The ethos of physical activity delivery in mental health:

A narrative study of service user experiences

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Issues in Mental Health Nursing, 33(3), 165-171.

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Abstract

Our research into the physical activity experiences of people with severe mental illness has led us to take seriously the social and cultural environment in which physical activity is delivered. In this study, through narrative methodology we examine service user accounts to illuminate the characteristics of physical activity groups which are experienced as positive, helpful, and/or beneficial. We present several qualities and show how effective leadership and coaching is central to their achievement. We conclude that it is not so much *what* activity is delivered, but *how* it is delivered that is critical for sustained participation and positive outcomes.

Keywords: coaching, physical activity, practice, narrative, severe and enduring mental illness

Introduction

Numerous studies and a series of reviews confirm that physical activity – in various forms – can provide valued mental and physical health benefits for people experiencing a range of mental health problems (e.g., Saxena, Van Ommeren, Tang, & Armstrong, 2005; Stathopolou, Powers, Berry, Smits, & Otto,2006). The strength of this body of literature has led some to call for physical activity to be routinely included within mental healthcare (Callaghan, 2004; Richardson, Faulkner, McDevitt, Skrinar, Hutchinson, & Piette, 2005; Roman, 2010). Although less research exists regarding the benefits of physical activity for people with severe and enduring mental illness (SEMI), a range of benefits have been documented, including: (i) physical health and fitness improvements (Beebe, Tian, Morris, Goodwin, Allen, & Kuldau, 2005; Fogarty & Happell, 2005); (ii) improved mental health (Ellis, Crone, Davey, & Grogan, 2007); (iii) redeveloping a positive sense of self and identity (Carless, 2008); (iv) providing structure to a person's day or week, which helps to reinstate a sense of purpose and meaning in day-to-day life (Carless & Douglas, 2008a); (v) increased self-esteem (Faulkner, 2005); (vi) valued opportunities for social experiences, engagement, and interaction (Carless & Douglas, 2008b); (vii) recreating a sense of optimism and hope (Carless & Sparkes, 2008); and (viii) valued opportunities for receiving and giving support and 'community building' (Carless & Douglas, 2008c). In sum, research seems to support increasing 'grass roots' awareness among some users of mental health services and mental health professionals of the benefits of various forms of physical activity.

Growing awareness of potential benefits has led to calls for more research into two particular areas. First, researchers have recently called for studies to explore the barriers and obstacles to regular activity participation among people with SEMI (e.g., Johnston, Nicol, Donaghy, & Lawrie, 2009; Roberts & Bailey, 2011). Critical to this research, Roberts and Bailey (2011) rightly suggest, is a focus on service users' own perspectives. Taking their experiences

seriously allows mental health service users to be viewed, "not as passive recipients of services but as active, knowledgeable agents with expertise rooted in using and surviving mental health services" (Barnes, Davis & Rogers, 2006, p. 330).

Second, some researchers (e.g., Saxena et al., 2005; Teychenne, Ball & Salmon, 2008) have called for further studies to establish the precise 'prescription' of physical activity (i.e., type, intensity, and duration) that leads to the positive outcomes. In the course of our own research which has focussed on service users' accounts of their experience (e.g., Carless & Douglas, 2008a, 2008b, 2008c, 2010), we have come to a somewhat different position. While prescription typically focuses on the technical or mechanistic aspects of provision, service user accounts often prioritise cultural and social aspects of provision such as (for example) social organisation, leadership style, or coaching approach. Given the challenges to physical activity initiation and maintenance among people with SEMI (McDevitt, Snyder, Miller & Wilbur, 2006; Carless, 2007; Hodgson, McCullough & Fox, 2011; Roberts & Bailey, 2011), it seems to us that the *way* physical activity is offered – aside from *what* is offered – may be critical in terms of participation. If this is the case, it follows that aspects of the *delivery* of activity provision – such as quality of leadership and/or coaching – will be an important factor in effectiveness.

