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Qualitative evaluation of a football intervention for people with mental health problems in the north east of London

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ABSTRACT

In recent years, football has seen increasing popularity as an adjunct intervention for people with mental health problems, aiming at improving their physical and emotional health as well as fostering their social inclusion and integration. Previous quantitative and qualitative studies have shown that football interventions can contribute to emotional and physical recovery as well as offer a context for people to connect to others and foster social skills.

In the present study, qualitative interviews were conducted with thirty participants and five stakeholders involved in the London based football intervention, Coping Through Football (CTF). These aimed to capture their experiences of the intervention, as well as to gain an understanding of challenges and difficulties that participants have encountered there.

Themes evidenced the strong impact of relational experiences which led to increased confidence and social skills. Both physical exercise and lifestyle advice also had a positive impact on physical well-being and lifestyle choices. Different paths to recovery were reported: participants benefitted from the intervention in very individual ways that depended on personal needs and motivation. The answers to the interview questions given by the participants as well as stakeholders highlighted problems surrounding recruitment and inclusion of women, on pitch conflicts and different levels of fitness and level of play. Overall, the findings underline the potential of football interventions as an adjunct treatment form that can lead to increased physical, emotional and social well-being of people with mental health problems as well as challenges that need to be addressed in the planning and implementation of such interventions.

1. Introduction

In recent years, the treatment of people with mental health problems has seen an increase in use of adjunct interventions that not only target symptom reduction but rather try to improve quality of life, physical health, relationships and social inclusion. A noteworthy and significant area is that of exercise interventions, as they often combine physical activity with social interaction and collaboration in non-psychiatric settings. The empirical evidence for the effectiveness of exercise interventions for people with mental health problems has increased considerably since the new millennium, with studies suggesting benefits for anxiety (Anderson & Shivakumar, 2015; Jayakody, Gunadasa, & Hosker, 2013), depression (Schuch et al., 2016), and schizophrenia (Campbell & Foxcroft, 2003; Carter-Morris & Faulkner, 2003; Faulkner & Sparkes, 1999). Importantly, these interventions also offer physical health benefits that are of particular concern in this usually under-treated population, for whom exercise is often notable by its absence. Cardiovascular functions can be impaired in people with mental health problems (see for example Batelaan, Seldenrijk, Bot, Van Balkom, & Penninx, 2016; Scott et al., 2016) which is a reason to include treatment components that target physical health problems in patients with depression and schizophrenia for example as part of their recovery (Osborn, 2001).

Social isolation is another common problem (see Brophy & Harvey, 2011; Wang et al., 2017) adding to stress and anxiety and thereby also contributing to early mortality (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). A number of studies have supported the potential of football to tackle isolation and loneliness (for an overview see Corretti, Martini, Greco, & Marchetti, 2011; Wang et al., 2017).

Of activity and exercise interventions, those based on football are a relatively recent area to receive evaluation (Battaglia et al., 2013; Friedrich & Mason, 2017). Some have argued football is particularly

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well-placed to increase social connectedness and inclusion (Darongkamas, Scott, & Taylor, 2011; Mynard, Howie, & Collister, 2009) as well as to foster confidence and feeling of empowerment in participants (Mason & Holt, 2012; McElroy, Evans, & Pringle, 2008). The psychosocial benefits of football, especially as regards inclusion, are not surprising as this sport has arguably a unique status, whose popularity stretches across a wide range of socio-economic and ethnic groups.

Oja et al. (2015) have compared different sport disciplines and their respective health benefits in a systematic review and concluded that football is particularly suitable to address cardio-vascular functions, which makes it an interesting candidate to help tackling some of the physical health problems mentioned above in people with mental health problems (see also Krustrup et al., 2013; Krustrup et al., 2014; Schmidt et al., 2013). Poor mental health is often associated with weight problems (Dickerson et al., 2006; Pratt & Brody, 2014) which in return can lead to cardio-vascular dysfunction as well as other physical health problems such as diabetes. Some studies have also shown that football is effective in helping tackling weight issues (Gray et al., 2013; Hunt et al., 2014). While these findings generally favour football interventions as a way of fostering health and well-being in people with mental health problems, there is a strong need for systematic evaluations of interventions if wider implementation is to occur (Pringle, 2009).

