Although leisure is recognised as a key aspect of occupational therapy, few studies have explored it in relation to people with enduring mental health problems. Using a qualitative design, semi-structured interviews were conducted with 10 participants with mental health problems living in the community, randomly selected from clients referred to a local assertive outreach service in South-East England. Initially, the data were analysed for content and the phrases, language and words used; subsequently, emerging themes were identified, which were confirmed by a second occupational therapist.

The three themes arising from the data reported here were the number and range of occupations engaged in, the factors enabling participation in leisure and the factors hindering participation in leisure. The range of leisure occupations was similar to that noted in the literature. The main enabling factor was having an adequate network of people to provide support, while the main hindering factors were physical limitations, lack of finances and lack of transport. In the absence of paid employment, leisure was important to the clients. Occupational therapists need to recognise that enhancing the factors enabling participation in leisure and assisting clients to overcome the factors hindering participation in leisure will lead to the increased wellbeing of people with enduring mental health problems.

Factors Enabling and Hindering Participation in Leisure for People with Mental Health Problems

Yvonne Pieris and Christine Craik

Introduction

Leisure has been identified in occupational therapy models of practice and theoretical frameworks, with most literature advocating its importance in providing a balanced lifestyle and thus improving quality of life. The value of developing theoretical concepts relating to occupational therapy is also emphasised, yet most of these issues have been based on literature analysis and expert opinion rather than on research studies. The latter have only just begun to emerge, with the evidence base still in its infancy. Recent reviews of the literature on leisure and occupational therapy by Passmore (2003) and Passmore and French (2003) support this view, confirming that there is limited evidence of the influence of leisure on wellbeing.

Literature review

Definitions of leisure

Leisure has been identified as an essential component of everyday living and of importance to many people's lives (Primeau 1996, Suto 1998). Leisure is considered to take place in a person's discretionary time, with the freedom to choose, and to be pursued for its own rewards (Trevan-Hawke 1985). There are many theories about leisure and its meaning for people. While some common factors emerge from the literature, it is also recognised that leisure is a complex concept which varies from individual to individual, with Passmore and French (2003) concluding that there is no accepted consensus on leisure. Research is advocated in order to enable clients to determine what leisure means to them (Söderback and Hammarlund 1993). The expectation is that this would lead to the provision of leisure as an intervention based on individuals' needs, rather than on those needs predetermined by the therapist according to cultural, economic and historical norms.

Leisure and occupational therapy

Söderback and Hammarlund (1993) aimed to create a model of leisure time through literature review, having recognised that few occupational therapy frames of reference highlighted leisure. In 48 articles on leisure, from either occupational therapy or related literature, eight related to mental health. From these 48 articles they distilled 14 dimensions which they incorporated into a flow chart, creating a leisure-time frame of reference that could be used in occupational therapy assessment (Söderback and Hammarlund 1993). The main dimensions were time, intrinsic motivation, free choice of leisure-time activities,

capability, structure of the social and cultural environment, leisure-time activities, goals and the influences on the leisure role and behaviours. This study, now more than 10 years old and based on earlier literature, is dated but provides a useful foundation.

In reviewing the literature on work and leisure, Primeau (1996) suggested that a healthy balance of occupations was a matter of the affective experiences of individuals whilst engaged in the various roles within their environment. Often, occupational therapy assessments focused on work and leisure in terms of the type of occupation engaged in. Primeau (1996) considered that in determining health and wellbeing, far more prominence should be accorded to the balance of affective experiences that might be achieved by engaging in a series of occupations throughout a person's day and lifetime rather than to the balance of work and leisure (Primeau 1996). This concept was further advocated by Wilcock (1998) in determining the purpose and meaning of occupation and its relationship to health. Rather than considering occupation in its arbitrary divisions of work, play, leisure and rest, she emphasised the profession's responsibility to recognise susceptibility to illness as a result of continuing occupational deprivation, alienation or imbalance.

