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An Exploration of the Lived Experience of Sport and Exercise for Mental Health Service Users - The Journey to Health

Luke Pickard 2014

Masters by Research

University of Huddersfield

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Co Supervisor – Kiara Lewis



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&

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Abstract

The aim of the study was to explore the lived experience of sport and exercise for mental health service users. There were three additional objectives; to investigate the effects of sport and exercise on mental health and wellbeing; to investigate the perceptions of mental health service providers regarding service delivery and finally to investigate fundamental issues of session structure. The study looked at the experiences of sport and exercise from both mental health service users and mental health service providers. Participants were recruited for the study from Leeds and York Partnership Foundation Trust and the lottery funded 'Let's Do This' scheme. The mental health service users had a range of mental health conditions, were from different ethnic backgrounds and aged over 18. Mental health service providers had a range of positions from management to direct service delivery. Semi structured interviews were conducted with five mental health service users and five mental health service providers. The data was analysed using interpretive phenomenology which drew on the work of Van Manen's methodology; this interpretive approach is utilised as both a research methodology and a method. A number of themes were highlighted including 'The changing self image through sport and exercise', 'Am I valuable' and 'Salubriousness of sport and exercise'. Two essential themes 'The cycle of recovery' and 'Intermittent health breaking through heavy clouds of illness' led to the development of an essential statement that illuminates the essential structure of the lived experience of sport and exercise for mental health service users. Sport and exercise can have an important role to play in the lives of mental health service users. The way in which the service is delivered can impact this role. Structure is important both literally and mentally. The research found a number of strengths of the service currently being delivered. These included the contribution of the staff; both in the management of the scheme and the flexible delivery. Coaches were respected for their sport and exercise expertise and were able to change or modify sessions to best serve the mental health service users. Mental Health service users' had trust in their coaches, they felt they were understanding of their conditions and cared. In some cases these relationships were potentially considered of greater importance than the content of the session. The way in which the scheme supported mental health service users in 'bridging the gap' between a mental health setting and being back in the community was another important finding. This type of finding can prove useful for those designing and delivering sport and exercise schemes for mental health service users. The findings also point to possible areas of future research and implications for practice and policy.

Chapter 1 - Introduction

'The National Institute for Health and Clinical Excellence has been recommending for the best part of a decade that depression patients be encouraged to exercise, up to three times a week if possible. There were spells in my own illness when I was too weak to exercise. But even then the medical advice was to try to do something active: a short walk, gentle gardening. And every time I got out to yomp in the park, I felt better. Once I was stronger, every swim, every cycle ride and eventually every game of football left me buzzing. It's not just the chemical effects on the brain, which I admit I am not qualified to talk about with any authority. It's the fact of taking yourself out of yourself for a few moments, forgetting your predicament, changing the wallpaper and breaking the cycle of rumination, mental agonising and loneliness that depression can inflict.

As for the scientists, one thing about their methodology strikes me as slightly awry, and that is the notion of "facilitated physical activity intervention". Being told to exercise might have a very different psychological effect to doing it autonomously. One depression sufferer, John Lake, told me recently that he had done the London marathon and triathlon. He felt so great, he came off his antidepressants. "That's why I found the running was great. It was taking back control from the medicine." There's something in that notion of empowerment that can be very nourishing to someone who has spent months, years even, hopelessly reliant on others.' (Mark Rice-Oxley 'I believe exercise can help beat depression' Guardian Online. June 6th, 2012)

The given introductory excerpt illustrates how sport and exercise can effect a person suffering from mental illness. Rice-Oxley (2012) demonstrates feelings of escapism and positive feelings related to the experience of physical activity. The piece contrasts medical advice with a powerful description of human experience. This short description of experience associated with being physically active illuminates my initial impetus for study. I am particularly interested in the wider benefits of sport and exercise for people with mental health problems.

Media attention upon the benefits of sport and exercise for those with mental health problems has been mixed. An article authored by Chalder et al. (2012) published in the British Medical Journal was discussed in the media as demonstrating that exercise has no positive effects for sufferers of depression. The article struck me as potentially damaging when there is a bigger need than ever to encourage healthy lifestyles, not least because of the reported obesity crisis (Stuckler and Basu, 2013). Interestingly upon reading the original article, a number of important factors were seemingly overlooked by the media. The potential wider benefits of sport and exercise were not conveyed.