In this study, we explored this perspective by considering the narrative accounts of individuals who take part in physical activity provision tailored for people who have been diagnosed with SEMI. This approach is in line with Glasby and Beresford's (2006) conceptualization of *knowledge-based practice* which values, incorporates, and responds to both the practice wisdom of health and social care practitioners and the lived experience of service users. Our primary interest is to reflect on the hallmarks or characteristics of physical activity provision which service users experience as positive, helpful and/or beneficial. We aim to improve understanding of the conditions of physical activity provision which is experienced as

valuable and meaningful by people with SEMI. The process therefore offers insights and direction for mental health nurses and activity coaches who are interested in making or improving physical activity provision in mental health contexts.

Methods

Our methodology lies within the interpretive paradigm where, in contrast to the positivist/post-positivist paradigm where the aims are typically explanation and control, we focus on *understanding* and *illuminating* human experience of the world (Sparkes, 1992). An important purpose of interpretive research is the elucidation of *meaning* which can lead to a questioning of existing assumptions regarding social experience. Like all research studies, our findings and interpretations are partial and situated. In recognition of this, we present our work in an effort "to sustain conversation and debate, rather than attempt to act as a 'mirror to nature', as a source of foundational, universal truth" (McLeod, 1997, p. 142).

Participants and Procedures

Data were gathered while conducting two commissioned evaluations of physical activity initiatives for people with mental health problems (Douglas & Carless, 2008, 2011) and during a research project which explored experiences of physical activity among people diagnosed with severe and enduring mental illness (granted ethical clearance by the local National Health Service Trust). We utilised three methods of data collection: (i) through a series of narrative interviews and focus groups we invited participants to share first-person accounts of their experience of and responses to physical activity and sport sessions. Through prompts and further questioning – from ourselves and sometimes other participants in the case of the focus groups – dialogues were initiated which extended and deepened these accounts. The interviews and focus groups were audio-recorded and transcribed verbatim; (ii) we engaged in several periods of participant observation at different activity groups, recording our observations in a reflexive research diary;

(iii) we also invited and received follow-up written correspondence, usually via email. Written communication was used by some participants to share sometimes sensitive experiences which enriched the issues and experiences voiced during interviews and focus groups.

Although in the course of this work many individuals contributed to interviews, focus groups, and participant observation (and have therefore informed the interpretations we present here), we focus on the experiences of three particular individuals, all diagnosed with SEMI (such as schizophrenia or bipolar disorder). We focus on these participants for three reasons: (i) given an inevitable trade-off between breadth (i.e., number of participants) and depth (i.e., level of understanding about each participant) in any study, we prioritise here a deeper level of understanding relating to the experiences of a smaller number of individuals; (ii) they were willing and able to share with us rich, detailed, evocative, and insightful accounts of their experiences; and (iii) during data analysis (see below), we identified in their accounts a number of issues that shed new light on the topic.

Analysis and Interpretation

Both researchers collaborated in a three stage processes of analysis and interpretation, incorporating different narrative analytical approaches tailored to the purpose of the study. After immersing ourselves in the data, the first stage was conducting a *thematic analysis* (see Riessman, 2008) to identify themes, typologies, or instances of paradigmatic categories. Here, we followed the process detailed by Lieblich, Tuval-Mashiach, & Zilber (1998, p. 12) where "the original story is dissected, and sections or single words belonging to a defined category are collected from the entire story." This first stage served as a form of *cross-case* analysis, allowing us to compare and contrast themes and issues evident in the accounts of different participants. The second stage comprised what Sparkes (2005, p. 195) terms a *narrative analysis of structure and form* in recognition that "the formal aspects of structure, as much as the content, express the

identity, perceptions, and values of the storyteller". This stage may be considered a *within-case* analysis as we focused on one participant at a time to reflect on the individual's own story. The third stage was to identify a series of critical incidents, moments, or epiphanies (Denzin, 2001) which offer valuable new insights or understandings into the research questions. In what follows, we present these in the form of extended excerpts from participants' stories together with interpretations based on theory, other research, and personal experience of physical activity provision.

