‘Think Football’: Exploring a Football for Mental Health Initiative Delivered in the Community through the Lens of Personal and Social Recovery.

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Abstract

The practice and discourse of mental health recovery is evolving, with increasing appreciation given to personal recovery and now social recovery. It therefore follows that we need initiatives that enhance levels of social capital, positive social identities and social inclusion within the community, not just within mental health services. These initiatives must bring people together in ways that allow them to feel that they have ownership of any new social infrastructures and use evidence-based frameworks to evaluate them. One context that has been given some consideration is the use of community sport. This paper therefore contributes to the steadily growing literature in this area by exploring the specifics of a community mental health football project, through the utilisation of the personal and social recovery frameworks that have been established within the 'mainstream' mental health evidence base. This relativist study utilised seventeen semi-structured interviews (with participants and staff) and, as a deliberate departure from existing research, chose to adopt a deductive, theoretical approach to the analysis that located the data within the personal recovery and social recovery literature. Both participants and staff were considerably positive about the sessions, and data suggested an adherence to the empirically based CHIME personal recovery framework. In terms of alignment with the social recovery concepts, the data was particularly robust in supporting active citizenship processes, which can increase levels of social capital and enhance social identities. Future work is required to further explore the contextual impact of poverty and employment, and the role that sport can potentially play.

Keywords: Personal Recovery; Social Recovery; Mental Health; Football; CHIME

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Personal recovery has an emerging prioritisation in western mental health services (Wallace et al., 2016), however, there is limited literature to support the filtering down of this focus into community contexts. Whilst there are numerous different interpretations of what personal recovery might mean, Anthony’s (1993) definition is most frequently cited, which outlines how it is “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness” (p.527). Personal recovery can be seen as a subjectively viewed and valued process (Borg & Davidson, 2008; Slade, 2009), which accepts that each individual’s experience is different and that there is no blueprint for recovery (Perkins & Slade, 2012), an approach that is gaining increased support (Watson, 2012). One issue of personal recovery is the degree of conceptual confusion or misunderstanding (Davidson & Roe, 2007) and also how it lacks an evidence base (Davidson et al., 2006). In response to these claims, there has been a body of work from Mike Slade and colleagues (the REFOCUS programme, see Bird et al., 2014; Slade et al., 2011; Wallace et al., 2016) that has aimed to address this. Their work includes the development and ‘validation’ of the empirically-based CHIME conceptual framework for personal recovery that comprises five recovery processes, namely Connectedness, Hope and optimism, Identity, Meaning and purpose, and Empowerment (Leamy et al., 2011). The implementation of this framework is gaining traction in varying contexts (e.g., Brijnath, 2015), although critics have claimed that the CHIME framework tends towards the positive or optimistic (Connell et al., 2014) and does not always encompass the difficulties faced by many (Stuart, Tansey & Quayle, 2016). The framework and subsequent critique have contributed to moving the

broader recovery discourse forwards, which has in recent years led to more attention being given to social recovery.

Ramon (2018) made the case to look at social recovery consistently alongside personal recovery. Existing literature suggests that there is not a specific definition of social recovery, instead that it reflects that health services, policy makers and practitioners must look beyond the person, and appreciate issues of social justice and social inclusion (Davidson et al., 2009), as well as considering how the recovery processes can be supported in communities and facilitate social relationships (Fenton et al., 2017). Personal and social recovery can be viewed as being interconnected and overlap in many ways, but to distinguish between them it is useful to consider social recovery as being an even more distinct departure from the clinical (or medical) model of recovery (than personal recovery). Whilst personal recovery still focuses somewhat on the individual and might not fully encourage an appreciation of the social context, the concept of social recovery aims to consider the social barriers or challenges that are limiting someone's recovery or negatively impacting upon their health (Ramon et al, 2007). This thinking has been influenced by the broader social model for disability (Repper & Perkins, 2003). As Tew et al. (2012) outlined, there is substantial evidence that demonstrates the importance of social factors in contributing to the incidence of mental health *difficulties*, but there is less emphasis on "how social factors may also play a central role in people's *recovery*" (p.444). Evidence suggests that both 'social' and 'clinical' recovery rates correlate much more closely with socio-economic factors (Tew et al., 2012), such as social class inequalities (Wilkinson & Pickett, 2018), employment rates (Burns et al., 2009) or cultural contexts (Clarke et al., 2016; Smith et al., 2016), than they do with any advances in medical treatment (Warner, 2004). In line with the personal recovery focus, social recovery is about "rebuilding a worthwhile life, irrespective of whether or not one may continue to have particular distress experiences – and central to this can be reclaiming valued

social roles and a positive self-identity" (Tew et al., 2012., p.444). Furthermore, Ramon (2018) highlighted the importance for people to lead "meaningful and contributing lives as *active citizens* while experiencing mental ill health" (p.1), which exemplifies going beyond the personal focus. Ramon's (2018) model for social recovery specifically highlights the key areas for consideration as being: Shared decision making, Co-production and Active citizenship; Employment; Living in poverty; the Economic case for recovery, and the Scientific evidence for the recovery model. Consideration of these social recovery elements can potentially compliment the personal recovery CHIME framework, and help to address some of the criticisms that Leamy et al.'s (2011) framework is overly positive and lacks appreciation of the difficulties (Stuart et al., 2016), many of which might be due to a person's idiosyncratic social context.