This observation reinvigorated my interest in the topic area and led me into a volunteer role with the Healthy Living Service Leeds and York Partnership Foundation Trust (LYPFT). The service works with people with mild to severe mental health problems. As part of the patient recovery process, a sport and exercise scheme is offered. Through this volunteer work an opportunity to conduct research on the scheme was provided by the clinical lead of the service. I wanted to investigate provision from the perspective of the service providers to provide an insight into what they have experienced

through their careers in terms the appropriateness of sport and exercise for mental health service users.

This chapter will set the scene for the thesis. Issues of definition and policy will be discussed, before the structure of the thesis is outlined.

1.1 Information on the 'Let's Do This' scheme



The 'Let's Do This' scheme was developed from a pilot scheme set up by a member of the Healthy Living Service LYPFT. The pilot scheme looked to provide free sports and exercise sessions for mental health service users. The pilot ran for 6 months and was well received. The Healthy Living Service LYPFT was then successfully granted funding from the 'The Big Lottery Fund' ¹ which awards funds from 'The National Lottery' to provide sport and exercise sessions in the community. The joint collaboration between the Healthy Living Service LYPFT, Leeds Mind², Aspire³, Touchstone⁴ and Leeds City Council aimed to improve the physical health of people recovering from mental ill-health. There was not an exclusion criteria based on mental health condition. Conditions ranged from anxiety and depression through to psychosis as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013). The sessions aimed to help reduce barriers individuals may face in accessing mainstream services once support from

¹ The Big Lottery Fund is responsible for distributing 40 per cent of all funds raised for good causes by the National Lottery - around £670 million last year. They deliver funding throughout the UK, mostly through programmes tailored specifically to the needs of communities in England, Scotland, Wales or Northern Ireland as well as some programmes that cover the whole UK

² Leeds Mind supports people with mental health problems, providing services throughout the Leeds area. They work with people to support them in achieving their goals and engaging in their communities including; Housing, employment, job retention and employment peer support, Wellbeing, befriending, counseling and peer support

³ Aspire is the Leeds Early Intervention in Psychosis (EIP) Service. They work with young people in experiencing early signs of psychosis. They provide a specialist service to people aged 14 to 35 in Leeds in the first three years of experiencing psychosis

⁴ Touchstone provides a range of innovative services that improve health and wellbeing in the Leeds area. NHS Leeds has commissioned Touchstone to improve the mental health and wellbeing of the seven largest BME communities in Leeds: African Caribbean, Bangladeshi, Chinese, Indian, Irish, Pakistani, and Refugee & Asylum Seekers.

mental health organisations is reduced. The 'Let's Do This' scheme looked to help bridge the gap between leaving mental health services and developing a regular routine to promote recovery and prevent any future relapse. The 'Let's Do This' scheme was delivered by coaches. These were council sports staff and mental health professionals at two leisure centres in Leeds. The term 'on the ground providers' will be used throughout the thesis to describe the coaches. The coach's role in the scheme was to decide on session content based on recommendations made by mental health and sports service managers and deliver the weekly sessions. The term managers will be used to identify these service managers, their roles include charitable mental health services, NHS mental health services and local council. The service managers created and developed the scheme. Mental health service users were referred to the 'Let's Do This' scheme through the Healthy Living Service, Touchstone Aspire or Leeds MIND. All sessions were deemed suitable for all abilities and levels of fitness; the sessions were flexible to ensure any specialised needs could be met by the sessions. The scheme structure generally complied with the National Institute for Health and Care Excellence (NICE) (2009) guidelines for physical activity (PA) and treatment and management of depression. No specific guidelines are recommended for the use of PA and the management and treatment of psychosis. The guidelines state that people with mild to moderate depression should be delivered exercise in groups with support from a competent practitioner and consist typically of three sessions per week of moderate duration (45 minutes to 1 hour) over 10 to 14 weeks. Individuals could attend up to ten sport and exercise sessions in total on the scheme; sessions were delivered once a week. This was appropriate given the aims of the scheme; the scheme looked to be a starting point for building healthy behaviour. One of the key ideas of the scheme was to introduce participants to a range of activities that they could potentially then undertake on their own following completion of the sessions. The scheme therefore acted as a pathway for the participants/mental health service users to gain confidence in utilising community provision in a local leisure centre while engaging in PA.