In a recent review Friedrich and Mason (2017) outlined the empirical evidence for the effectiveness of football interventions for people with mental health problems. Despite a wide variety of target groups, aims and measures, the range of outcomes are encouraging. Qualitative evidence repeatedly suggests increased social skills, confidence and feelings of empowerment. Since this review Lamont, Harris, McDonald, Kerin, and Dickens (2017) have reported strong psychosocial benefits of football interventions in a Scottish mental health context.

Two previous studies have reported on the London based “Coping Through Football” (CTF) intervention, a project that aims to improve mental, physical and social health in people with severe and enduring mental health problems. CTF was established in 2007 in a collaboration between London Playing Fields Foundation, NELFT (the local NHS Trust) and Leyton Orient Community Trust. Recent quantitative evaluation of the project (Friedrich & Mason, 2017b) found an increase in vigorous and moderate physical activity in participants, as well as self-reported quality of life and self-esteem in the short term follow up. Furthermore, Friedrich and Mason (2018) used the categories from Seligman's PERMA model (Seligman, 2011) to carry out a content analysis model on the CTF participants' self-reported life improvements – these short statements were collected as part of the regular (semi-annual) assessment of the participants by the Occupational Therapists. The results showed that participants reported experiencing positive emotions, feeling engaged, having positive relationship experiences, and a sense of achievements as a result of participating in the intervention. Prior to 2012 the project operated in one London borough, in this context Mason and Holt (2012) interviewed a small number of participants, coaches and referrers and outlined a range of personal and social benefits. Since that time, the project has expanded to cover four London boroughs and operate at other geographical sites on a larger scale. In order to understand the mechanisms of the interventions better and to triangulate with recent quantitative data, a further qualitative study of the participants' and stakeholders' experiences was carried out seven years after the first, and thus with an entirely different constituency.

2. Methods

2.1. Study design

We conducted face-to-face interviews with 30 participants and five stakeholders to gain a deeper understanding of their expectations and experiences of the intervention. Research design and the approach of the analysis were planned in accordance to the decision-making process suggested by Braun and Clarke (2006).

The analysis was inductive, rather than theoretical, as no particular theoretical lens was taken through which to approach the study. Furthermore, we were interested in the semantic themes that arose directly from the narratives of the interviewees, rather than trying to discover latent themes. We used an essentialist/realist method which ‘reports experiences, meanings and the reality of participants’ (Braun & Clarke, 2006, p. 81) in contrast to constructivist approaches which interpret participants' statements as expressions of societal discourse. While studies of similar projects provided a general framework to our approach, we aimed to stay as close as possible to the participants' narratives and ‘bracket off’ any prior knowledge and expectations based on the literature. We received ethical approval through the NHS Research Ethics Committee in respect of interviews with patients, and additionally from within University College London in respect of the interviews with non-patient stakeholders.

2.2. Setting and participants

2.2.1. Interviews

The intervention is delivered at three community sport venues, and recruitment drew from all three. Two sites are located in Waltham Forest and one in Redbridge – areas of considerable cultural, social and economic diversity within the north east of London. Thirty participants were interviewed at the training locations, mainly before and occasionally during the training. All participants were recruited and consented by an Occupational Therapist working on the project. Also, five stakeholders were interviewed (see below for more details).

Care was taken to ensure that there is a variety in the sample with regard to age, diagnosis, gender, length of participation, severity of symptoms and degree of functioning, to safeguard a variety of points of views and contribute to the breadth of data. While the original plan was to also interview participants who had already left the project, this proved not to be possible. The interviewer visited training and social events (like tournaments) at several occasions before starting to conduct the interviews so became familiar with the project.

Each session lasts 90 min and starts with a warming up followed by 5-a-side games. The sessions are facilitated by both a trained NHS mental health practitioner and coaches from the football club, access to facilities is via both the football club and the London Playing Fields Foundation. The latter also provides infrastructure support, obtains funding, and reports routinely on the project to the funders. Participants' physical and mental health is monitored regularly by trained mental health staff (at the start date and semi-annually thereafter when possible). Furthermore, finding exit routes such as new employment, volunteering opportunities or participation in training courses as well as general recovery are discussed between staff and participants.