It therefore follows that we need initiatives to enhance levels of social capital, positive social identities and social inclusion within the community (not just within mental health services) as a whole. These initiatives must bring people together in ways that allow them to feel that they have ownership of any new social infrastructures and use evidence-based frameworks to evaluate them (for instance, the CHIME framework and the social recovery model), or as Tew et al., (2012) suggested, we need to continue to explore 'what works?' (p.455). One specific area that might 'work', which is gaining momentum, is sport and physical activity, especially football.

Enhancing Mental Health Through Sport

Whilst various policies in the UK are, gradually, focusing more on the potential benefits of community sport to enhance mental health and wellbeing (terms often used interchangeably), Smith et al. (2016) highlighted the ongoing confusion in policies between sport, physical activity (PA) and exercise. For example, the UK's Department of Health's (2015) 'Future in Mind' policy specifically highlighted the scope available for general

practitioners and other professionals to offer social prescribing of activities such as sport (but does not mention exercise or physical activity) to improve wellbeing and mental health. The Government's (2015) 'Sporting Future' strategy places emphasis on mental wellbeing within the nation's sporting agenda, and Sport England's (2016) 'Towards an Active Nation' attempted to outline how key performance indicators would be evaluated and met in regards to sport for the government's priorities, including mental health and/or wellbeing. However, the existing evidence-base for these policies is predominantly based on PA or exercise, not for sport, which is significant, due to sport differing from PA and exercise in a range of ways. A key difference is the competitive and organised nature of sport that necessitates interaction with other people in a number of different ways (Carless & Douglas, 2008), as opposed to PA or exercise that is often (but certainly not always) undertaken as a lone activity (for a more robust analysis, see Smith et al., 2016). Therefore, before bold policy statements relating to the relationship between sport and mental health are made, and outcomes are potentially 'measured', the evidence base that recognises the nuanced complexity of different sports in different contexts needs to be developed and appreciated. Furthermore, much of the evidence focuses on how PA and exercise may "alleviate symptoms, impairment, and dysfunction rather than its potential to contribute meaning, purpose, success, and satisfaction to a person's life" (Carless & Douglas, 2008, p.140). Exploring the potential of sport and how it could contribute to a person's life more broadly would not only help to inform evidence-based practice, it also aligns well with the personal (Leamy et al., 2011; Watson, 2012) and social (Ramon, 2018; Tew et al., 2012) recovery approaches.

Football (or soccer) is the sport that has received the most attention in terms of being used to enhance mental health in the UK, which is perhaps due to it being the most popular sport (The FA, 2015; Sport England, 2018). Friedrich and Mason's (2017a) review found there to be sixteen football for mental health (or similar) studies published (the majority

conducted in England, with two in Scotland and one in Australia), with a key finding from the review being that the projects investigated were very different in a number of ways (for instance, target audience, form, frequency, cultural context, clinical staff involvement, type of location). This further demonstrates the idiosyncratic and complex cultural manifestations of sport in a mental health context, as assuming that projects delivered in a football club setting (e.g. Henderson et al., 2014) are synonymous with projects delivered in mental health service settings (e.g. Lamont et al., 2017) would be problematic. Friedrich and Mason (2017a) therefore declared that it is vital to have more specific, empirical studies to continue to inform the evidence-base and 'make the case' to policy makers and funders that football (or sport) may have the potential to be beneficial, but as Smith et al. (2016) have cautioned there needs to be due consideration to complexity and context. A clear theme across Friedrich and Mason's (2017a) review was that the cultural nature and popularity of football was providing a 'hook' to engage groups of participants, and the review and a further study by (Friedrich and Mason, 2018) viewed there to be "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" (p.136). It does remain prudent, however, to consider that the 'hook' of football (or sport more generally) may well privilege some groups over others, for instance, Spandler and McKeown (2012) highlighted the difficulties relating to gender and masculinities within a football for mental health project. It still remains heartening that studies have found benefits from football for mental health projects, which include: helping to open up about health concerns (McKeown et al., 2015; Spandler et al., 2013), tackling stigma (Magee et al., 2015), helping people to (re)discover their identity (Brawn et al., 2015) and recover personal and social roles (Mason & Holt, 2012), often engaging those 'hardest to reach' who are most at risk (Lewis et al., 2017; Spandler & McKeown, 2012). There is also growing evidence that physical activity levels increase through involvement in these types of

projects (Friedrich & Mason, 2017b), although it is not clear if this increase is sustained beyond the project. However, the literature remains sparse rather than extensive and compelling, as the varied contexts, project approaches and types of participants, combined with established conceptual or theoretical frameworks (or lack thereof), are not always reflected in existing published studies. This paper therefore aims to contribute to the steadily growing literature in this area by exploring the specifics of a community mental health football project, through the utilisation of the personal and social recovery frameworks that have been established within 'mainstream' mental health evidence. The rationale for this, in line with Friedrich and Mason's (2017a) call to move beyond the current inductive studies that find similar themes, and instead to add some coherence and robustness to the analysis by locating this work within the broader health service literature in order to add to the evidence-base and contribute to making a strong case to policy makers and funders for any future projects, given that initial findings in this area appear positive.