1.2 Issues of definition

In a lot of the literature related to sport and exercise specific to clinical populations and more generally, there is definitional debate and a use of varied terminologies. It is therefore important to firstly clarify the wider definition of physical activity and its relatedness to the operationalised definitions of 'sport' and 'exercise' in the current study. The following definition by Caspersen, Powell & Christenson (1985) defines physical activity (PA) as:

‘Any bodily movement produced by skeletal muscles that result in energy expenditure. The energy expenditure can be measured in kilocalories. Physical activity in daily life can be categorized into occupational, sports, conditioning, household, or other activities.’ Pg 126

Despite the age of the definition it is still the most widely used within the literature. Other definitions have been proposed and used but these are generally based on the Caspersen et al. (1985) definition (Strath et al., 2013).

One sub category of PA is exercise. Caspersen et al. (1985) state that exercise is:

‘Planned, structured, and repetitive and has as a final or an intermediate objective the improvement or maintenance of physical fitness. Physical fitness is a set of attributes that are either health- or skill-related. The degree to which people have these attributes can be measured with specific tests.’ Pg 126

In addition, ‘sport is viewed to be a subset of exercise that can be undertaken individually or as part of a team. Participants adhere to a common set of rules or expectations, and a defined goal exists’ (Khan et al., 2012 pg 59). There are many definitions of sport; this definition is used as it omits the term ‘competitive situation’ which is utilised in many alternative definitions (Pringle, 2012). This is an appropriate given that some of the activities delivered by the scheme involve playing a sport such as table tennis or badminton but the emphasis is on coaching technique and skill rather than point scoring. Given the participants are taking part in a scheme where PA sessions are organized, the terms ‘sport’ and ‘exercise’ are more appropriate than the general term ‘PA’.

Thomas (2009) stated ‘wellbeing is, intangible, difficult to define and even harder to measure’ (p. 11). The following definition of wellbeing has been chosen for the current study mainly to be considered as a general point of reference as it considers wellbeing to be a state not a construct; it avoids describing and attempts to define wellbeing using both hedonic and eudaimonic approaches. ‘Stable wellbeing is when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge’ (Dodge, Daly, Huyton & Sanders, 2012, pg 230). This definition is appropriate as it can be used to help understand how people handle change and how their wellbeing levels or resources are affected. The aspiration is that the scheme will enable mental health service users to experience sport and exercise and feel that they increasingly have the resources to meet their daily challenges. The current study aims to explore the participant’s experiences and at some level be able to elicit an understanding of wellbeing as relevant to the given context.

The research has a focus upon people with mental health problems. The term mental health service user is a label commonly used within health and social care organisations in the UK, academic literature and policy (Simmons et al., 2010). It is a term broadly used to describe an individual who has a mental health problem and is in receipt of mental health or social care services.

The term mental health service provider is also used in the current study rather than other labels such as 'health professional' or 'practitioner'. This is to cover the range of positions the participants occupy; from management through to on the ground delivery. The term also highlights how these individuals are involved in delivering interventions for mental health service users. The term is used in other recent health based studies (e.g. Glisson, Williams, Green, Hemmelgarn, & Hoagwood (2014); Green, Albanese, Shapiro & Aarons 2014; Levy & Strachen 2013).

1.3 Policy considerations

Public health and mental health policy regarding sport and exercise is of particular interest to the current study. The Mental Health Foundation (2014) states that one in four people in the UK will suffer some kind of mental health problem in the course of a year, the most common being depression. In the year 2010/11 in Leeds there was 323 contacts with mental health services per 1000 people, while 11.2% of adults were classified as suffering from depression (Community Mental Health Profile [CMHP], 2013). These figures are typical of rates throughout the UK (313 contacts per 1000 & 11.68% depression). There were 24.9 per 100,000 new cases of psychosis in England 2012/12 and 65 hospitalizations for psychosis related conditions in Leeds between 2009/10 and 2001/12, this is higher than the national average of 57. Recovery rates in Improving Access to Psychological Therapies (IAPT) service is 43.8% UK wide (Glover, Webb & Evison, 2010), over half of referrals are therefore not receiving the care they require through the talking services (CMHP, 2013).