Reviewing the literature on the approaches to leisure in occupational therapy, Suto (1998) concluded that they were predominantly influenced by theories outside the profession and that future assessments should relate more to client-centred occupational performance issues. Reflecting on the previous 15 years of literature in the two principal North American occupational therapy journals, she cited only six articles on leisure, confirming the lack of research on this topic. Suto (1998) then examined leisure in the Occupational Performance Process defined by the Canadian Association of Occupational Therapists in 1997 and acknowledged that leisure was an important component. However, the predominant view was that productivity was more important and that leisure might be difficult when there were other more fundamental unmet needs. Nevertheless, although the experience of leisure may not either cure or eradicate the effects of mental health disorders, ageing or chronic health issues, it may have the potential to change the quality of life for individuals and communities (Suto 1998).

Similarly, Lobo (1998), examining the relationship between work and leisure, suggested that owing to the work ethic, leisure had a lower status than work. However, he noted that marginalised groups, including unemployed people, had time for leisure, if not the finance to enjoy it. Earlier, Trevan-Hawke (1985) had suggested that people with enforced leisure time, such as prisoners, unemployed people and hospital patients, might view leisure from a different perspective to those who were employed.

Leisure and mental health

A survey of United Kingdom (UK) occupational therapy practitioners in mental health (Craik et al 1998) did not support the opinions of Suto (1998) and Lobo (1998). From a choice of eight interventions, work emerged as the least used, with 19 of 101 (18.8%) practitioners reporting daily use. However, 119 of the 137 practitioners surveyed used leisure, with 40 (33.6%) reporting daily use, making it the most frequently used intervention, although there was no detail of what constituted leisure (Craik et al 1998). Meeson (1998) investigated the intervention choices of 12 occupational therapists based in community mental health teams in South-East England. Leisure was used more often than productivity, although at fifth and seventh, respectively, of the most frequently used of 21 interventions, the contrast with Suto (1998) and Lobo (1998) was not as striking as in the study by Craik et al (1998). Again, no detail was provided about the leisure, but this was not unexpected because neither UK study focused specifically on leisure. However, these UK research studies, despite their limitations, indicate the place of leisure in occupational therapy in mental health, in contrast to the views of Suto (1998) and Lobo (1998) which were based on the literature.

Using questionnaires with people with enduring mental health problems and their families in the United States of America, Perese (1997) noted their difficulties in having their needs met in the community because of limited resources and stigma The key areas of dissatisfaction were linked to money, enjoying leisure, the number of friendships and the state of their physical and emotional wellbeing. Mayers (2000) interviewed 11 clients with enduring mental health problems about their priorities in life with regard to improving quality of life. Seven interviewees reported that they would like to do more sporting activities and some expressed difficulties in forming relationships which led to loneliness. Of those involved in some form of leisure, two interviewees reported that this involvement made their life worthwhile, especially since they were unemployed.

Hodgson et al (2001) investigated how clients with a dual diagnosis experienced disruption to their daily occupations and considered their leisure participation. The findings of in-depth interviews with four outpatients supported the need to understand their leisure occupations. Leisure was seen as part of the recovery process, but loneliness, transport difficulties and financial constraints all contributed to the clients' difficulties in pursuing leisure interests.

The factors that influenced occupational engagement for eight people with schizophrenia living in the community were investigated by Chugg and Craik (2002). They found that the individual's mental and physical health, occupational routines, external factors such as the presence of others and having responsibilities at an optimal level, and internal factors such as self-efficacy and challenges at a manageable level all contributed to the level of engagement. Although they were not asked specifically about leisure, the participants reported that they were not able to work.

Nagle et al (2002) conducted in-depth interviews with eight people with mental health problems living in the community in Canada. The participants were not in paid employment so their occupational choices included leisure, although this was not the specific focus of the study. The participants wished to engage in more leisure occupations, especially those that they had done before and those that

were social; however, their involvement was curtailed by a lack of money. They valued socialising and doing things within a network of people.

In summary, the literature on leisure is mainly opinion based and the research studies are small scale and do not focus exclusively on leisure. Passmore and French (2003) concluded that the evidence for the effect of leisure on mental health was limited. In particular, there was little research exploring leisure in relation to people with mental health problems from their perspective. The present study aimed to address this situation.

Aims of the study

This study explored the leisure occupations of people with enduring mental health problems living in the community in order, first, to establish if the participants would have similar perspectives on leisure to those in the literature and, secondly, to determine the value that the participants placed on leisure.

