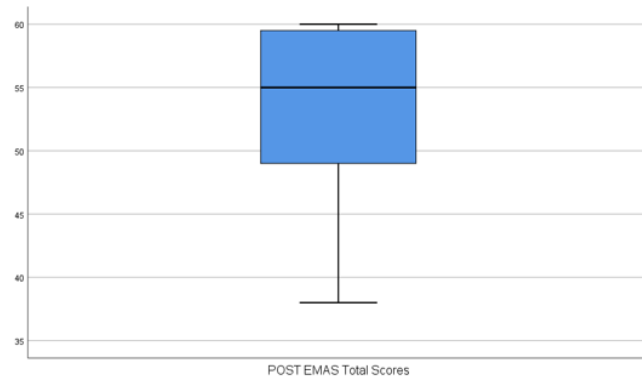
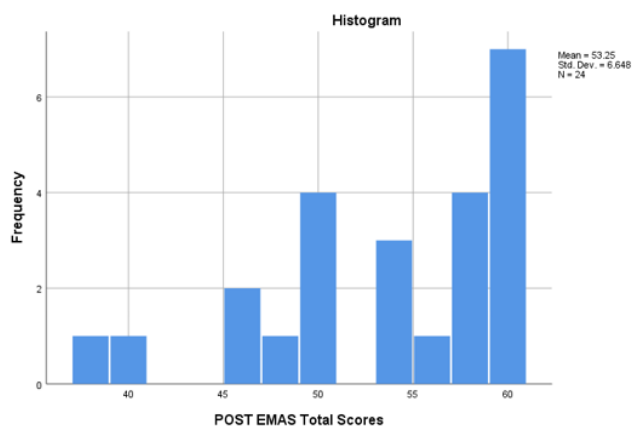
Outcome: Outliers (2) identified (P5 & P23)

Total EMAS Average Score Post-test (Re-run Descriptives with outliers above removed)

Mean: 53.25

5% Trimmed Mean: 53.7

Difference: 0.45

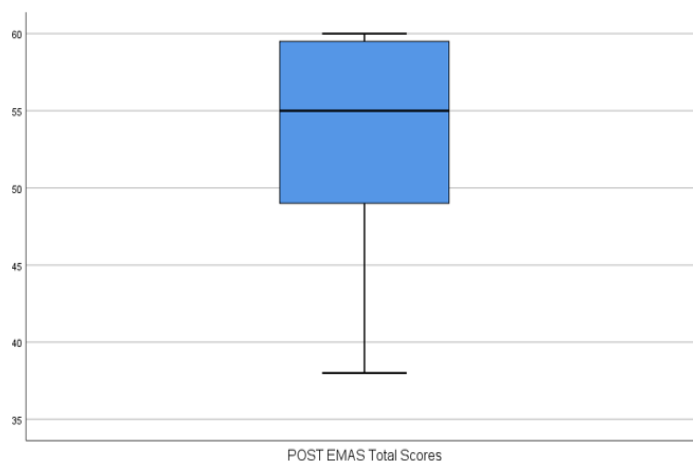
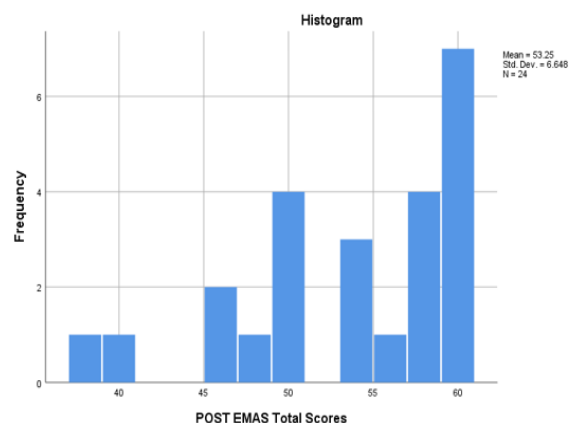


Total EMAS Percentage Score Post-test (Re-run Descriptives with outliers above removed)

Mean: 88.6571

5% Trimmed Mean: 88.6571

Difference: 0



Outcome: No further outliers identified.