Collaborative Partnership Working in Practice

In order to align with Friedrich and Mason's (2017a) review, so comparisons can be made with other projects when required, this section outlines the key components of the Think Football project in a similar fashion.

Project name and description: The project was called 'Think Football', and was advertised as being for 'personal and mental wellbeing', and was initially a thirteen-month pilot project beginning in March 2017, which has since been extended beyond the pilot phase. The project was a collaboration between Aston Villa FC Foundation, and Birmingham MIND, and was part-funded by Sport Birmingham, BT Sport and the Premier League, with Newman University being the research partner. The project can be viewed as sitting under a broader umbrella partnership in the West Midlands between the local mental health trust, the county sports partnership, the university, the combined authority and sporting organisations

who aim to work together in the community to enhance mental health through sport (see MentalHealthThroughSport.com). This study was of the initial pilot phase of Think Football, which was initially planned to be six months but was extended to a total of thirteen months.

Form/Frequency: Sessions ran each Wednesday from 11am to 12.30pm, in the Academy Building, which is located on Aston Villa FC's Villa Park stadium site. Sessions are free to attend. The activities within the session were deliberately varied, but generally comprised of initial warm-up drills and basic ice-breaker activities, followed by different football-specific coaching style elements (that were sometimes designed and led by participants), before having either small-sided games (5-a-side) or larger games (11-a-side) depending on what participants wanted to do (or the practicality of numbers of attendees present). The design of the sessions incorporated a non-football-related workshop style delivery towards the end that would provide information, advice or practical skills that might benefit the participants. For instance, basic fitness sessions, information on nutrition, team building activities, advice on other local services or activities that they could get involved in, having time to sit and talk after the football whilst having a cup of tea and some biscuits, offers from the local council, and so on. These additional workshop elements were delivered by various organisations that were working in partnership together (see above). It is to be noted that during the early months of the pilot phase, these workshop sessions were quite infrequent, but became more regular and established towards the end of the pilot phase. Approximately every two months there was a football tournament, during which teams from other mental health football initiatives (regional and national) would come and compete against the Think Football participants, during the same time period on Wednesdays in the same location.

Target group: Although the sessions were advertised generically as being for personal and mental wellbeing, it was the specific aim to engage men and women over the age of 18

who had low level mental illness, which the organisers deemed to be most commonly depression and/or anxiety. Participants were to be from the community (i.e., not formally referred from health services), and were able to self-refer themselves by contacting the project lead based at Aston Villa's Foundation and registering their information prior to attending. Whilst an informal discussion was had regarding their suitability for the sessions, the decision was made by the organisers to not record specific mental illness diagnoses (or lack of) or seek evidence of previous diagnoses or treatment, in order to provide an open, relaxed and most importantly non-clinical environment. Participants in the sessions could register and join at any point after the project started, and in total during the thirteen month project period there were 94 people who registered. During the first six months of the project the average number of attendees each week would fluctuate between 12-22, but by the end of the period the weekly average number of attendees was approximately 30-35.

Intended outcomes: Given that the project encouraged self-referrals and participants were from a range of backgrounds and had varied mental illness experiences, the outcomes for the pilot were deliberately kept broad and open; aiming to help to improve the mental health and recovery of the participants, which included increasing participants' feelings of social inclusion, confidence and levels of physical activity, alongside being able to use football as the hook to engage participants with other related services or support.

Methods of evaluation: Semi-structured interviews with participants and also staff leading the sessions.

Identified themes: These shall be outlined in the results and discussion.

Method

It is important to understand people's experiences in order to understand recovery, due to the subjective and idiosyncratic nature of a person's recovery journey (Slade et al., 2012). So it follows that adopting a qualitative methodology is a suitable approach, as it

enables exploration of individual experience in context (Stuart et al., 2016). This approach was underpinned by the philosophical assumptions of a relativist ontology (assumes numerous subjective realities) and a constructionist epistemology (our understanding is based on appreciating multiple social constructions of knowledge; Williams et al., 2018), as the study sought to make sense of the socio-cultural contexts and structural conditions that influenced the participants' experiences (Braun & Clarke, 2006), relating specifically to the concepts of personal (Leamy et al., 2011) and social recovery (Ramon, 2018; Tew et al., 2012.