Method

Design

The study took place in an assertive outreach service in South-East England for people living in the community who had a major mental health problem causing difficulty in their functioning. A qualitative design was adopted to elicit subjective responses, with an emphasis on developing a theory or concept. The intention was, as far as possible, to move away from the preconceived notion of what leisure meant and to gather data in the form of opinions and experiences. Because the study examined the participants' individual experiences, asking open-ended questions provided an opportunity to engage in conversation regarding these experiences.

Semi-structured interviews were conducted with 10 people using an interview schedule with nine questions, some developed from Söderback and Hammarlund's (1993) leisure-time frame of reference. Prior to the interview, the participants were told that questions would focus on their leisure, that there were no right or wrong answers and that their experiences and opinions were important. First, the participants were invited to describe the previous day and to indicate if it had been typical and if weekdays and weekends differed. Further questions elicited how much time during a day or week, and how many of the activities that they had mentioned, they considered to be leisure and what made it leisure. Given their choice, they were asked how they would spend their leisure time, what their favourite activities were and how these made them feel. Next, they were asked the importance of having the resources to do these activities and, assuming there were no limitations, if there was anything in relation to leisure that they wanted to do but were not doing. Finally, they were asked how they would feel if they did not do the leisure activities and then they were invited to add additional information.

A pilot interview resulted in removing a question about what influenced the way in which the participants spent their time. The pilot participant struggled with the concept of influence and rephrasing the question did not elicit an answer. The pilot interview was included in the analysis because this question was not asked at subsequent interviews and it did not affect other questions posed to the pilot participant.

Ethical considerations

The proposal was considered by the Brunel University ethics committee, which recommended refinements before allowing presentation to the local research ethics committee of the National Health Service trust. Following the provision of additional information, approval was granted. The inclusion and exclusion criteria, recruitment of participants, methods of obtaining informed consent and arrangements for the interviews were all designed to protect potentially vulnerable clients.

The inclusion criteria were clients of the assertive outreach service, aged between 18 and 65 years, able to speak English and to give informed consent to participate in the study. The exclusion criteria were clients who, at the time of the study, were in an acute phase of their illness, those believed to be under the influence of drugs and/or alcohol and those who, in the opinion of staff, would be caused distress by participation in the study. One person was excluded owing to hearing problems. Having applied the exclusion criteria, a random sample of 15 people was selected. To represent the caseload ratio, the caseload was separated into male and female categories and nine male clients and six female clients were chosen using a table of random numbers (Bahn 1972).

Recruitment

Having identified the potential participants, the recruitment process was designed to ensure that the clients would not feel obliged to participate in the study or be put at risk by doing so. This was important because the principal researcher (YP) worked in the service and might have been known by the potential participants. First, the Responsible Medical Officer ensured that the clients' circumstances had not changed and that they could still be approached. The clients were then invited to take part via their care coordinator, who had an outline of the study, a copy of the information sheet and the consent form. This procedure enabled the clients to discuss potential concerns with their care coordinator, who could also observe any signs of anxiety, and provided a further layer of protection for clients. The clients were encouraged to discuss their inclusion in the study with family or friends. Once the consent forms were returned, a mutually convenient time was agreed for each interview and the care coordinators were advised.

Seven of the nine male clients and two the six female clients agreed to take part in the study. A further male client and four female clients were randomly selected. The male client agreed to take part but withdrew on the interview day and one female client agreed to take part, two declined and the other withdrew on the interview day, resulting in 10 participants.

Interviews

The interviews lasted between 20 and 40 minutes and took place at the assertive outreach service team base, a neutral location familiar to the participants where support would be available should they become distressed by the interview. The participants were asked again if they agreed to the interview being tape-recorded and were reassured that they could seek clarification of the questions and could withdraw from the interview at any time without giving a reason. The intention was to pose the questions in the same order each time, although in some instances this was not possible because of the way in which the conversation progressed.

To maintain anonymity, the participants were assigned a pseudonym sequenced alphabetically in the order of the interviews. The audiotapes of the interviews and the transcripts were kept secure and were accessible to the researcher only. The transcripts were available to the senior occupational therapist who conducted independent analysis of the data.