Discussion of Findings

Consider the following excerpt from an interview with Laura, a member of a badminton group, in which she describes her experience of taking part in gym-based exercise:

> If you got your PC out and ran, like, fourteen web searches and eight lots of Photoshop and Word for Windows, it would gradually crank to a halt. And that's exactly what going to the gym is like for me. It's like, putting myself in a position of vulnerability, having to meet lots of new things, people that aren't necessarily predictable, I can't always say who's going to be there, or who's not going to be there. And that's aside to any other symptoms I have. I have problems of people controlling me, and so I have to do a lot of CBT around that in order to be able to cope with the fact that it's a coached session. And, you know, its, people think, 'Oh! It's just a badminton session!' But its not, there's a hell of a lot more to deal with.

This evocative account offers several important insights concerning what contemplating and experiencing physical activity can be like for a person with serious mental health difficulties. On the one hand, Laura makes reference to particular and quite specific personal difficulties ("I have problems with people controlling me") which require a deliberate management strategy in order for participation to be possible. In this sense, Laura's account illustrates what we have heard and

observed among many other participants – namely that there are an almost limitless variety of possible 'obstacles' or 'barriers' to participation that *might* arise for a given individual. Some of these have much in common with the kinds of barriers anyone is likely to face when initiating or resuming physical activity. Others, as Laura's account illustrates, will be more closely connected to each person's particular mental health issues and, therefore, will be highly individual-specific. This understanding suggests that while research which identifies barriers to activity for a population (e.g., McDevitt et al., 2006; Johnston et al., 2009; Roberts & Bailey, 2011) can be a useful starting point, general findings have limited relevance when it comes to appreciating the barriers or obstacles a *particular individual* faces. In the day-to-day world of practice, it seems to us that the specific barrier/s faced by the individual need to be addressed to arrive at a unique support package *for that individual*.

In addition to illustrating how an individual can face unique or highly specific issues, Laura's account also illustrates several more general points which we have heard about or observed among other individuals with SEMI. The first of these is the understanding that by engaging in physical activity provision an individual is likely to feel *vulnerable* ("It's like, putting myself in a position of vulnerability"). This is likely to be heightened in the case of initiating activity or attending a different group, when the *newness* of the situation inevitably creates uncertainty regarding what will happen. In Laura's account, this feeling of vulnerability is ongoing because, for her, contemplating attending each and every activity group raises a host of unpredictable eventualities concerning the people who will be there and how they might behave on a given day. A second point, well made by Laura, concerns the *magnitude of challenge* that individuals face. The metaphor of an overloaded PC "gradually crank[ing] to a halt" powerfully evokes the way an individual can have so many issues to address that the task of participating in physical activity (a task many 'mentally well' individuals in the population are also unable to

manage) becomes highly intimidating and problematic. In this sense, the complex difficulties experienced by many people with SEMI, when added to the recognised difficulties of exercise adoption and adherence, create a very significant obstacle to participation.

Obstacles of this scale and complexity suggest the need for careful and considered responses if they are to be surmounted. Another female activity group member, Suzie, offered (during a focus group) this account of her experience of two activity groups:

> I started my activities with the self-defence group … and it was the first activity which I started to do after leaving hospital so it was really a very important event in my life.
>
> *Why was it so important?*
>
> First of all, because I was recently out of hospital and I had a really bad self image, because I was still very, very overweight and I was extremely unfit. And because the whole atmosphere of both groups was constant encouragement and support and people around were understanding and no-one was doing negative remarks, I felt that it was a pleasure to do physical activity … Let's say I wasn't performing very well, no-one would laugh at me, everyone was really friendly and I felt accepted as I am, so I didn't have to worry about the problems I had. I probably wouldn't be so keen to join an ordinary group or gym or do any sporting event if it wasn't in this specially designed group for people who have mental health problems. I just felt I am able to relax and just do my best, but I don't have to be perfect, I am accepted as I am.