Participants and Procedure

Semi-structured interviews (see Appendix A for the interview guide) were undertaken in a one-to-one style, in order to focus on the voices and experiences of those whom actually experience this social phenomenon. These methods have been used by a number of studies related to this topic (see Carless & Douglas, 2008; Crone, 2007; Spandler et al., 2013, 2014). Semi-structured interviewing allows for a pre-planned interview guide to direct the discussion, whilst still allowing participants flexibility in expressing their opinions through open ended questioning (Williams et al., 2018). Initially, the questions were straightforward in order to help participants feel comfortable ("Can you tell me about some of your experiences during the sessions, e.g., what are some of the things you have enjoyed, disliked, found challenging?"; "What are some of the benefits for you personally?") ranging to more probing questions ("What has your experience been in terms of interacting with others during the sessions?"; "To what extent do you feel you have had the opportunity to have a say in what the sessions involve?"; "How do you think the sessions could be improved?"). Whilst the researchers have no control over who attends the sessions each week, in terms of the semi-structured interviews during the data collection process, purposive sampling (Cresswell, 2007; DiCicco-Bloom & Crabtree 2006) was used, as individuals were selected who it was

felt (following engagement with them during the sessions) may provide further insight into the experiences of those that attend the sessions. The total number of participants was seventeen, with thirteen being participants and four being those involved in the delivery of the sessions (referred to henceforth as staff). The age range of participants was between 18 and 55 years of age. No participants below the age of 18 are able to attend sessions. Participants were approached by the lead researcher after a session had finished and were given a participant information sheet and the opportunity to ask any questions about the study, prior to being asked to complete and sign a written informed consent form. Only at this point would an interview be arranged and subsequently undertaken. Interviews were undertaken in the building where the football sessions were held, either in a separate room or next to the pitch after sessions had finished once others had dispersed. Interview length varied between 15 and 51 minutes. Interview data was recorded on password-protected smart phones by the researchers, and then transcribed.

Ethical considerations

Ethical approval was gained for the study from the lead author's institution. Due to the nature of the football sessions, and the potential sensitivity that can be related to some mental health issues, the researchers initially attended sessions in an informal, voluntary capacity. This helped the participants become acquainted with the researchers' presence and rapport to be developed (Flick, 2014), prior to outlining the nature of the study and seeking consent. As is the focus of the advertised sessions, all of the attendees are considered to have some form of 'low-level' mental illness. Whilst consideration was given to the mental capacity (based on the Mental Capacity Act 2005) of participants to provide informed consent, it was not envisaged that this would be an issue for the participants attending these sessions. For instance, the participants have made the decision to attend the optional football sessions and make their own travel arrangements. Also, at the heart of the Mental Capacity

Act is the assumption that people do indeed have capacity (in this case, to provide informed consent) unless an assessment has proven otherwise. Given the nature of the sessions being aimed at low level mental illness, it was considered extremely unlikely that anyone would have been formally considered to lack capacity to consent, however, in the unlikely event that this was a possibility, the sessions were attended by MIND staff, whose role it was to work with people with mental illness in the community, and there were also qualified support workers from various services present with attendees, so researchers had the opportunity to seek guidance from these individuals. However, as anticipated, this did not materialise as an issue during the study. Debriefing was regarded as the on-going engagement with participants as the researchers regularly attended the weekly sessions (in an informal manner, not formally observing), and as part of the reflexive process (Etherington, 2004) the researchers repeatedly discussed on-going findings and analysis with participants throughout the data collection process (which spanned five months) as initial themes were identified, informally discussed and anything unclear could be clarified. As rapport had been developed with participants over time, this informal interaction and discussion was considered to be more suitable than, for instance, formal member checking (which does not necessarily provide more rigor, see Smith & McGannon, 2018) as the researchers did not want to add additional formal burdens upon any participants, like asking them to stay behind after sessions for a second or third time for a formal debrief and discussion of ongoing analysis. The researchers also answered any questions that participants had about the research during this time. The participants remain anonymous, with pseudonyms used throughout the analysis and dissemination of the research.

Analysis

Once transcription was completed, transcripts were read and re-read to ensure familiarity with the data (Jones, Holloway & Brown, 2013). As outlined previously, Friedrich

and Mason (2017a; 2018) suggested that existing studies in this area have all been inductive and have found similar thematic outcomes, but remain relatively conceptually isolated within the broader literature. As a deliberate departure from the existing research, rather than again adopt an inductive approach, this study chose to adopt a deductive, theoretical approach to the analysis, as outlined by Braun and Clarke (2006), through the utilisation of the personal and social recovery frameworks that have been established within 'mainstream' mental health evidence.