Data analysis

The most common method of analysing data from semi-structured interviews is content analysis, which involves identifying general themes mentioned during the interviews and then counting the number of occasions on which they are mentioned (Hayes 2000). However, this tends to simplify content, reducing rich information to numbers. Hayes (2000) argued that the frequency of a theme being mentioned did not necessarily convey its importance. Nevertheless, as some questions identified the number of occupations that the participants engaged in and which ones they judged to be leisure, the use of content analysis was appropriate for the initial analysis.

The interviews were transcribed verbatim by the principal researcher as soon as practicable after each interview. Through this process, immersion in the data began, with no predetermined categories searched for. Then, the transcripts were read, noting items of interest and recording these for each interview. The issues or phrases that could be categorised between all the interview transcriptions were highlighted, noting their frequency. Attention was afforded to the words, phrases and language used, the form and structure of the dialogue and the sequence of interaction (Mason 1996). No themes were decided upon at this stage.

Once the categorisation and frequencies were reviewed, the next stage of the thematic analysis involved looking at the emerging themes, in relation to the participants and their context within the interview (Hayes 2000). Theory-led thematic analysis (Hayes 2000) was also employed when the data were searched for theories relating to leisure, such as time, activity and experience.

Once the themes were gathered, the transcripts were read again to search for additional information in the light of the emerging themes. To increase the trustworthiness of the analysis, a senior occupational therapist working for the team also analysed the data (Mays and Pope 1995). She was made aware of the questions asked, was given the interview transcripts to analyse and was asked to identify four to six themes. The themes she found matched those of the researcher. In naming the themes, the terms from Nagle et al (2002) of 'supporting' and 'hindering' occupational engagement were influential in this study; however, the term 'enabling' was used in preference to 'supporting'.

Findings

Details of the seven male and three female participants are displayed in Table 1. Six main themes arose from the interviews: the number and range of occupations, the factors

Table 1. Participant information

Pseudonym	Age (years)	Diagnosis	Accommodation	Living arrangements	Support
Adam	38	Paranoid schizophrenia	Council flat	With partner	Care coordinator, workshops, groups
Beth	57	Schizoaffective disorder	Council flat	With family member	Care coordinator, workshops, groups, family
Charlie	29	Drug-induced psychosis	Council flat	Alone	Care coordinator, workshops, family
Dave	50	Depressive disorder	Council flat	Alone	Care coordinator, workshops, groups
Eddie	28	Obsessive-compulsive disorder	Supported accommodation	Other clients	Care coordinator, groups, friends, work experience
Fran	65	Depressive disorder	Own house	Alone	Care coordinator, friends, family
George	55	Depression and anxiety	Staffed accommodation	Other clients	Staff, workshops, groups, family
Harry	55	Depressive disorder	Rented flat	Alone	Care coordinator, workshops, family
Ian	52	Recurrent depressive illness	Council flat	With family	Care coordinator, workshops, family, friends
Jane	30	Schizoaffective illness	Own house	Alone	Care coordinator, groups, family, friends

that hindered participation in leisure, the factors that enabled participation in leisure, why certain occupations were identified as leisure, feelings experienced during leisure and the value of leisure. The first three themes are presented here.

The number and range of occupations

Asked to recall a typical day, Jane said:

> Well there isn't one really, a typical day seems to involve doing a hell of a lot of washing, washing clothes, I like having a rest and a long hot bath, I like that. I sometimes go through phases of reading poetry and other times look through a parish magazine to see what's on, I go to the cinema, sometimes we see lots of films sometimes we don't.

Ian recounted the day before the interview:

> Yesterday, well I'm repairing a car for my son … most of my leisure time is spent mending cars, doing welding, maintaining them.

Comparing weekdays with weekends, Jane said:

> It is different, I feel I do more around the house at the weekend, I might see my family, I might do some ironing, the bathroom … for the last four or five weekends my boyfriend has had to work on a Saturday, so that's been hard.

In describing the occupations that they engaged in, the participants identified which of these they thought were leisure. When asked what she considered to be leisure, Beth said:

> Well usually it's evenings really, it's a case of me and my telly in the evenings you know, so I quite like some of the programmes, I'm interested.

Dave described his favourite leisure pursuits:

> I would say music is very important, going round friends for meals or having people come round for meals... having people round is very enjoyable… I've always enjoyed people's company, so that is what I call important.