2.3. Data collection

Interviews were chosen instead of focus groups for two reasons: Firstly, as mental health related recovery is a very personal process, it was felt more appropriate to collect the qualitative data in a private one-to-one meeting rather than in a group setting. The hope was that the participants would feel encouraged to be open and feel comfortable to share their personal experiences and to also mention negative experiences and/or possible dissatisfaction with the project. Secondly, as group discussion can lead to more extroverted/assertive study participants to dominate the floor, we wanted to make sure that each and every participant was given an equal chance to express their views and experiences and have enough time to do so as necessary: this was particularly important as some participants experience learning difficulties.

Participants were contacted by one of the NHS staff involved in their care and asked whether they would like to participate in this evaluation study. If they agreed, participants were handed an information sheet and a consent form which was read out aloud to them with the opportunity for any further clarification. Participants were informed that participation was entirely voluntary and could be ended at any point without detriment to their care or in any other way. Furthermore, confidentiality was assured and that any citation of their statements would be anonymised and could not be tracked back to them. In addition to this it was explained to the potential interviewees that their participation would not impact in any form on the treatment they receive. In order to take part in the study, participants gave signed consent to NHS staff, including for interview recording. Interviews were conducted one-to-one in a personal, confidential setting in a closed office space to guarantee privacy and confidentiality during the interviews. These lasted between 16 and 40 min. Participants received a gift voucher (value £20) as recompense for their time and effort, and to cover any travel costs.

Before the start of the interview, the interviewer (first author) reiterated the purpose of the study, her independence from the facilitators, and anonymity of all stored data. Participants were asked to inform the interviewer if they became distressed or upset during the interview. In only one instance did a participant do so; reporting the presence of 'voices that acknowledge what is being said'. The participant felt comfortable to complete the interview as, according to them, the voices were not interfering just 'acknowledging the presence of the interviewer'.

Five stakeholders were also interviewed: one occupational therapist who coordinates the project, one football coach, two NHS mental health referrers, and the peer support worker. The peer support worker also assisted with three stakeholder interviews. The purpose of the study and the overall evaluation was briefly explained to the stakeholder at the beginning of the interviews and informed consent was taken, including that for recording. Interviews lasted between 45 and 60 min and provided an open opportunity to discuss any issues felt pertinent to interviewees. The peer researcher helped choose questions for the topic guide and jointly conducted three of the five interviews by asking the questions that were included in the topic guide as well as follow up questions. His input as a former participant was very helpful as he had more awareness of the intervention in detail and could raise issues appropriately with stakeholders. This familiarity with the intervention and his informal interview style helped stakeholders to open up and cover relevant topics and issues. The interview with the peer researcher was the final interview so gave them an also opportunity to reflect on and discuss the other completed stakeholder interviews.

2.3.1. Explanation interview schedule

Semi-structured topic guides were developed collaboratively with a range of stakeholders and continued to develop during the course of the interviews. General information was obtained as to age, ethnicity, gender, physical health, current participation, employment status, voluntary work and other activities. The interviewer then inquired about their understanding of the aims of CTF, different areas of outcomes (improvement of physical and mental health, feeling connected), changes in lifestyle, challenges/areas of improvement, relative importance (whether CTF is the main trigger of change in their lives), whether participants perceived that CTF has helped them (or could help them in the future) in finding new opportunities for employment and volunteering. At the end of the interview participants were given the chance to state what they would like to see done differently in any way. In conclusion, the participants were given the opportunity to bring up anything that had not been mentioned so far. For the stakeholder interviews, the topic guide was adapted to accommodate for the information these interviewees could provide given their role in the interventions.

2.4. Data analysis

Initially, interviews were read thoroughly by the first author noting general themes following the theory of Braun and Clarke (2006) for thematic analysis. Subsequently data codes were derived from further systematic readings that were then organised into a coding system. The codes were then shared with the second author for cross-checking, and the coding system further revised in discussion. The codes were then checked again by both authors against this system, and themes and subthemes identified. These were reviewed and revised by both authors to makes sure they cover the range of all participants' experiences in a meaningful way. Stakeholder interviews were started after the first round of analysis of participants' interviews was finished enabling themes to be explicitly raised with stakeholders for further discussion.