Before providing some valuable insights into how the *process* of provision and delivery can be enhanced in ways that facilitate overcoming obstacles to participation, Suzie's account reinforces other research (e.g., Carless & Douglas, 2008a, Carless & Sparkes, 2008) which shows that – for some people diagnosed with SEMI – physical activity participation is personally meaningful and highly valued. For some, in short, activity *matters*. Like Laura, Suzie describes feeling

vulnerable, uncertain, and insecure when both contemplating and attending a physical activity group. However in Suzie's account, this is tied to "a really bad self image" on the basis of being "very, very overweight" and "extremely unfit" following a period of hospitalization. Whatever the cause, these feelings need to be negotiated if participation is to be initiated and sustained. How might this be achieved?

In Suzie's words, it was the "whole atmosphere" of the groups that allowed her to overcome her vulnerability and insecurity. "Constant encouragement", "support", and "understanding" – combined with an absence of "negative remarks" or laughter when "I wasn't performing very well" – led Suzie to begin to enjoy the activity groups. Importantly, the source of encouragement, support, and understanding is not *only* the activity leader/coach. Rather, in Suzie's account, the other group members also play a part in creating, enacting, and sustaining this positive atmosphere. In Suzie's words, "everyone was really friendly" and "no-one would laugh at me." As a result, Suzie describes feeling "accepted as I am" to the extent that "I didn't have to worry about the problems I had." Here, it is clear that it is not necessarily the case that personal "problems" are eliminated or even tackled, more that through achieving a positive and supportive "whole atmosphere," personal problems cease to be a cause for personal concern.

Suzie's account illustrates well an insight we have gained from other participants' stories too: that it is the *culture* of an activity group that creates the circumstances for participation to become possible, sustainable, and beneficial. A positive and supportive culture incorporates the behaviours of not only the group leader/s, but the other group members too, and fits with previous research (Carless & Douglas, 2008c; Douglas & Carless, 2010) which documents how support is not something that simply flows from professionals to service users, but *between* service users too.

An excerpt from a written account (received via email) by Ana, a member of a badminton group, offers further insights into this issue:

> When I self harm, I feel less judged on my bruises/marks at the badminton group than I do with other people. Like when I go to my volunteering at the charity shop, I wear long sleeves to cover my arms, whereas at badminton I feel comfortable wearing a t-shirt. Another thing is, if we talked too much about our illness/problems to so-called 'normal people' they might think we are a bit self obsessed, whereas in the badminton group because we all have similar problems, it is good to share it with each other.
>
> It's good because nothing is expected of you. You take it at your own pace. If you are having a bad day and just feel like watching, that is OK. It is a good place to build your confidence and social skills too. Like for me, before I started at the group, I had lived a very secluded life … and I didn't have a network of friends. It's helpful to have this sort of group to go to, if only to get people out of the house for an hour, rather than sitting on your own feeling depressed. Even if I feel crap some days, I will still make an effort to get to badminton cos I know I will be glad I did it afterwards. (Like today that happened to me – my dizziness was really bad in the morning so I thought about not going, but then I was determined to make it there because I know it's better than sitting wishing I had).
>
> Badminton has been a good place to meet people without necessarily having to sit and have a full conversation, particularly when you first start the group and are very nervous. It's nice that some of us meet afterwards for coffee, etc. in the leisure centre cafe. Again there's no pressure to stay – no-one is expected to stay for a drink, but everyone is welcome to. That is something we do generally without the coaches being involved, so again it helps us build friendships and a time to chat if we want to.

Ana's account offers several insights regarding what she experiences as a positive culture, atmosphere, and environment in a badminton group. With reference to the visual evidence of her self harming, Ana says she feel "less judged" within the badminton group, in comparison to her more public work in a charity shop where she feels a need to "cover" up with long sleeves. Here, through an activity group is a sense of a *community* of people who do not judge her by reacting in some way to her bruises and marks – it is not just the leader/coach but also the other group members who Ana is referring to. For Ana, this seems to be a sense of safety which is, firstly *felt* and, secondly, potentially *confirmed* by people's actions. Closely related to a sense of safety is Ana's description of feeling able to talk about her "illness/problems" with others because, by virtue of common experience, negative reactions are unlikely. Implicit once again, then, is the suggestion of an understanding or empathetic stance on the part of group members towards each others' difficulties: Ana feels able to share her vulnerabilities, secure in the knowledge that others will (try to) understand.