While Adam said:

> Well we don't go every week, it's about once a month we go to church, we have tea and sandwiches, a chat with the others, there's a small service then a big service afterwards… That's leisure yeah.

Table 2. The number of occupations undertaken by the participants and the number and percentage of those identified as leisure

Pseudonym	Occupations (No.)	Identified as leisure (No.)	Identified as leisure (%)
Adam	25	17	68
Beth	11	6	55
Charlie	10	6	60
Dave	15	11	73
Eddie	10	7	70
Fran	10	9	90
George	5	3	60
Harry	16	14	88
Ian	9	7	78
Jane	15	13	87

In relating how they spent their time, the participants described occupations that could be categorised as self-maintenance, leisure and productivity. The content analysis of these occupations and the percentage that the participants identified as leisure are noted in Table 2. This ranged from 55% to 90%. All the participants were unemployed and, although some considered that they did not work, others thought that attending sheltered workshops, work experience and helping others constituted work. Some occupations related to the participants' health issues and were difficult to categorise, such as seeing the doctor, keeping in contact with their care coordinator and having blood tests. Although these occupations could be considered as self-maintenance, they specifically related to the participants' health status and accounted for regular commitments in their lives.

The wide range of occupations that the participants deemed to be leisure was recorded using the participants' own words and, through content analysis, the findings are noted in rank order in Table 3. Socialising was reported by all the participants, with watching television and videos, eating out and visiting places also being among the most popular. A wide range of leisure occupations is noted, some conducted alone and some with other people.

Table 3. Occupations engaged in by the participants which they identified as leisure in rank order

Occupations participants identified as leisure	No.
Socialising	10
Watching television and videos	7
Eating out	6
Visiting places, e.g. tourist attractions	6
Seeing family	5
Driving	5
Listening to music	4
Visiting the cinema	4
Cooking	4
Caring for pets	4
Playing badminton	3
Reading	3
Attending the theatre/concerts	3
Helping others	3
Listening to the radio	3
Playing cards, board games, doing puzzles	3
Church activities, e.g. attending services, singing	3
Cycling	2
Walking	2
Swimming	2
Sewing and knitting	2
Gardening	1
Jumble sales	1
Supporting charities	1
Car rallies	1
Gambling	1
Holidays	1
DIY	1
Evening classes	1
Building models	1

Factors hindering participation in leisure

The participants described how important it was to have adequate and appropriate resources to engage in leisure. This led to them identifying the factors that hindered their involvement in leisure. Some of these were extrinsic, such as lack of money, limited transportation and physical difficulties; others were intrinsic, such as fear, previous bad experiences and symptoms of mental illness, such as lack of motivation, lack of energy and ritualistic behaviours dominating events. Six of the 10 participants stated that their physical problems were more of a barrier to participating in leisure than any mental health symptoms.

Harry explained the difficulties that he had experienced when trying to engage in leisure:

> … I can't walk long distances because my feet are bad, I can't go swimming because of my skin, I'd like to do a bit more cycling but I'm worried about the cars … if there are more than six people in the swimming pool I won't go in on my own you know, that's why I like the sea.

All the participants were in receipt of benefits and perceived this as a financial constraint, although the extent to which engagement in leisure pursuits was curtailed differed. For some participants, the lack of money prevented them from pursuing leisure occupations, whereas others made choices that cost less or prioritised their spending to enable a minimum level of leisure participation. Harry said:

> If I had more money I could afford to go to the theatre up in London, see operas … walking is very cheap, all I need is a bit of petrol to get to a destination and then I'm off for 2 or 3 hours. Going to the sea is not bad, swimming is not too dear.

Several participants perceived financial limitations and were concerned about spending money even though they felt that they could afford to do so. Beth, when asked whether financial constraints affected her, replied:

> Oh yes all the time, because of taxis and that, mainly taxis I suppose … yes financing them holds me back that's true.

Access to events in terms of transport also became a barrier for a number of the participants. They were living in a relatively rural area where public transport facilities were restricted, so getting to venues became a major issue in terms of engagement. Five participants had their own transportation, but there remained some anxieties around confidence in getting to venues and the cost of running their own vehicles. Jane said:

> Well I haven't been abroad since 1994. I enjoy it but it's quite a bit of hassle … well if I could get down to Devon with [my boyfriend] I'd call it an achievement you know, we can build from there and go abroad together … it's the process of travelling really, taking your tablets, planning the route, train car whatever.