3. Results

The ethnic diversity of the thirty participants is considerable and representative of the mixed ethnic makeup of the group: seven are white British, six are black Caribbean, five black African, five mixed race, three Asian Indian, and three Asian Pakistani. The age ranged from 20 years to 56 years, with an average of 34 years (SD = 10.4 years). Two of the interviewed participants were female. This was slightly below the ratio of women in the project, however others did not wish to take part. All participants were still attending the scheme at the time of the interview, with one participant not being currently able to play due to physical health problems – he joined the meetings nevertheless in order to enjoy the company of the other participants. When asked about their general physical health, twenty participants said they had no acute physical health problems, eight participants reported mild issues and only two indicated that they currently felt in bad health. The range for the time participants had been part of CTF prior to interview ranged from 1 month to 10 years. The mean length of participation was around 2 ½ years. Out of the thirty participants, only two had regular, paid employment and seven participants were doing volunteering work. Based on clinical case-notes, twenty participants had a psychotic disorder, eight had one or more emotional disorders, and two participants had a neurodevelopmental disorder.

We identified three major themes, some with several sub-themes: *What I get from the intervention*, *Personal Changes*, and *Wider Connections*.

3.1. 'What I get from the intervention'

This theme captures features of the intervention that participants reported as personally significant and had four sub-themes; (1) Relationships, (2) Something to do, (3) Getting exercise at CTF, (4) Love of football and (5) Lifestyle advice. While there was considerable heterogeneity, most of these themes were endorsed by a majority of participants.

3.1.1. Relationships

Most participants reported that building relationships with other participants and the experience of feeling part of a group were key features improving their well-being.

> "I love coming here […] we have a lot of banter…which I think is important. You've got, you've got to be able to… You've got to feel relaxed in your environment and here I think most of us are relaxed from my view anyway, the ones that I talk to…I mean we enjoy each other's company which is a good thing." (P21). For many participants, the special bonding experience was influenced by that fact that they shared lived experience: "I am like them. I feel like we are in the same boat." (P23) The importance of peer relationships was also highlighted by the coordinator: "And their peers are telling them, you know, you're okay, you're doing well, um, and… you know, so their confidence will increase" (Coordinator).

Some participants reported not feeling the need to make friends at the intervention as they already felt well connected in their own circle of friends. Some participants mentioned finding it hard to connect with others and there were frequent reports of participants feeling distressed by conflicts that erupted between other participants on the pitch.

A number of participants reported feeling distressed by conflicts on the pitch which is a topic that was also addressed by a stakeholder: *" I have entertained these angry people for far longer than I should have. It was a learning curve for myself in that I thought that these people were angry. If you take them off to one side, talk to them or get… talk to them at length, remind them of what the group is, um, and get them to be looking at, you know, what's going on, what are you fussing about, what's the problem, um, and then they can go back and join the group, and then, yeah, they're, they're calm… calmer"*

Another issue that kept coming up was the integration of women which seemed to be problematic, as both females expressed a certain degree of discomfort: *"… with coping through football here I don't feel that I'm given a chance in one way because people don't…Mainly the men but there's hardly any girls playing anyway, they don't really pass me the ball."* (P8; female)

3.1.2. 'Something to do' (P11)

Another major aspect was the fact that people were given an opportunity to get out of the house and engage in a meaningful activity that can help structure their day which was particularly important for those participants who had no other regular activities:

> "Um, it's [CTF] given me like a routine as well…which is good like because when I get better and I start work or have a routine, so now like I go to bed at this time, wake up at this time, so I'm setting myself a routine. It has helped me plan my days and stuff." (P28)

Furthermore the coordinator pointed out that getting out of the house and overcoming the anxiety of meeting others was a core aspect of the healing process for some participants with severe mental health issues: *"… due to their mental health issues, they've been scared to come out of the house and very insecure in themselves, ….it's a… an effort for them just to even get there, um, and be around all these people*" (Coordinator).

3.1.3. Getting exercise

Participants indicated that they found engaging in exercise at CTF very beneficial to their well-being and they enjoyed experiencing an improvement in their physical health, fitness and ability at football.

> "*I was starting to get fitter and I was actually starting to get a better touch on the ball as well …*" (P17)

The coach felt that assessing the fitness of the participants and increasing it according to their potential was one of his main aims: "*So I get the guys working, see their ability, see their level, see their health, you know, um, push them as far as you can, ah, within reason so they're going to get benefit, ah, but make sure they enjoy it."* Some participants mentioned that they were struggling at the beginning to keep up with the level of exercise required in the game whereas those who also engage in sports activities outside of CTF found it very easy.

A number of participants were already engaging in physical activity in other sports club when joining the intervention - these participants did not report that CTF had a significant impact on their fitness as they already had good stamina according to their reports.