Therefore, the coding of the data was informed by both the concepts relating to social recovery (Ramon, 2018; Tew et al., 2012), and also the CHIME framework (Leamy et al., 2011) in a similar way to the work of Bird et al. (2014) and Brijnath (2015) that both used deductive analysis that sought to explore the adherence of data in differing contexts of 'mainstream' mental health recovery frameworks. Specifically, data was coded using the concepts relating to the CHIME framework (Leamy et al., 2011), which are Connectedness, Hope and optimism, Identity, Meaningful activities and Empowerment; and also relating to social recovery (Ramon, 2018; Tew et al., 2012), which consisted of Shared decision making, Co-production, Active citizenship, Employment and Living in poverty. During the initial phases of the analysis, some themes were developed that were subsequently not utilised during the deductive analysis as they were not judged to fit within the chosen frameworks. The coding of this data gives some insight into these initial themes that were not included in the results and discussion, as they included: 'having fun versus coaching'; 'improving fitness levels'; 'initial anxiety'; 'feeling comfortable'; and 'positive comments about sessions'. As is explicated further in the discussion, in many cases certain data could have been judged to align with more than one of the CHIME or social recovery themes. Therefore, the researchers had frequent discussions together in order to make judgements about coding, and sometimes

sought clarification from participants. These judgements highlight the subjective nature of this relativist approach.

Results

Following the theoretical coding and analysis, the findings are presented here in order of the extent to which they aligned to the personal and social recovery concepts, i.e., Connectedness was interpreted as being the most significant theme from the data and Poverty the least. However, it is acknowledged that there was often overlap amongst these related concepts in the analysis.

Connectedness

This was a key theme, as many participants spoke about their lack of social interaction prior to the Think Football sessions, and their limited social networks. The following comment is indicative:

> *Yes, absolutely. Like I say, it's been a really good experience, as I say because as soon as I turn up… I've never been particularly good being around people… new people. I kind of get a bit anxious, a bit socially anxious. For me it was quite a bit of a… I had to really push myself to get into it in the first place. Now, because I've seen all the lads, we've pretty much all been here from the very start. (Jay, Participant)*

The theme of having a supportive community amongst participants was very strong throughout, and the development of communication outside of the sessions was reported as being particularly helpful for a number of participants.

> *They're all communicating and talking with each other. We have a WhatsApp group, too. All of them coming together and talking to one another… Obviously, in comparison to the first week where it was very hard to get them all to engage with one another, they've come on massive leaps and bounds. I'd say that there is a general*

connection within the group, and a group feel, and great group cohesion between all of them. (Nick, Staff)

These social benefits are in line with findings from previous studies, for example, Dyer and Mills (2011) found that for their participants the "social aspects are as important and enjoyable as the physical" p.35. The data suggested that the sessions were also beneficial for the coaching staff to make new relationships and to support people in new ways, which are important elements within Leamy et al.'s (2011) conceptualisation of connectedness. This was especially important as staff were quite open that they had not worked within a specific mental health context previously.

Active Citizenship

For Ramon (2018), having something that facilitates an increase in active citizenship is vital for the social recovery model. This involves exploring ways people can contribute to the wider community, enlarging social networks and advocating for change, whether that be from within a local family circle or ranging up to membership in a political party. At a basic level, the data suggested that the Think Football project was helping with the initial development of the elements highlighted by Ramon, many of which participants seemed to have struggled with previously, as the following comments reflect on:

For me, I've always, always, always, loved football and I've always felt a lot more positive when I'm playing. I was in a position where I just didn't even want to play at one stage. Now for me, doing this every week, now I genuinely I've got better, I play other football as well now outside of this. I'm back in. I absolutely love my football again now. I physically can't play enough at the minute. (Simon, Participant)

Some of the benefits I've witnessed were all of them being more social together. For example, after the first couple of weeks, a load of them went to the cinema with each other, which we were very, very, surprised at. (Dee, Staff)

I've enjoyed just learning some new skills, and meeting new people, having a laugh, having fun, and doing some new training. Yes, I feel happier. I'm meeting new people, just having a good talk to them, which isn't always easy. (Ahmed, Participant)

It has been demonstrated by empirical research that people who increase their citizenship activities increase their recovery (Pelletier et al., 2015). Therefore, it is worth highlighting that data supported all of the elements of Ramon's (2018, p.6) view of what active citizenship should involve:

Enlarging one's meaningful network, moving from being a passive to an active citizen, being validated by other people in the community, learning skills necessary for the specific activity, learning more about one's potential and one's strengths, and becoming motivated for further such activities due to the success experienced. The fact that many such activities take place outside the arena of mental health services is a bonus, as it expands and reinforces people's connectedness, living beyond the illness, and their recovery capital.

Meaning in Life and Meaningful Activities

Another key process in terms of maintaining or recovering mental health is doing things in your everyday life that you find meaningful and improves the quality of life (Leamy et al., 2011; Slade et al., 2012). For these participants, this was evident through their passion for and enjoyment of the football sessions:

I think the variety of things we've done as well, so going from the football games, to the fitness sessions that we've done as well, as I say, I've done quite a lot of stuff. I've

really found it good, really, really enjoyed myself to be fair, every week I've been here. (Darren, Participant)

Key elements of this process for Leamy et al. (2011) were 'rebuilding life' and 'social goals', and for many participants the sessions provided them with a process that helped them with the relatively fundamental underpinnings of making positive changes, including fitness and having a goal to get out of bed for:

When I first came, I couldn't do nothing because of my fitness. But obviously, coming here has made me fitter, and I enjoy it more. Each and every week it just gets better and better. (Musa, Participant)

There remained an overwhelming sense that the sessions were facilitating the participants doing something meaningful, which was exemplified most succinctly by Simon (Participant):

I've enjoyed every single week. I'm happy when I'm playing football. I'm happy with the ball at my feet.