Factors enabling participation in leisure

While the participants discussed the factors that hindered pursuing leisure interests, the focus naturally led towards their stating what would enable more leisure participation. A common theme appeared to be social issues relating to the lack of a reasonable network of people to help to organise leisure pursuits and an absence of friends to share an occupation or time with. George exemplified this when he said:

> … it's very lonely, I'm a very lonely man, very lonely, I've got to go out with somebody… Just to be friends for the time being and just to cut the boredom.

While Harry said:

> … you can't go tenpin bowling on your own very well can you? There's no fun in it. I suppose being on your own is a restriction.

The participants who had regular contact with their families engaged in leisure pursuits with them, some of which were organised by their families. A further issue that arose in relation to the factors that enable leisure was the participants' preference to have events organised so that they would not need to take too much responsibility. They would be able to join in knowing that all eventualities would be catered for in terms of, for example, bookings, transportation and refreshments. When doing something for the first time, Harry said:

> I need to take someone with me for that first time in order to break the ice really.

Fran explained how she felt when she went out with friends and her input was at a level that she could cope with, which encouraged her to continue to engage socially:

> I think possibly when a group of us or a couple of us go out in the evening the conversation goes on and I don't have to be the centre of the conversation. I can just sit and listen … yes I enjoy it with the others when we go out for meals as a group, well I don't drive you see so to that extent I'm not responsible for getting there.

Discussion

The number and range of occupations

Using the traditional divisions of work, self-care and leisure, all the participants were unemployed, although a few felt that they engaged in work-related occupations such as work experience and helping others in need. Many described their involvement in self-care activities; therefore, for most participants, their discretionary time available for leisure was that left after their self-maintenance needs had been met. This may account for the number of occupations that the participants categorised as leisure and the time that they spent engaged in leisure, which for all participants was over 50% of their time and for three was over 80% of their time.

No particular patterns were evident in terms of solitary and group occupations or passive and active pursuits, suggesting that experiencing mental health difficulties does not necessarily curtail the variety of leisure occupations in

which an individual is prepared to participate. The formal and informal network of people around the participant appeared to influence the number of leisure occupations pursued. The occupations were not necessarily carried out in the company of others, but they may have encouraged, organised or initiated the leisure pursuit. For some participants, their network included health professionals.

It is clear from the participants in this study that they derived great benefit in terms of satisfaction and enjoyment from their engagement in these leisure occupations. In the absence of work, leisure assumed greater importance for them (Trevan-Hawke 1985) and many participants appeared to achieve their occupational balance through the variety of their leisure occupations and the time spent engaging in them (Primeau 1996, Wilcock 1998).

Craik et al (1998) and Meeson (1998) identified that leisure was a frequently used intervention in occupational therapy in mental health in the UK. This study confirms that clients with enduring mental health problems living in the community value participation in leisure and that occupational therapists should continue to use leisure as an intervention and to appreciate its validity and value for clients. However, some occupational therapy literature (Lobo 1998, Suto 1998) has suggested that work is more important than leisure. It seems unlikely that the participants in this study would support that view. Occupational therapists need to respect that occupational balance may be achieved through participation in a wide variety of leisure occupations and to facilitate this as a legitimate goal of intervention, rather than viewing leisure, even inadvertently, as a subsidiary goal.

Factors hindering participation in leisure

Factors that hindered and enabled leisure emerged from discussing how important it was for the participants to have adequate and appropriate resources to assist them to engage in leisure occupations. Lack of money, limited transportation and physical difficulties featured as the most restrictive factors. Passmore and French (2003) reported money and transport as inhibitors to engagement in leisure for adolescents as did Hodgson et al (2001) for clients with a dual diagnosis, while the participants in the study by Nagle et al (2002) reported financial limitations. In this study, the participants with their own means of transport felt that it gave them the freedom to pursue the leisure occupations of their choice whereas others had overcome financial difficulties by selecting occupations that cost less or had made lifestyle adjustments to accommodate leisure, albeit to a limited extent.