3.1.4. Love of football

The playing of football was described by many as a positive and enjoyable experience which seemed rewarding in itself.

> *"It makes me feel, um… like, people on the pitch what play football are mad about football; not mad in the head, I'm talking about they love football so much, it's, like… it's, it's, like, a man's dream, basically, playing football, and they look… I think they all want to be professional and it's good… it's good, cuz you get to be a footballer and you play football…Every boy and every man loves football; it's their dream, isn't it, so …"* (P14)

Referrers stressed that football offered a challenge that participants valued at whatever level a player could play at: "You know, we're not asking only David Beckham to apply for the project [laughter]. You know, it's… it's not about being good at football it's about, you know, giving yourself a .. challenge …hat you …might benefit from …" (Referrer)

However, a number of participants reported struggling to keep up with the level of play and worrying whether they are good enough. Others, however, expressed the wish that the game was on a more competitive level as they felt under-challenged.

3.1.5. Getting healthy living advice

Many of the participants' commented on the impact of the advice and support received on the topic of healthy living, in particular with regard to diet and weight management.

> *"… [the coordinator] gave me some advice about trying to lose weight which I asked about and you know that was to try eating a bit more because before I was only eating like once a day which clearly isn't good enough."* (P21)

The advice provided by a professional doctor from a football club made this particularly interesting for the participants: "… because of Coping Through Football, …I came to know so many new things, …so proper professional doctor who is working with the [football] club… came to us and… … he told us the different diets…so I never knew these things." (P15)

3.2. Personal changes

This theme describes changes experienced throughout the course of the participation in areas of (1) Emotional well-being; (2) Confidence and social skills; (3) Changes in life style and physical health; and (4) New life skills.

3.2.1. Emotional well-being

"*Yes, it [CTF] makes me… it makes me happy*." (P4)

For many, the enjoyment gained from participation stemmed mainly from the positive relationship experiences noted in the previous theme. Some stated the benefits in symptomatic terms:

> *"it's helping me a lot with my depression now. I feel it's not let me…I mean I know that trauma is never, it's never going to go. It just helps me with that…It helps my wellbeing in that I engage with more people …. When here, when doing this, I don't feel alone, I don't feel like I am a bad person, like I am the worst person in the world. Here I don't think anyone really judges me for that."* (P21)

Participants found contact with the other participants contributed to their well-being and helped them cope with mental ill-health:

> "*I was really negative… I had negative er thoughts. And then when I came… When I started to make friends and I felt I wasn't excluded but included with life. It was like a family we were all together.*" (P 23)

Some however reflected on the potential stigma of associating with a 'mental health' project and the peer support worker reflected on this potential dilemma: *"… it's a quite hard one really, but, um, they shouldn't be ashamed of having a mental health problem, from my point of view …, I agree, uh, however, I kind of get the point that they don't want in their spare time to be reminded …. But there's no, no shame in having a mental health problem".*

3.2.2. Confidence/social skills

Participants reported greater confidence and an increased belief in

own skills.

> "*It's helped feel more confident in myself and, like, helped me to interact with people easier*." (P3).

Positive feedback was seen as crucial by some: "there's still a long way to go before I could say that I am confident, but I would say I've improved, yea…Um, well, just, when people, sort of, give you praise for how you're playing, that helps you…well, it, it generally gives you a boost …" (P15)

For others, it was social interaction that led to improved social skills and an increase in confidence: "When I first started, I wasn't confident at all, and now I'm very confident… Because I've been more comfortable with people there, receiving advice from people .. or staff, being accepted in the group." (P12)

For some, new-found confidence was also transferrable to other social situations:

> "It's helped feel more confident in myself and, like, helped me to interact with people easier …, yeah, like… when I'm getting served in shops, I feel more confident to speak and that." (P3).

These improvements were echoed by almost all other stakeholders. Several participants mentioned that CTF did not increase their confidence as they already felt very empowered and self-confident when joining the intervention.

3.2.3. Changes in lifestyle and physical health

Some participants reported making changes to their lifestyle: "I don't drink so much fizzy drinks no more, cut down on takeaways" (P14). One referrer felt CTF was particularly useful for weight loss: "*I've got a few of my clients who are, um, overweight and, um, they experience tiredness all the time and so as soon as they say that, I say: right, okay, maybe you need to do some sort of activity, …how about 'Coping Through Football?'*" (Referrer).