The Annual Report of the Chief Medical Officer (2013) states the treatment of mental health patients should be on a par with treatment of physical health conditions. The report goes on to state; 'Whilst there is a wealth of robust evidence for public health approaches to mental illness prevention and mental health promotion, England needs a better defined, policy-relevant focus on these concepts' (Chief Medical Officer, 2013, p.12). This document states the financial implications of mental health issues in the UK economy; up to £100 billion per year, accounting for 70 million sickness absence and 23% of the national disease burden. Investment in real-terms in mental health service has fallen.

The PA strategy Leeds (The Leeds Initiative, 2008-2012) highlighted the need for a city wide general practitioner (GP) referral system; it has yet to be implemented. The GP would generally be the patient's first contact with a health professional regarding a problem, this highlights the importance of GP's promoting healthy behaviour such as PA, sport and exercise and referring people and prescribing such for patients. National policy regarding GP referral to PA schemes (NICE, 2014) states that:

- Poor mental health can also be exacerbated by a lack of exercise.
- Exercise referral schemes may be cost effective in encouraging PA among specific groups. For example, they may help people with multiple disease risk factors such as hypertension, obesity or poor mental health, or those who would not otherwise have access to supervised exercise programmes.
- It does not cover structured exercise programmes designed for managing a specific health condition or rehabilitation following recovery from a specific condition.

Specific NICE (2014) guidelines for the treatment and management of depression in adults states that people with persistent sub threshold depressive symptoms or mild to moderate depression should be offered one or more of the following interventions, guided by the person's preference:

- Individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
- Computerised cognitive behavioural therapy (CCBT)
- A structured group PA programme.

While there are guidelines for depression, no PA interventions are recommended for psychosis and schizophrenia (NICE, 2014). IAPT's policy is in contrast to the NICE guidelines. It states that only 'low intensity' patients should be encouraged to exercise (Gyani, Shafran, Layard & Clark, 2011). The importance of exercise is merely mentioned in self help materials, it is not delivered by competent staff in a prescribed group format as suggested in NICE guidelines (2014).

The cross-government mental health outcomes strategy for people of all ages 'No Health without Mental Health' (Department of Health, 2011) states that:

- The Government will ensure that the population as a whole knows what it can do to improve its wellbeing and stay healthy.
- There are many things individuals can do to improve their own mental health; for example, drinking within safe limits, taking regular exercise and participating in meaningful activities, such as arts and sports activities and experiencing the natural environment.

This is a key document regarding mental health. Despite the recommendations highlighted in the other policy documents, this document only includes two statements in reference to the importance of sport and exercise for mental health service users. This is also the case in the Leeds 'Improving Health, Improving Lives' 2013-2018 document (Leeds Sport and Active Lifestyle Strategy, 2011) which outlines a number of key strategic objectives and priorities with regard to mental health, none of which are directed towards using sport and exercise for improving mental health. This document is based on a number of national policy documents, including the 'No health without mental health' (Department of Health, 2011).

1.4 Structure of the thesis

The research aim of the current study is to explore the lived experience of sport and exercise for mental health service users. Related objectives include:

1. To investigate mental health service users perceptions of the effects of sport and exercise on their mental health and wellbeing.
2. To investigate the perceptions of mental health service providers regarding service delivery and the impact of sport and exercise on mental health service user's mental health and wellbeing.
3. To investigate fundamental issues of session structure.

The study uses an interpretive phenomenological design which draws on the work of Van Manen's (1990) methodology. This interpretive approach is utilised as both a research methodology and a method.

Chapter two details the literature review. The background issues deemed relative to the phenomena under study are addressed. The literature review draws on peer reviewed research within sport and exercise and explores the impact on mental health and wellbeing. The chapter details current gaps

in knowledge and further evidences the rationale for the current study focus, the main research aim and related objectives of the current study.