Mental health issues around motivation and confidence as well as particular features, such as ritualistic behaviours, affected leisure participation and these issues corresponded to those reported by Hodgson et al (2001). The extent to which physical difficulties limited the pursuit of certain chosen leisure occupations supported the findings of Chugg and Craik (2002) where clients' physical health issues restricted occupational engagement, sometimes more than mental health problems.

Factors enabling participation in leisure

The factors that enabled involvement in leisure included having a formal or informal network of people, echoing Nagle et al (2002). Other factors, such as having things organised, leisure becoming part of the participant's routine, not having to be responsible for or taking on the burden of planning events and the lack of partners, all evolved from issues around loneliness and the lack of a network of supportive people. Mayers (2000) found similar concerns about the difficulties in forming relationships, which resulted in problems in networking and thus loneliness and isolation. Hodgson et al (2001) also found loneliness to be a social barrier to engaging in leisure, which in turn meant relying on family members or taking part in leisure pursuits alone.

In this study, the lack of a close friendship or an intimate person in the participants' lives affected their overall enjoyment generally and taking part in various leisure pursuits in particular. For some, this was in not having someone special to share enjoyable events with or someone to come home to. Four participants specifically stated that an intimate partner would enable more leisure participation and they felt that it would also improve their quality of life. This reflects the findings of Perese (1997), where the respondents indicated that their unmet needs related to a friend, a role in life, belonging to a group, self-identity and information and/or help. The respondents specifically indicated that a girlfriend or boyfriend was an unmet need.

Implications for occupational therapy

Occupational therapists need to take account of clients' intrinsic and extrinsic limitations as well as clients' capabilities in assessment and treatment planning, as recognised by Söderback and Hammarlund (1993) and Suto (1998). These authors suggested that people's physical and mental impairments restrict leisure participation and their ability to participate in community-based facilities. The resources available in terms of the structure of the social and cultural environments have an impact on leisure engagement and these need to be addressed by the occupational therapist in negotiating treatment programmes with individual clients.

From the findings of this study, it appears that occupational therapists should concentrate on overcoming the extrinsic factors hindering participation in leisure, such as transport difficulties and financial limitations, and enabling socialising and networking. These can more readily be addressed than those intrinsic factors such as lack of motivation and concentration that are more central to mental illness but which are also more difficult to ameliorate. This is not to suggest that occupational therapists should neglect interventions based on symptom reduction and improving function, but they should endorse enhancing occupational engagement as a worthy aim.

In particular, having a supportive network to facilitate socialising occupations would appear to be as important to

some participants as having someone to accompany them on social events. This suggests a substantial role for occupational therapists in less direct forms of intervention aimed at empowering people with mental health problems to set up their own networks. Nearly 20 years ago, leisure was advocated by Trevan-Hawke (1985) as a realistic treatment aim. Although this advice remains pertinent today, the focus has widened to enable people with mental health problems to lead a satisfying life in the community. Using leisure more beneficially and therapeutically means that occupational therapists can be instrumental in facilitating community-based participation for this client group and hence can contribute to their wellbeing

Critique of the study

Providing the participants with an opportunity to express their own views, opinions and personal perspectives in relation to leisure was a strength of this study. This is in keeping with occupational therapy's view of empowering individuals to influence their own lives and with Government policies (Department of Health 1999) of user involvement in shaping future health interventions and service provision. However, this was a small-scale study and thus its impact may be restricted. Nevertheless, when taken in conjunction with other studies it adds to the evidence base of the profession in relation to the value of leisure occupations for people with mental health problems. In particular, the finding of the impact of physical health in limiting engagement in leisure occupations echoes a similar finding by Chugg and Craik (2001) and provides useful information for occupational therapists working with this client group.

Conclusion

The main factors hindering participation in leisure were transportation difficulties, lack of finances and physical limitations, which reflected previous findings with a similar client group. The main factor that enabled leisure participation was a sufficient network of people to support engagement in leisure as well as to socialise with. The participants appeared to value leisure as a part of their everyday lives and, therefore, the possibilities of leisure as a valid and meaningful form of occupational therapy intervention are advocated. Future areas of research should address the ways in which occupational therapists can assist clients with enduring mental health problems to overcome the barriers described in this study and how communities can assist and enable leisure participation.

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