Total outliers identified from post-test EMAS: 2 (P5 & P23)

Appendix 12: Ethical Approval from Trinity College Dublin Faculty of Health Sciences Ethics Board



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

Hannah Casey
Discipline of Occupational Therapy,
Trinity Centre of Health Sciences,
St James Hospital,
Dublin 8

14th December 2018

Ref: 181001

Title of Study: A quantitative investigation of quality of life, social gains, recovery orientation and meaning associated with football pre and post involvement in the 'Kickstart to Recovery programme' for mental health service users.

Dear Hannah,

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,

A handwritten signature in black ink, appearing to read 'Prof. Brian O'Connell'.

Prof. Brian O'Connell
Chairperson
Faculty Research Ethics Committee

Appendix 13: Ethical Approval from Research Ethics Committee, HSE, North East



Regional Manager Consumer Affairs HSE Dublin North East

Bective Street, Kells
Co. Meath
A82 NX32

Tel: +353 (0) 46 9251262/263
Fax: +353 (0) 46 9251774

Loughree Business Park
Drumalee, Cavan
H12 Y329

Tel: +353 (0) 49 4377343
Fax: +353 (0) 49 4377379

Email: consumeraffairs.hsedne@hse.ie

Dr Clodagh Nolan
Asst. Professor
St. Brigids Complex
Kells Road
Ardee
Co Louth

13/12/18

Re/ Research Study Proposal:

"A pilot quantitative investigation of quality of life, social gains, recovery orientation and meaning associated with football pre and post involvement in the 'Kickstart to Recovery Programme' for mental health service users"

Dear Dr Nolan

I refer to your email correspondence of the 13/12/18 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.

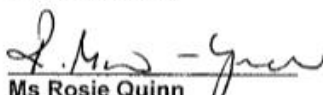
Approval is now given to commence the above Study.

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

HSE North East Area Research Ethics Committee
HSE Dublin North East, Bective Street, Kells, Co. Meath

List of site/s with favourable opinion/approval

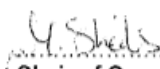
Research Identification

Title of Research: A pilot quantitative investigation of quality of life, social gains, recovery orientation and meaning associated with football pre and post involvement in the 'Kickstart to Recovery Programme' for mental health service users

Approval to commence the study was given on 13/12/18.

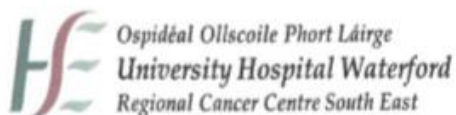
The study approval is extended to each of the site/s listed below.

Applicant	Site/s
Dr Clogagh Nolan	Ashbourne, Navan

Signed: .....
Chair of Committee

Date: 13/12/18

Appendix 14: Ethical Approval from Research Ethics Committee, HSE, South East



Research Ethics Office Old School of Nursing
University Hospital Waterford
Tel: 051- 842026/051-842391

27 February 2019

Dr Clodagh Nolan
Assist. Prof. Trinity College Dublin
Occupational Therapy
Trinity Centre for Health Sciences
James St
Dublin

STUDY TITLE: "A pilot quantitative investigation of quality of life, social gains, recovery orientation and meaning associated with football pre and post involvement in the 'Kickstart to Recovery Programme' for mental health service users."

STUDY STATUS: APPROVED

Dear Dr Nolan

The Research Ethics Committee Co-ordinator, REC, HSE, South East reviewed the above study.

Expedited ethical approval has been granted for the above study and constitutes full ethical approval.

The following documents were reviewed and approved:

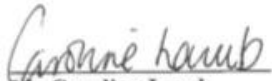
1. Research Ethics Standard Application Form
2. Research Proposal/Protocol
3. Questionnaire/s
 - Short Form Survey (SF36)
 - Recovery Assessment Scale (RAS-DS)
 - Engagement in meaningful activities (EMAS)
4. Participant Information sheet
5. Participant Consent Form
6. Letter of Invitation from service leads
7. Ethical Approval Letter, REC, HSE, North East

8. Declaration Form
9. CV of Principal Investigator
10. Insurance Document

In addition this study will be outlined at the next planned Research Ethics Committee Meeting for the HSE, South Eastern Area by the Research Ethics Committee Coordinator and any comments made at this meeting in relation to your study shall be communicated to you in writing.