Chapter three describes the philosophical underpinnings of the current study and the appropriateness of phenomenology for the current research aim.

Chapter four outlines the current study design and the methods conducted, detailing operationalised methodology and practical procedures.

Chapter five presents the thematic findings; the exploration of the lived experience of sport and exercise for mental health service users. The overlapping perspectives of both mental health service users and mental health service providers will be reported and explored.

Chapter six includes a summary of the main findings of the study and a discussion around what is considered to be the essential nature/structure of the experience. The chapter also includes reflection on the methodology, considers the strengths and limitations of the study, the possible implications of the research and future recommendations.

Chapter 2: Literature review

This chapter provides an overview of the relevant literature in the field of PA, sport, exercise and mental health. The focus is upon peer reviewed literature surrounding sport and exercise for mental health service users. An internet based search of relevant literature (1980-2014) was conducted. Post 1980 was selected as the large scale closure of mental health institutions had taken place and there was a move towards community mental healthcare (Gilbert et al., 2014). The less contemporary articles were included in order to comment on how literature, theory and ideas of PA, sport, exercise, mental health and wellbeing have developed over time. The review operationalised a systematic search, using the Summon indexed publications. The list of journal titles indexed in Summon does effectively overlap with many of the traditional databases including PsycArticles, PsycINFO, PubMed and Science Direct. The search strategy included the research topic, method and methodology. The search was conducted using combinations of key words: 'exercise' or 'sport' or 'physical activity' and, 'health' or 'mental health' or 'wellbeing'. Additional terms were later added including 'experience', 'psychological', 'physiological', 'fitness', 'policy', 'endorphins', 'neurochemical', 'physical', 'intervention', 'mood', 'inactivity', 'physical education', 'team', 'individual', 'green activity', 'provision', 'schemes'. The literature review was not restricted to articles retrieved this way, further articles were found through referenced work. Articles were included in the review if they addressed an adult mental health population and explored issues of sport and exercise. All articles reviewed were published in English language. The abstracts of yielded articles were reviewed to aid the decision to include or not. The aim was to not produce a systematic review but to produce a literature review resultant of a systematic search.

The importance of an active lifestyle including regular sport and exercise is researched widely from a number of epistemological and ontological positions. Current literature in the field ranges from biopsychology; investigating neurochemical and physiological effects of PA (Dinas, Koutedakis, & Flouris, 2011), through to psychosocial research which examines psychological wellbeing, self esteem, self efficacy, cognitive functioning and identity (Barton, Griffin & Pretty, 2012).

2.1 Biopsychological research

From a physiological and neurochemical viewpoint, the endorphin hypothesis (Lahti, Rahkonen, Lahelma & Laaksonen, 2013) found that vigorous exercise correlates with an increase in endorphin levels of the neurotransmitters serotonin, dopamine, acetylcholine and norepinephrine in blood plasma (endorphins are peptides that act similarly to morphine and produce a natural high)

(Leuenberger, 2006). These are implicated in mood elevation, anti depressant qualities and improved cognitive abilities (Deslandes et al., 2009). It is possible, that individuals experience different levels of endorphins and neurotrophic factors when being physically active and as such sport and exercise can affect people in contrasting ways. Research in this area has also found that endorphin activity may be different depending on the individual, creating difficulty in analysis (Dinas et al., 2011). Some researchers (Da Silva et al., 2012; Di Luigi, Guidetti, Baldari, & Romanelli, 2003) have also found non-significant data in terms of endorphin levels. Inconsistent methods and experimental techniques have been attributed for reasons for these inconsistencies (Knochel et al., 2012).

Exercise has also been found to improve biological risk factors such as dyslipidaemia, glucose intolerance and vascular dysfunction. These have been related to mental health issues such as depression and dementia. Exercise is said to improve mental health through reducing biological stress reactivity (Barton et al., 2012; Knochel et al., 2012).