Often, the ability to contribute to the game was the main motivation to change the lifestyle

> "Yeah, yeah, because I need to be more, you know, active and more strong and more powerful, that people couldn't, ah, criticise me when I play …" (P15)

Football seemed to serve as a trigger for some to make wider changes to their lifestyles:

> "The physical is alright, um, because, um I'm playing football, I go for a walk when I go home, I do exercises before I go to bed so it's really helpful, the football side of it is helpful because it's only two hours, you know, it's very helpful to me… Yah-yah, it helped to, you know, for, for motivation…And I exercise, I exercise more too and I go for a walk, I'm trying to walk twice a week." (P6)

3.2.4. New life skills

Some participants mentioned having acquired additional life skills such as equipping them to support other people in emotional crisis, as well as plan and manage their time. In the view of the coach, developing/fostering these skills around discipline and punctuality are essential for participation: *"there's still some disciplines so what we'll do [at CTF], you know, you need to be here on time, so you've got to learn […] punctuality.*" (Coach)

> " …. to be, like, on time for things and that ….um, like, this morning, I, I knew I had to get up at, like, ten at the latest, so, so I got up at ten and had my shower, got ready for football, sorted all me kit out, and, and it was about 12:30, and then [name] called me and, yeah, and then, then I just got here" (P3)

The development of skills in how to help people who are less well than themselves is an essential part of the peer support system according to the coordinator: "Those further along in the recovery journey are… well, they'll see who needs a bit of encouragement, um, and they will encourage them, tell them, 'well done'." This point was backed up by P17: "It helps me in dealing with other mental, mentally ill people. If, if … had a breakdown in front of me, before I wouldn't have known what to do, but I actually got a, a better idea as to how to handle that kind of thing."

3.3. Wider connections

This theme encompasses a wide range of connections made through the scheme, both within it and, in some few cases, beyond it. A minority of participants found opportunities in employment and education as a result of attending the intervention: most who found exit routes did so through a wide range of other services. One particular opportunity provided by the intervention was to take Football Association level 1 and 2 coaching courses: "*… they've, ah, arranged for me to go on a coaching course, so, you know, if… it's, like, a backup plan: if I can't play, then I'd like to coach football…So, um, they've helped with that, Coping Through Football. The coaches let me coach a few sessions, um, and they've encouraged me in it.*" (P12). This had also led to ongoing coaching opportunities for the peer support worker at a local school, as well as with the scheme itself.

Participants highlighted a sense of feeling connected and valued as a result of participating and the relationships they developed. Critically, they felt connected to and part of a group with a '*family atmosphere*' (P22) with benefits in the wider world. It motivated many to confront their isolation and contribute more widely both at the scheme in other areas of their lives.

> "Coping Through Football has in a way sort of changed me as well and ah I've become more like open … make me more like feel better as a person and ah being a good friend to other people in Coping Through Football." (P5)

> "When I was at the…volunteering place…I did find it easier to talk to people. Because I started meeting people here and I overcame that challenge of coming out of my shell and meeting new people." (P28)

4. Discussion

The outcomes of our study triangulate findings of the recent quantitative evaluation (Friedrich & Mason, 2017) that showed that many participants report increased physical activity, increased perceived quality of life and self-esteem – results that were also reported here. Furthermore, a content analysis of statements on perceived life improvements (Friedrich & Mason, 2018) for which Seligman's PERMA model was applied (Seligman, 2011) had shown that the intervention triggered changes with regard to emotional well-being, engagement, relationships, and sense of achievement; all these aspects were also reflected in the outcomes of this qualitative evaluation. The findings also seem to align with those of other similar evaluations. In a recent study for example Lamont et al. (2017) similarly identified themes reflecting "perceived relational, personal and physical recovery-related benefits" (p. 116). Findings here add to a developing consensus that there is a range of benefits from football interventions that go beyond physical improvements to include well-being on an emotional and social level. Lamont et al. (2017) also highlighted the importance of staff members' role in supporting the recovery process and addressing relational needs. Similarly, the themes identified by Darongkamas et al. (2011) (social inclusion, changes in attitude and behaviour, enjoyment and importance of the club, changes to mental health, and self-confidence) could be found in this study and confirm the broad spectrum of potential benefits of football interventions. One important finding in this study was that most participants felt more confident and encouraged to interact with others as an outcome of their participation – similar to observations of participants as well as carers and family

members in an Irish context regarding feeling more socially proactive and confident (OKane and McKenna., 2002). McElroy et al. (2008) similarly found that participants reported developing new coping mechanisms and reduced anxiety. Overall, outcomes here support those of other qualitative studies into the effectiveness of football interventions for people with mental health problems.