Ana contrasts this environment with her more public work in the charity shop. Although she does not describe actual moments when people have reacted to her bruises and marks, Ana communicates a feeling that people *might* potentially do so and, therefore, lacks the sense of safety she experiences in the badminton group. This feeling of threat is not unreasonable, as accounts of stigma, mistreatment, and prejudice towards people who have (or are thought to have) mental illness are numerous. Grant (2010), for example, portrays negative reactions from some family members to his diagnosis, suggesting belief in "the hype of the mentally ill as potentially dangerous" (p.112) despite an absence of any 'dangerous' behaviours. Although stigma and discrimination was not a direct focus of our research, other participants have from time to time also recounted instances of negative comments and reactions from others (see, for example, Carless & Douglas, 2010). Ana's concerns therefore seem justified given the concrete

lived experiences of many service users – her actions of 'covering up' outside the safe space created by the badminton group are an entirely reasonable strategy to maintain relationships and safety in a world where 'hype' is too often still believed.

A second point concerns how "nothing is expected of you" and you can "take it at your own pace" during the activity session. Ana returns to this idea later when she describes meeting in the café afterwards where "there's no pressure to stay … but everyone is welcome to." These remarks indicate the presence of a degree of *awareness* – on the part of the leader/coach and other group members – of the kinds of issues individuals may be facing as a result of their mental health problems. They also implicitly reveal the need for flexibility and adaptability on the part of a leader/coach to allow each individual to "take it at [their] own pace," even to the extent that a group member might just watch the session. Importantly, while activity might not feel possible for the individual that day, s/he is still able to be included socially as a spectator.

Third, Ana refers to the social opportunities that the badminton group provides, which she portrays almost as an *antidote* to the conditions that can accompany long-term mental illness (in Ana's account: "a very secluded life", "sitting on your own", "I didn't have a network of friends"). Ana's account illustrates how these opportunities are made possible by several qualities of a group being: (i) a manageable duration (1 hour) which gets her out of the house; (ii) a place to meet people under the auspices of an activity, which takes the pressure off needing to sustain conversation; (iii) a way to extend relationships through choosing to share a drink and a chat in the café afterwards. Finally, Ana's account hints at the importance and value of being able to take some responsibility and exert choice over behaviours when she describes how it is the group members (rather than leader/coach) who organises post-activity socials.

The accounts we have presented so far have focussed primarily on the ethos, interpersonal environment, and atmosphere of activity groups which, in a sense, might be seen as somewhat

'separate' to the activity itself. In other words, the characteristics we have discussed could also apply to other types of groups besides exercise and sport activities. Through our research we have also, however, come to appreciate the importance of factors relating to leadership and/or coaching which are directly connected to the activity form itself. Participants have routinely spoken of the place and value of specific coaching or teaching input – to do with, for example, the technical requirements of a particular sport, the possibility for improvement, mastery, and even becoming a coach oneself. In the following excerpt, Suzie compares her experience of two different coaches/teachers at two different activity groups (tennis and badminton):

> I have to say that I wanted to join the tennis group because I used to play tennis … So I went to where the group was held, and what happened, and I have to say this is something negative that I have noticed, the coach, he didn't motivate people enough to try their best, he essentially treated all the people who came as if they never had any skills. He didn't even attempt to teach any proper skills in the game. He offered several games that were really fit for small, primary school children and we were all grown ups, and essentially most of the people were ready to play a good game … I felt this was really sad, that he lowered the level of expectations, and if anyone really could play, he just wouldn't allow them to play. The whole routine of the session was so organised that he neither gave us the chance to learn anything or to practice what we knew ... I felt the coach should be someone who encourages you to do your best rather than someone who completely treats you like someone who is hardly able to move. I was thinking maybe it was because he'd been having classes with people with learning difficulties an hour before and he was coming to us with extremely low expectations ... I felt very, very frustrated, I thought beautiful day, wonderful weather, we have good equipment, perfect facilities and people are really wanting to play but somehow we were not allowed to do anything which is real tennis ...