Despite much of the literature concurring on the described benefits of being active, methodological problems such as issues of determining causality affect the generalizability of research findings. Even the most robust and rigorously conducted studies fail to account for all the variables that could play a role in this research area (Barton et al., 2012), such as the variety of psychosocial outcomes. What is important to draw from this body of research is that throughout many years of research, the physiological effects of PA are generally positive. By exercising people become physically fitter and healthier (Chaput et al., 2010). By becoming healthier physically, invariably people's mental health and wellbeing improves (Carek et al., 2011).

2.2 Psychosocial research

Psychosocial research on PA, sport and exercise provides different explanations for the positive effects participants receive; these are based on things such as social interaction, achievement and distraction. Many positive effects of PA have been shown in clinical populations. Positive correlations have been found between PA increased self esteem, self efficacy, cognitive functioning and psychological wellbeing (Barton et al., 2012; Callaghan 2004; Hassman, Koivul, & Uutela, 2000). Barton et al. (2012) found that stress and anxiety can be reduced in a single exercise session and that exercisers have higher self esteem levels than non exercisers. Theory proposed by Daley (2002) suggests that sport and exercise acts as an escape or distraction from everyday problems and stressful situations and as such may also offer some people a coping strategy.

In a meta analysis of 28 exercise studies investigating wellbeing and cardiovascular risk, Boehm and Kubzansky (2012) highlighted a series of holistic wellbeing factors achieved through exercise. One of these factors is eudaimonic wellbeing which encompasses links between PA and life purpose, optimism, personal growth, vitality, self acceptance, autonomy, life satisfaction and positive affect. A review article conducted by Eime, Young, Harvey, Charity and Payne (2013) looked specifically at sport; outcomes included a reduction in social anxiety, improved social functioning and competence, a sense of belonging and friendship. Levy, Nicholls and Polman (2012) believe competitive sport can improve mental toughness, mental toughness can aid in emotional and life control as well as interpersonal confidence, all of which could be considered beneficial to a person's mental wellbeing. These findings infer that the benefits of sport on psychosocial factors may even surpass physiological benefits. The difference in findings between sport and exercise is clear. The sport research highlights social issues whereas the exercise research highlights individual benefits. Therefore encouraging a combination of sport and exercise for mental health service users could be beneficial individually and socially (Khan et al., 2012). However, Stubbe et al. (2006) argue emotionally well adjusted individuals are more attracted to exercise and naturally have a good level of mental health and wellbeing. This suggests that those with mental health problems may not be interested in exercise participation.

2.3 Sport, exercise and mental health

Mental health service users are typically more sedentary, smoke and drink more alcohol than the general population (Richardson et al., 2005). These risky behaviours exasperate mortality rates. They also contribute to co morbidity; depression is twice as likely in patients with type II diabetes, and mental health service users are more likely to be obese and are therefore more likely to develop type II diabetes (Harkness et al., 2010). Furthermore, mental health service users are given medication that can cause many unwanted side effects, exasperating sedentary and unhealthy behaviour including weight gain, dizziness and tiredness (Kikuchi et al., 2010). The idea that by encouraging a healthier lifestyle which includes PA offers the potential for patient's lives to be extended is a simple yet profoundly powerful association. An unhealthy population would see the most dramatic improvement, it is therefore vitally important that PA is promoted in such populations (Richardson et al., 2005). Richardson et al. (2005) also noted that health professionals have a responsibility and an obligation to make sport and exercise readily available to patients with mental health problems in an attempt to improve their physical health.

The perceived benefits of sport and exercise in the general population have encouraged psychologists and health professionals to try and implement sport and exercise in clinical settings. Martinsen and Medhus (1989) asked mental health patients to evaluate fitness training in comparison with more traditional forms of therapy such as medication and psychotherapy. Patients ranked fitness training as what helped them the most. More recent research (Duda et al., 2014; Stubbe et al., 2006) found within a mental health population, regular exercise was linked to greater life satisfaction, happiness and wellbeing. Furthermore, PA can provide preventative resilience to mental illness (Griffiths et al., 2014). De Moor (2006) in a study of 19000 Dutch nationals found that lack of exercise was cross sectionally associated with depression and exercise correlated with greater social functioning and lower anxiety. Research conducted by Strohle (2009) demonstrated that 30 minutes of treadmill walking for 10 consecutive days can produce a significant reduction in depression.

