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Qualitative investigation of the role of collaborative football and walking football groups in mental health recovery

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ABSTRACT

Efforts to increase physical activity levels in people with serious mental health conditions are viewed as desirable but little is known about how best to support this group to engage in exercise over extended periods. From a personal recovery perspective, the dominant paradigm in current mental health service delivery, one promising route involves *participation with*, rather than *administration to* or *supervision of*, mental health service users in team sports, usually football, in order to foster sharing of common interests and experiences. We aimed to explore the factors underlying the success of four collaborative mental health football (soccer) projects and the role played by football in mental health care delivery and in personal recovery. We held semi-structured focus groups with service user ($n = 18$) and staff ($n = 7$) participants from four football groups (two 'walking' football and two regular football) in two geographical National Health Service Boards in Scotland. Thematic analysis revealed that, perceived *relational*, personal and physical *recovery*-related benefits; *competition and collaboration*-related aspects were important drivers of interest in and commitment to the groups. Further, participants identified *barriers to and concerns for* continued success; specifically, they expressed that they need more explicit support from senior management. The clear emerging message was that collaborative football groups were perceived by participants as a conduit for recovery and an important aspect of mental healthcare delivery. Playing football was associated with a sense of wellbeing, and enhanced relationships between service users and staff.

1. Introduction

In Scotland, 15.4% of the population are reported to have poor mental health (Ul-Haq, Mackay, Fenwick, & Pell, 2014), with conditions such as schizophrenia, and bipolar disorder each affecting up to 1% of people (Scottish Public Health Observatory, 2016). Self-report surveys in Scotland have found between 12% and 20% of the population experience symptoms of depression and/or anxiety; with those living in the most deprived areas at four times greater risk (Scottish Government, 2015). The prevalence of mental health conditions does not appear to be reducing, however more people are accessing treatment and support as awareness increases (Kings Fund, 2008). Interventions such as physical activity and peer support are considered to have a positive impact on mental health by improving community integration, and reducing feelings of stigma associated with having a mental health problem (Repper & Carter, 2011).

There are mixed findings about the benefits or otherwise of exercise and physical activity-based interventions for people with serious mental health conditions (Schuch et al., 2016). Exercise-based interventions are found to reduce symptoms of depression; improve aerobic capacity, and quality of life (Rosenbaum, Tiedemann, Sherrington, Curtis, & Ward, 2014). In psychoses, a meta-analysis has shown that, despite exercise-related

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interventions improving levels of physical activity, the effects on negative or positive symptoms of schizophrenia, anxiety and depressive symptoms, or quality of life in respect of physical and mental domains are doubtful (Pearsall, Smith, Pelosi, & Geddes, 2014).

Despite the uncertainty of potential benefits of exercise and physical activity, interventions to promote recovery from a range of mental health conditions are clearly promising and recommended by professional bodies (Royal College of Psychiatrists, 2012), and third sector organisations (Mind, 2015). In the UK, guidelines on prevention and management of psychosis and schizophrenia recommend that mental healthcare providers offer service users a physical activity programme (NICE, 2014). Likewise participation in group physical activity for mild to moderate depression is one of a suggested range of recommended options for care and treatment (NICE, 2009).

One specific type of physical activity, namely sport, has been suggested as a good option for increasing physical activity (Vancampfort et al., 2012), and is associated with personal identity, social confidence, social support, and a sense of belonging (Corretti, Martini, Greco, & Marchetti, 2011; Soundy, Kingstone, & Coffee, 2012). A systematic review of sports participation for people with schizophrenia found that sport may be associated with reduction in Body Mass Index (BMI) and reduction in psychiatric symptoms, but concluded that better studies are required (Soundy, Roskell, Stubbs, Probst, & Vancampfort, 2015a).