> The coach in badminton, they try to bring out the best in everyone while the tennis coach didn't really act as if he believed that anyone could make progress, so there was a real difference. One was very dynamic and didn't give you any chance *not* to practice and you tried to do your best, while the tennis coach, I felt, didn't. I think this is really important. After a session of badminton I feel so energised and so happy and trying to do my best, but after the tennis, I had to move back where maybe I was when I was only a few years old, at that level, as if I we were completely physically disabled. But we are not physically disabled. I think it's really important to stimulate us and encourage us to do your best all the time, and it makes a difference not only in feeling better about yourself but it's definitely progress.

This account illustrates how the quality and nature of coaching/teaching provision can profoundly affect the nature of a person's experience of an activity, as well as the benefits – or otherwise – that accrue. Within this account is a strong sense of *low expectations* in terms of the tennis ability and experience of a group of people diagnosed with SEMI. These expectations are demonstrated by, for example, the tennis coach setting tasks and games that were inappropriately basic for the actual level and proficiency of some group members. Tied to this are *low aspirations* for the potential of this group of people with SEMI, with the coach – in Suzie's account – seeming to hold little hope for group members improvement and development, demonstrated by offering little technical tuition. Low expectations and aspirations have been reported among some mental health professionals, and these can limit the hopes and potential of service users (see Repper & Perkins, 2003; Grant, Biley, & Walker, 2011). There is no reason to believe that these will be any less damaging in an activity context than any other area of mental healthcare. Certainly, Suzie's account illustrates the negative motivational affects (e.g., "I felt

very, very frustrated") of a perception that a leader/coach holds low expectations and aspirations for one's abilities and possibilities.

This excerpt draws attention to the importance of coaching provision that is *appropriate* for the needs, abilities, and aspirations of group members. It is fair to say that, in any context, mixed ability groups make this aim a challenging – though not impossible – one for coaches/teachers to face. How might appropriateness be realised? Suzie's description of the badminton coach illustrates some possible strategies. First, the badminton coach, it seems, tried "to bring out the best in everyone." This indicates an orientation which tries to focus on each individual's needs, prioritising personal progression (i.e., charting progress against the individual's own skills, as opposed to external standards) over competitive or comparative progression (i.e., winning competitions or comparing individual scores). When a coach works in this way, it is possible for *all* members of the group to achieve and succeed. Second, the badminton coach is described as "very dynamic" in a way that "didn't give you any chance *not* to practice." This description conjures an image of a coach who maximises *time on task* – ensuring that group members are not left standing around with nothing to do, but instead the pace and progression of tasks and games is maintained. These – and other – qualities of effective coaching and leadership of physical activities can be considered 'good practice' among sport coaches, exercise leaders, and physical educators. While not often considered in the context of mental healthcare, this literature (see, for example, Cross & Lyle, 1999; Jones & Turner, 2006) offers useful information regarding how leaders/coaches working in mental health contexts might improve their physical activity provision. This includes information concerning (for example) effective management and organisation of sessions, different styles of coaching and leadership, ways of adapting activities to suit individuals of differing ability, and how to promote positive interactions between group members.

Considering Suzie's account alongside those of other participants, it appears that problems are likely when it is perceived that a leader/coach: (i) did not help motivate the individual to improve their skills; (ii) treated participants as if they had few skills; (iii) gave insufficient information to help participants progress; (iv) held low expectations regarding people with mental health problems; (v) overly controlled sessions. Conversely, in addition to the interpersonal qualities discussed above, participants appreciated and valued leaders and coaches who: (i) allow the individual to play at their own level while at the same time providing motivation and stimulation to strive for improvement; (ii) offer input concerning technique and how to improve specific skills which are necessary for overall play to develop (for example, the serve in badminton).