It is a requirement of the REC, HSE, South East that you send copy of your study to the Research Ethics Office on completion.

Yours sincerely,



Ms Caroline Lamb
Research Ethics Committee Coordinator
Health Service Executive, South Eastern Area

The Research Ethics Committee, HSE, South East is a recognized Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human use) Regulations 2004 and as such is authorized to undertake ethical review of clinical trials of all descriptions and classes for the Republic of Ireland.

The Research Ethics Committee, HSE, South East issues ethical approval on the basis of information provided. It is the responsibility of the researcher to notify the Research Ethics Office of any changes to a study to ensure that the approval is still relevant.

Appendix 15: University Limerick Hospitals Group, Research Ethics Committee



Appendix 16: Sections Removed from Participant Information Leaflet and Consent Form for Sites 3, 4, 5, 6 and 7

In order to obtain ethical approval from the Research Ethics Committee, HSE, South East, the committee requested that the participants be offered the opportunity to have a copy of their questionnaire stored in their clinical file.

This option was explained in the Participation Information Leaflet (A) and the option given in the consent form (B) for sites 1 and 2.

When the study expanded, ethical approval was sought from Research Ethics Committee, HSE, South East and University Limerick Hospitals Group, Research Ethics Committee. These committees requested this option be removed. The Participation Information Leaflet and consent form did not contain (A) or (B) for sites 3, 4, 5, 6 and 7.

(A) Section of Participant Information Leaflet removed for Sites 3, 4, 5, 6 & 7

As this questionnaire may also benefit the mental health service you receive, it can be kept as part of your client file and can be accessed by your mental health team if you so wish. There is a section on the consent form for you to tick YES if you wish for a copy of the questionnaire to be placed in your file. This will mean that your name will appear on the copy of the questionnaire for the client file and it will be placed in your file by your occupational therapist.

However, for the purpose of this research there will be no names kept on the questionnaire and your data will be kept confidential.

(B) Section of Consent Form removed for Sites 3, 4, 5, 6 & 7

Copy of the Questionnaire for the File: I consent to a copy of my questionnaire being stored in my clinical file.	Yes ☐	No ☐
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Appendix 17: Intervention Fidelity Document 1

Complete once at the start of the programme:

1) Has the Kickstart to Recovery programme run in your service previously? YES ☐ NO ☐

If yes, how many programmes has there been?

Location

1) Outdoor grass pitch ☐ Outdoor AstroTurf ☐ Covered all-weather pitch ☐

Indoor hall ☐ Other or comments:

2) Accessibility and facilities of the location (e.g. public transport, free parking, no services etc.)?

Please comment

Sessions

1) Number of expected sessions in this block:

2) Intervals between sessions in this block:

3) Length of each session:

Participants

1) Anticipated number of participants:

2) Number new to Kickstart programme:

3) Number previously participated in programme:

Involvement in football session

1) Does the OT participate as a player in the football session? YES ☐ NO ☐

Comments:

2) Is there any additional persons (e.g. students) who are expected to participate in the sessions and if so which weeks? ☐ YES ☐ NO

Comments:

3) Has the coach participated in the Kickstart to Recovery programme previously (in this or any service)? YES ☐ NO ☐

If yes, have they facilitated Kickstart to Recovery with this group before? YES ☐ NO ☐

If yes to above, how many programme blocks_____

Continued.

Structure of sessions:

1) Is there any additional aspect beyond the football session (e.g. meeting before, “tea” after, additional fitness sessions, etc.)?

Comment_____

2) Is there a framework/outline /protocol of the Kickstart to Recovery programme that is followed in the service? YES ☐ NO ☐

If yes, can this framework be provided for purpose of intervention fidelity for this research?