There were several issues that participants found challenging: The range of football skills and levels of fitness led to some feeling underchallenged and others somewhat intimidated by the game. Furthermore, there were on-pitch disputes and gender issues.

The results shed an interesting light on how recovery operated in a range of different ways for different individuals. Themes and codes broadly fell into socio-emotional processes related to recovery, or aspects of physical health and fitness; though these are certainly interlinked for some participants. As an example, 'Love of football' seemed to serve both physical health and fitness (through the actual playing) as well as social and emotional processes (through shared enjoyment of the game). Furthermore, some participants gained confidence and social skills through both positive relationship experiences as well as their love of playing the game. Lifestyle improvements (such as exercise, dieting, weight loss) were partly triggered by the lifestyle advice participants received; by the exercise; as well as by their love of football (as they wanted to keep fit and healthy to take part in the game). Wellbeing was consequently influenced by these social improvements (social skills and confidence), as well as by physical health improvements (fitness, lifestyle). The results support a diversity of routes to recovery that is entirely consistent with the conclusion of the most widely cited review of physical activity interventions to date: 'Thus physical activity interventions are a critical component of a biopsychosocial approach in recovery-oriented mental health services' (Richardson et al., 2005, p. 329). Individuals may benefit from physical activity interventions in a multiplicity of ways that are not well accounted for my traditional behaviour change models (Rebar & Taylor, 2017).

4.1. Study strengths and limitations

The sample size and depth enabled a good level of data saturation and there was a strong overlap between participants' and stakeholders' understanding of the aims and the effectiveness of the intervention. The sample was very diverse in age, gender, mental health, physical health status, cognitive functioning and football abilities, all of which are relevant to their experience. However, despite efforts to recruit former participants and learn about their reasons of leaving, this could not be achieved for a variety of reasons. While social desirability and the tendency to focus on positive feedback can always be an issue in responses given in qualitative interviews, problems with the interventions did come up and there was a strong overlap in what aspects some participants found problematic, so it is likely that the most pressing and common issues regarding this intervention were reported in these interviews.

An important area deserving of remark is the role of gender commented on by the participants and stakeholders who shared their concerns regarding inclusion of women in the group or activity. Referrers felt that ideal solutions might be a greater representation of women and/or a separate scheme. These comments resonate with the issues raised by Spandler and McKeown (2012) concerning machismo in football, and how using sport as a way to improve health can create "paradoxical spaces" in the sense that while supposed to enable inclusivity there is an ever-present risk of reinforcing gender stereotypes as identified by both women interviewed. Therefore it might be worth developing and evaluating interventions for women only and investigating whether the experiences of participants of such interventions would be markedly different from those of women who attend mixed groups.

5. Conclusions

In this study, we interviewed participants and stakeholders to gain better understanding of how the intervention impacts on participants' well-being, and to learn of problems and challenges they might have encountered. Participants reported having gained a range of benefits from participating in the intervention, in areas such a physical health (fitness, weight management, increased exercise) to mental health benefits (symptom reduction, increased self-confidence, decrease of anxiety) – furthermore they reported having gained a sense of belonging and inclusion and many participants stated that they now found it easier to engage with others which helped in some cases to tackle issues of isolation. Main problems centred around the inclusion of women; differences in physical fitness and ability; and arguments on the pitch which caused some distress.

This paper highlights how the outcomes in different areas and themes (confidence, skills, relationships, ability to provide peer support for others) are interlinked and how individual the pathway of recovery as well as the challenges are different for different participants, reflecting individual needs and approaches. This emphasise the importance of using a person-centred approach to these interventions to optimise outcomes and adequately deal with problems encountered by the participants.

Our study has shown very similar outcomes to comparable research projects on football interventions for people with mental health problems. The empirical evidence highlights the potential of football interventions as adjunct treatment form for people with mental health problems to foster emotional, physical and social well-being but also the importance of addressing the problems that can arise in such an intervention.

Conflicts of interest

The authors have no conflict of interest to declare.

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