It seems to us essential that coaches and leaders who offer physical activity provision in mental health contexts strive for a balance which offers ability-appropriate tuition that works towards personal skill development and progression, alongside a sensitivity to the possibility that individuals may require greater levels of support than others, on one day than another, or with certain types of task. Successfully achieving this, we suggest, results in the provision of high quality and appropriate tuition which is valued by a participants. Often, participants cited this in itself as an incentive to maintained participation – because learning was pleasurable and led to observable improvements in one's ability. Because outcomes necessarily depend upon participation, it seems to us that more often than not the outcomes of activity (in terms of physical health, mental health, and psychosocial outcomes) are good when coaching practice is sound, but poor when it is not.

Conclusions

We have been struck by the extent to which, in describing their experiences of physical activity, participants' stories portray the importance of cultural and social factors for their

ongoing participation and the benefits that accrue. A social environment characterised as friendly and welcoming combined with a culture of mutual understanding, support, and acceptance allows people to feel safe to share aspects of their lives with each other without feeling the need to 'cover up' aspects of themselves. When a positive socio-cultural environment is present, participants' accounts portray the confidence and motivation to maintain participation. For many individuals, attendance is dependent on knowing that the session will be socially inclusive and welcoming, non-pressurised, accepting, and flexible. Conversely, when it is absent, participation is likely to cease. Because *any* benefits depend upon participation, it also follows – as participant accounts suggest – that the socio-cultural environment also influences the personal benefits that are experienced.

Reflecting on these points, we suggest that it is not so much *what* physical activity is delivered, but *how* it is delivered that is critical in terms of both participation and outcomes. In other words, the physical activity 'prescription' (e.g., type of activity, intensity, duration) is less important in terms of mental health outcomes than the presence of a positive socio-cultural environment or atmosphere. Creating an appropriate ethos for provision is therefore essential if physical activity opportunities are to be experienced as meaningful, valuable, and beneficial. On this basis, it is perhaps time that physical activity and mental health researchers began to consider not only what activity 'prescription' is best suited to mental health improvement, but also the social and cultural conditions of delivery that underlie improvement.

While the socio-cultural environment is necessarily shaped by all group members, it is the activity leader or coach who is central to its initiation, modelling, reinforcement, and continuation. A fine balance of appropriate expectation – without exerting inappropriate pressure – combined with realistic aspiration helps motivate, encourage, and build personal confidence. The ability to provide effective and appropriate coaching or teaching of the technical skills

necessary for personal development and progression was also identified by many participants as important. To cater for the complex needs of some people with SEMI, a degree of flexibility, adaptability, awareness, and sensitivity is required of leaders/coaches. These qualities, skills, and attributes are not easy to develop and, therefore, leaders/coaches will need support and education which helps them work towards this ideal. Participation in a good quality coaching course should help mental health professionals who are interested in physical activity or sport provision to develop a sound, person-centred approach. For coaches interested in working in mental health contexts, we suggest mental health awareness education to help tailor their practice to people with complex mental health needs.

Given the importance of the skills, attributes, and approach of the physical activity leader/coach, we would argue that their role is as significant in terms of therapeutic outcomes as is the role of the therapist in counselling, CBT, or psychotherapy. While the nature of the therapeutic relationship between therapist and client is consistently reported to have the greatest influence on outcome across the psychotherapies (Pilgrim, Rogers, & Bentall, 2009), research is yet to seriously consider this relationship in physical activity and mental health contexts. We suggest that the relationship between leader/coach and activity group member/s is no less important than the therapist-client relationship when it comes to the outcomes and success of physical activity provision.

Acknowledgements

We thank the mental health service users who have contributed to our research and evaluations. This work would not have been possible without their generosity. We would also like to thank the mental health professionals involved for their continued support. Finally, we thank the anonymous reviewers for their comments and support of an earlier version of this paper.

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