YES ☐ NO ☐

Comments: _____

If no, please provide an outline of the intervention provided within the service below (please include aims and objectives of the intervention):

Appendix 18: Intervention Fidelity Document 2

Complete at the end of each session:

Date:

Session number: /

Weather:

Length of session:

Number of participants present:

Activities completed during session (fitness activities, match, drills, etc.)

-
-
-
-
-
-

Was anything different during this session to other sessions or to the programme framework?

Appendix 19: Audit Trail Extract

14/03/19	Sourcing HSE Ethics for X: Email sent to Person Y to request update on request to source correspondent for ethics board in X.
15/03/19	Sourcing HSE Ethics for X: Email from Person Y stating they were recently made aware that X ethics board were not accepting new applications at this time.
15/03/19	Sourcing HSE Ethics for X: Email sent to Person Y to thank for support and information on same.
15/03/19	Site X: Email to OT in X to state X ethics board currently not accepting new applications and to thank for her support. (<i>*Unless change in circumstance, this closes attempt to utilise Sites in area X as a recruitment site*</i>)
15/03/19	Inserted reflective diary entry.
18/03/19	Site S7: Email from OT with provisional group dates – tbc by FAI. Happy to arrange meeting.
18/03/19	Site S7: email sent to OT to request appropriate days for meeting.
18/03/19	Meeting with supervisor.
18/03/19	Inserted reflective diary entry.
19/03/19	Sites S5 and S6: t/c to OT manager. They confirmed that study has been given local EMT approval to proceed.
19/03/19	Site S5: Email sent to OT to inform of local approval and request information on group meetings.
19/03/19	Site S6: Email sent to OT to inform of local approval and request information on group meetings.
19/03/19	HSE South East Ethics Approval letter arrived via post
19/03/19	HSE South East Ethics Approval letter sent to S3 OT via email
19/03/19	HSE South East Ethics Approval letter sent to S5 OT via email
19/03/19	HSE South East Ethics Approval letter sent to S6 OT via email
19/03/19	HSE South East Ethics Approval letter sent to S7 OT via email
19/03/19	Inserted reflective diary entry.
20/03/19	Site S5: Email from OT requesting next step of process and confirming dates of group block.
25/03/19	Site S6: Email from OT with potential date for meeting with group to discuss study and distributed Information Packs.
26/03/19	Site S6: Email from OT to confirming date for researcher to meet with group to discuss study and distributed Information Packs
21/03/19	Meeting with supervisor.
21/03/19	Inserted reflective diary entry.
21/03/19	Site S5: Email to OT to arrange meeting with group to discuss study and distributed Information Packs.
21/03/19	Site S5: Email from OT to confirming date for researcher to meet with group to discuss study and distributed Information Packs
26/03/19	Site S5: Met with Kickstart group to discuss study and distributed Information Packs to interested service users.
29/03/19	Met with S7 OT in person to discuss plan to speak to group about the study.
29/03/19	Inserted reflective diary entry.
02/04/19	Attended 'Engage National Men's Health Training Unit 6 – Connecting with Young Men' one day course.
02/04/19	Inserted reflective diary entry.

Appendix 20: Reflective Journal Example

This extract was originally hand-written in the researcher's reflective journal. It has been typed for the purpose of this document.

Purpose: Meeting with S3 group to provide information packs on the study.

There was a light mist when I pulled into the sports facility where S3's football group was on. I met with the OT at the entrance, where we had a short recap on what I would be discussing with the group. It was decided that I would speak to the group after their football session, to allow the session to start on time. I took this opportunity to look at the facilities available in this centre. Indoors, there was a large hall, that the session was taking part in, a gym area, a swimming pool and a kitchen area. Outdoors there was a playground, astroturf and a tennis court. I met with the group in the kitchen area. The OT explained that the group meet for tea and sandwiches after every session to socialise and relax after the football. The OT introduced me to the group, emphasised that this study was not compulsory and that they need only take the information if they are interested. I then discussed the study and provided the opportunity to ask any questions. I offered the information packs to anyone interested, which every person took. I explained I would return on the first day of their Kickstart block to complete the questionnaires with anyone interested. When it was clear there were no further questions, I thanked the group and left, so not to impose on their time socialising.