To date, few studies have examined the psychosocial benefits of sports participation for people with mental health conditions from their subjective perspective. A recent systematic review by Soundy et al. (2015b) identified eight studies, with only one involving football (Carter-Morris & Faulkner, 2003). The review found that participation is associated with reduced isolation, and improvements in social confidence, autonomy, and independence. According Carter-Morris and Faulkner (2003) regular participation in football also improved individuals' quality of life and emotional wellbeing. McKeown, Roy, and Spandler (2015) have highlighted reciprocity and mutual support as key outcomes of mental health football projects, in specific contrast to experiences that people may have had in mainstream mental health services. Mason and Holt (2012) examined the role of a community-based football and mental health projects; they noted it as a service with a difference, offering scope for social opportunities, self empowerment, and increased wellbeing in a safe, understanding environment. In Scotland, a national initiative to promote involvement in football as a way of tackling social exclusion, for reasons of homelessness or mental ill health, is considered to have had some success (Street Soccer Scotland, 2015). Similarly, a recent study by Brawn, Combes, and Ellis (2015) found service users participating in a football league described a greater sense of wellbeing, and perceived it to have facilitated a reconnection to community inclusion, their sporting history, and personal growth.

Some football projects appear to develop organically as a co-production between mental health service users and care workers and resonate with ideas for a potentially radically different and sustainable NHS which is co designed, co delivered, and people-powered (Nesta, 2013). There is currently a lack of evidence about how these projects operate, their similarities and differences, their prevalence in health and social care, the factors necessary for success or otherwise, or about the benefits for service users and practitioners. Additionally, there has been growing interest among mental health professionals in the value of *sports* in particular as opposed to *exercise* or *activity* in general; and, further, participation by professionals *with* service users, together with a greater willingness to disclose common interests and share experiences (McKeown et al., 2015). From this perspective, there is an increasing alignment of mental health care to the principles of personal recovery (Shanley & Jubb-Shanley, 2007); led by service users rather than professionals (Slade, Oades, & Jarden, 2017), and which promotes the development of a new sense of self in the presence *or* absence of symptoms (Anthony, 1993; Deegan, 1996). This could justify the role of collaborative sporting participation from a theoretical perspective since it could play a part in social integration, and personal recovery.

1.1. Contribution of the current study

In the current study, we collaborated with mental health practitioners and service users to design and conduct a study about the biopsychosocial benefits of football groups from the perspectives of all participants including service users and staff. The study aimed to explore the experiences of players in four collaborative football and mental health projects related to; i) the perceived benefits of participation from an individual and community perspective; ii) the key elements underlying success or otherwise of the project as defined by participants, and iii) the role played by football in both the delivery of mental health care and in the promotion of personal recovery.

2. Methods

2.1. Study design

The study was initially developed by authors 1 and 5 who have an interest in mental health practitioners working in collaboration with service users in service development. We conducted a qualitative study using focus groups as a method of gathering data about the experiences of mental health service users and practitioners in collaborative football groups. The epistemological underpinning of the study was essentialist/realist as described by Braun and Clarke (2006). In brief, research conducted from this perspective posits a relatively straightforward relationship between experience, language and meaning such that what people say is assumed to largely reflect their experience and meaning. As such, the analysis will focus on the data as emanating from within individuals and be reflective of their own motivation. This contrasts with constructionist perspectives, which assume that meaning is socially produced (Braun & Clarke, 2006; Burr, 1995). Selection of either an essentialist/realist or constructionist approach, therefore, places limits on what the researchers can reasonably say about the data. A 32 item checklist, COREQ has been used to report important aspects of the study (Tong, Sainsbury, & Craig, 2007).

2.2. Ethical considerations

The study protocol was approved by the Abertay University Research Ethics Committee and the NHS Research Ethics Committee (15/LO/1127). Permission was sought and granted from the Research and Development departments in both health boards involved.

2.3. Setting and participants

Previous research suggests that three to six focus groups are sufficient to identify the vast majority of discoverable themes in qualitative research studies (Guest, Namey, & McKenna, 2016). A purposive sample of participants were recruited from service users and staff in four football groups operating in two geographical NHS Boards in Scotland. Authors 2 and 3 co-ordinated and participated in the football groups, and acted as gatekeepers to potential participants by generating interest and discussing the study with them