Hope and Optimism about the Future

An important element for good mental health and for personal recovery is hope for the future (Wallace et al., 2016), and data suggested that the sessions help to provide hope for the participants, both in terms of short term (looking forward to something each week), and also longer term (making plans). For instance, following the feedback from participants on wanting to get involved in coaching more outside of the sessions, the Foundation subsequently ran coaching qualifications for the participants.

Yes, the sessions help me feel more optimistic about my future, definitely. I want to play football when I get out [of the health unit] now, and just keep at it. Even if I start coaching and stuff, I really want to keep up football now. (Sam, Participant)

Identity

Many participants highlighted just how important football specifically is to them and their identity, and how they valued coming to the sessions. Leamy et al. (2011) highlighted how (re)building a person's social identity is vitally important to their recovery, and data suggested that sessions and playing football at Villa specifically was significant for participants:

> *They have all been given a reward after the ten weeks. They get a Villa shirt. Literally three quarters of them, apart from the ones that are West Brom fans, they wear their Villa shirt so they can identify that they play at Villa. They all wear their Villa shirt to the tournament so they identify themselves as being at Villa, as I think that Villa is a big thing for them. I think if it wasn't Villa and it was a normal Leisure Centre, you wouldn't get as many. (Nick, Staff)*

Empowerment

Perhaps the most difficult element of the CHIME processes for organisations to facilitate are enabling genuine empowerment in the activities in a certain context (in this case, football sessions). Participants spoke warmly about having the opportunity to lead parts of sessions and having some input, but this is perhaps an area that could receive more attention moving forwards, to have more input from participants on the broader running – perhaps an advisory group made up of participants, staff and external partners. However, as the data suggested, empowerment can look different to different people who are in different places in their lives/recovery, and many were very positive about their involvement:

> *It's great to be able to have an option of what you want to do. You never want anything to get repetitive, so it's great to be able to have that bit of variation as well. We've done different aspects of football, we went from playing games just to doing the drills and then throw in the extra bit of fitness as well. The fitness sessions which I've really enjoyed as well. I 100% can't complain. I think it's been really good, we've*

been given every opportunity to be able to do what we wanted, lead the session our way. (Ahmed, Participant)

Shared Decision Making and Co-Production

In a similar manner to the Empowerment for attendees, the interview data suggested that they were involved in making some decisions, and that the staff responded to the feedback, but this was arguably retrospective, rather than, for instance, having some of the attendees on the steering group to shape decision making from the start in a more genuine co-production. Participants reported that the feedback was often related to the desire for sessions to be longer and having some focus or ice-breaker activities earlier in the sessions when some people get nervous or anxious before the start. These are elements that could have been highlighted even prior to the first session if (potential) attendees had been involved in decision making, and this could also have helped to break down power differentials that exist within any intervention (Ramon, 2018).

Employment

To provide some context, the majority of those that attend sessions came from Aston and the surrounding wards in Birmingham. According to the most recent 2011 Census data (Birmingham City Council, 2018), Aston had an unemployment rate of 13.2%, compared to 9.3% for Birmingham and 5.8% for England. 41.6% of the Aston population between 16-64 years of age were economically inactive, which was higher than the rate for Birmingham (30.7%) and England (23.0%). The wards immediately surrounding Aston had similarly high levels of unemployment, ranging from Stockland Green (10.1%) and Gravelly Hill (11.3%) to Nechells (14.1%), Lozells (14.3%) and Newtown (15.0%). Given that the sessions are based within a broader societal context that has significant issues regarding employment, it was perhaps somewhat surprising that this was not a concept that participants discussed to any large extent. This may reflect where individual participants were in their own recovery

journey, and how employment fits (or does not), as there remain issues both for people with mental illness to gain employment and also mental illness for an estimated 60% of those in employment (Ramon, 2018). Some participants were perhaps not in a position to seek work, and the sessions were an earlier stepping stone in their journey, although they were not always explicit about work:

> *I got my qualifications years ago, and I worked as a coach, but it was the same thing, I just completely lost it - didn't want to know. Gave up that as well. So [leading parts of the Think Football sessions] felt quite good as well, to go in and do that again because it's been a long time. That again, was quite a pretty terrifying thing to go and do because it's been so long since I've done it and my self-confidence with it was just so low. (Jordan , Participant)*

Alternatively, Shay (Participant) used the sessions to help share experiences and maintain mental health whilst in employment:

> *I come here, I take time off work to come here and when I come here, all the past experiences… some of us have been in hospital, some of us have been in respite, some of us now with our doctors in the communities. We talk about all the experiences. Some, they're even escorted into being told what to do, when to eat, when to do this. When we meet here it's very different to all that.*

Poverty

As a city, Birmingham suffers from high levels of deprivation, being the 6th most deprived authority in England, with 40% of its population living in wards that are classed within the most deprived 10% of the country. Aston is the 11th most deprived ward (out of 69 wards) in Birmingham, with the immediately surrounding wards of Newtown, Nechells, Birchfield, Lozells and Gravelly Hill all within the top ten most deprived wards. All of those wards are also within the 10% most deprived areas of England (Birmingham City Council,

2018). Similarly to employment, there was not a strong focus on poverty within the participant data, other than when barriers to attending or ceasing attendance were discussed. Finance was frequently cited as an issue, despite the sessions being free. Transport to the sessions was highlighted as an issue for participants, even considering the relatively short distances required to travel across the city, which perhaps highlights the degree of the financial issue for many, Neil's (Participant) comments were indicative: "*Not having money to get here is a barrier, not so much for me but I know for a lot of the fellas who come… its hard".* Given the limited data on both employment and poverty here, there is therefore further need to explore experiences of these elements relating to social recovery within sporting contexts.

Discussion

The overall sense of the analysis is that both participants and staff were considerably positive about the sessions, and that data suggest an adherence to the empirically based CHIME personal recovery framework (Leamy et al., 2011; Slade & Longden, 2015) and the social recovery approach (Ramon, 2018) that have been found to support and facilitate recovery. Specifically, the five super-ordinate categories of the CHIME framework were all supported within the analysis. As evidence suggests that Think Football facilitates connectedness, hope, identity (re)development, provides meaningful activities and a level of empowerment (that might otherwise be lacking), then it can be said that Think Football sessions (and other sessions run in this specific way in the community) can benefit individuals' personal recovery and mental health due to the facilitation of these underpinning processes. Leamy et al. (2011) proposed that their framework could help to identify and organise these specific recovery-related processes, in order to aid someone in their own idiosyncratic journey. Judging by the most prominent themes, for the participants, football acted as the vehicle to provide many of them with connectedness and social relations (in line

with findings from McKeown, Roy, & Spandler, 2015) that it would appear they are lacking at their particular point in their journey. Similarly, the meaningfulness of football (specifically, as an activity) was also central to the participants' experiences, which supports the narrative synthesis of Leamy et al. (2011) that highlighted the importance of quality of life, doing meaningful activities and how these activities may help people rebuild their lives. Continuing work could explore further the role of sport in this sense, whether it is just an early stepping stone or something more substantial that can help to rebuild lives.

Despite the positivity of participant data, there is a danger of adopting an overly functionalist approach (Giulianotti, 2016) in praising the personal and broader societal benefits of sport, whilst neglecting to learn from areas that need improving. As Stuart et al. (2016) argued, the 'difficulties' within mental health contexts need to be appreciated more in the CHIME framework (as they advocated for it to be CHIME-D). An aspect to reflect on here is the empowerment within the sessions, as especially in community settings it can often be context specific for individuals depending on their health or personal journey, for instance, they might have either very little or actually quite considerable empowerment in their everyday lives (when compared to someone who might be in secure care). Also, the limited empowerment might have been self-imposing (or at least, social actors are complicit within patterns of disempowerment and stigma), as people could accept the stereotype of the mentally ill person, and subsequently contribute to their social inclusion when in community settings. Whereas, it has been found elsewhere (Warner, 2010) that those who accept their illness and begin to achieve some form of mastery over their lives (and their social environment) have better outcomes. Therefore, what one person considers to be empowering might be experienced very differently by someone else in the group, so it is imperative that those designing and leading sessions take time to get to know their attendees and find out 'what works' (Tew et al., 2012) for them. It is also acknowledged that interviews were

undertaken with participants that had attended the sessions regularly, so as with other studies of this nature little is known about the experiences of those who ceased attending, which is an area for future work to explore.

In terms of alignment with the social recovery concepts, the data was particularly robust in supporting active citizenship, as outlined by Ramon (2018). Whilst the elements of shared decision making and co-production were less favourable, the basis for active citizenship that the sessions were found to provide could, in time, arguably facilitate participants having the confidence and experience to push for more decision making involvement, as opposed to the expectation of adjunct interventions 'handing it over' to participants. However, in line with the social model, it is still imperative that interventions are designed in such a way so that the emphasis or blame is not on the individuals (Warner, 2010), so there remain lessons to learn for practitioners and educators. In terms of the broader inequalities that underpin mental health prevalence (Wilkinson & Pickett, 2018), and the context of poverty and employment specifically, a limitation of this study is that there could have been more of a consistent focus on these elements within the data collection process, as the social and economic deprivation in Aston and surrounding areas could be playing more of a part than is currently understood. Upon reflection, the sensitive nature of these elements within a hegemonically masculine environment (Spandler & McKeown, 2012) might have meant that participants were not comfortable discussing these aspects with researchers during interviews, for fear of it damaging their cultural capital (Bourdieu, 1984). Therefore, to remedy this, future work could potentially adopt an ethnographic approach in order to spend more time with participants inside and outside of the sessions via participant observation (as advocated by Pilgrim, 2009) to further explore their context and how issues relating to poverty and employment might be impacting their social recovery, and what role sport can play.

Practice Implications

Sport potentially offers a social space to work with those who suffer, and also work developmentally with their friends, family and communities, as Tew et al. (2012) suggested we must do more in this regard. Community projects of this nature make this (more) achievable in a practical sense (as opposed to clinical settings). Attention must be given, where possible, to participants' journeys and the nuances that are involved that mean they experience adjunct interventions (for instance, football) in different ways. Encouraging and facilitating active citizenship appears to show potential for making a real difference to people's lives, and incorporating activities (e.g., workshops on personal finance or nutrition, volunteering opportunities) and community partners (e.g., engagement with local council, MIND and other sporting organisations) alongside the sessions can enable further development outside of the intervention. Those considering establishing sessions of this nature should work hard for genuine co-production, as participants, service-users, volunteers and staff do not necessarily share the same understanding of what recovery is, therefore, working in collaborative ways and educating each other about mental health recovery-oriented initiatives (and how they might be viewed differently) will benefit both the individuals and the community, as advocated by Bedregal et al. (2006). Friedrich and Mason (2017a) highlighted that evidence for football sessions of this nature was vital to facilitate more funding and changes in practice, and upon completion of this study of the pilot phase of Think Football it was possible for the authors to feedback to the collaborative partnership and they have since implemented recommended changes and also secured more funding for the sessions to continue, which shows a demonstrable research impact on the community.

Academic Implications

The idiosyncrasies and nuances of participants' experiences in this study add further weight to the evidence that people from different backgrounds can experience recovery very

differently, so researchers need to be methodologically creative and flexible, and recognise that personal and social recovery contexts do not always lend themselves well to certain methodologies, for instance, randomised controlled trials. As suggested previously, further evidence and understanding is required of how the underpinning inequalities that impact mental health prevalence (Smith et al., 2016; Wilkinson & Pickett, 2018) are influencing community contexts and specific interventions, such as sport-based interventions that continue to demonstrate a positive impact on personal and social recovery. Furthermore, future research needs to consider how these inequalities and/or intersectionalities might be experienced differently by individuals or groups in these types of contexts.

Conclusion

This study responded to the call of Freidrich and Mason (2018) to add to the limited, but growing, evidence base of 'adjunct interventions' (or alternatives to mainstream or 'clinical' services) of this nature. Tew et al. (2012) stated that we need to know 'what works' in terms of specific social recovery focused interventions that may enable processes of recovery and enhance social capital, positive social identities and social inclusion. This is the first study that has placed a community football for mental health project within the personal and social recovery context, and specifically made use of the CHIME framework (Leamy et al., 2011) and the social recovery model (Ramon, 2018) together in order to add to the evidence base, in a similar way to Bird et al. (2014) and Brijnath (2015) in different contexts. More broadly, locating work within the established personal and social recovery frameworks helps to avoid the danger highlighted by Bedregal et al. (2006) that "recovery may become simply the latest fad in the line of social policies informing— but not yet dramatically changing— community mental health" (p.97), and as discussed in the implications section, these frameworks are arguably already informing community practice.

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Appendix A

Semi-structured Interview Guide (Not including probes)

1. How did you hear about the sessions, and what made you join?
2. What were your first impressions when you joined? Were the sessions what you were expecting?
3. Can you tell me about some of your experiences during the sessions - i.e., what are some of the things you have enjoyed, disliked, or found challenging, and why?
4. What are some of the benefits for you personally? Have you noticed any changes in yourself, especially outside of the sessions? If so, why do you think this has happened?
5. What has your experience been in terms of interacting with others during the sessions?
6. Having come to the sessions across a number of weeks, do you feel connected to the group (or members of the group), and if so, in what ways?
7. To what extent do you feel you've had the opportunity to have a say in what the sessions involve?
8. Do you feel it has been beneficial to have choices during the sessions, e.g., on what activities you do, and how the sessions work?
9. How would you say playing football each week makes you feel? Do you think about the sessions during the week, or look forward to playing?
10. How important is football to you, and what role would you say it plays in your week?
11. To what extent would you say that football is a part of your identity, and in what ways?
12. How do you think the sessions could be improved? Are there specific things that make it difficult for you to attend?

13. Are there any examples of people you know who could benefit from the sessions, but there is something specific that is preventing them from attending - as we want to know how sessions could be more accessible to a range of people?
14. How have you felt about the engagement with the coaches during the sessions?
15. Would you like the sessions to continue, and are there things you would like them to include in the future?
16. Are there any other things you would like to say about the sessions that we have not covered?