2.4 Cost benefits of sport and exercise

Knubben et al. (2007) in a randomised controlled trial found exercise to be more beneficial than antidepressants. Hamer, Stamatakis and Steptoe (2008) found that the mental health benefits associated with sport and exercise in clinical populations can be seen at a minimum level of 20 minutes of exercise per week, this emphasises the positives of including sport and exercise in recovery programmes in terms of cost effectiveness and patient benefits. Cognitive behavioural therapy (CBT) and medication are both costly, whilst waiting lists for CBT continue to increase due to increased patient demand (Fox et al., 2000).

2.4.1 Who benefits?

Vancampfort et al. (2011) conducted a systematic literature review of quantitative studies looking at PA and psychosis. They found that PA increases the confidence of psychosis sufferers and therefore increases the chance of treatment success. In another literature review by Holley, Crone, Tyson and Lovell (2011) the focus was on PA, wellbeing and schizophrenia. They found PA increases social interaction and social competence. Acil, Dogan & Dogan (2008) conducted a 10 week PA scheme with psychosis patients and found a statistically significant reduction in visual hallucinations. Furthermore they found sleep quality benefits along with an increase in self-respect.

Other benefits to the clinical population have been discovered. Manger and Motta (2005) highlighted the benefits of sport and exercise for post-traumatic stress patients. Esquivel et al. (2002) found sport and exercise to have an anti-panic effect and therefore beneficial for patients with panic disorder. The positive effects of PA are not restricted to one or two specific mental health conditions, the benefits have been demonstrated throughout a wide range of conditions including anxiety, depression, low mood and panic. Medication for different mental health conditions varies greatly to achieve positive results in different patients, while PA remains consistently effective (Carek, Laibstain & Carek, 2011). This is an important factor especially when considering sport and exercise could be used to supplement or even potentially replace medication in some cases for patient recovery in a non-invasive healthy manner (Searle et al., 2011).

2.4.2 What are the benefits?

Carless and Douglas (2008) raise a number of crucial points in a narrative investigation into identity and mental health. Recovery is not just about alleviating symptoms, it is also about rebuilding the self, social identity and a sense of hopefulness for the future. Sport and exercise can deliver a sense of meaning, purpose, optimism and hope to mental health service users (Carless & Douglas, 2008). It can help people rediscover a sense of identity (Carless, 2008). The reasons suggested for the benefits are action, achievement, social relationships and support from other participants and staff involved. An interesting discovery made by Hodgson, McCulloch and Fox (2011) who interviewed mental health service users from a regular exercise scheme found that feelings of achievement are received not just through winning but also through regular attendance. Much of the focus from a medical perspective looks to make people less impaired, dysfunctional, disadvantaged and less 'abnormal'. As academics, service providers and health professionals we should be striving to make people more satisfied with life, giving them more purpose and more success (Carless & Douglas, 2008). A greater emphasis could be placed on enhancing individual's lives rather than alleviating problematic symptoms (Dinas et al., 2010). The holistic benefits of sport and exercise explored demonstrate the positive effect we can possibly bring to someone's wider life including self esteem, self efficacy, relationship development and social competence (Vreeland, 2007).

Similarly, Crone, Smith and Gough (2005) in grounded theory research found self acceptance, achievement, belonging, purpose and coping were all themes which mental health service users associated with regular sport and exercise. Crone and Guy (2008) advocated the inclusion of exercise programmes into care and treatment plans after mental health service users described the positive

effects of structured sport and exercise. Positive effects included increased wellbeing, self-satisfaction and management of a range of mental health conditions. Wright et al. (2011) found through descriptive content analysis that the main therapeutic elements of PA for people with bipolar were the mood regulating effect of participation and the structure regular participation brings to a person's life.

The transition from an institutionalized setting for mental health service users has been found to be difficult. Chow and Priebe (2013) conducted research into psychiatric institutionalisation and commented on 'adaptive behaviour' and 'social withdrawal' both of which contribute to the loss of independence and responsibility. This may have a detrimental effect on management of everyday demands. Therefore the benefits highlighted may aid the mental health service users to function within a non-institutional setting. Stevens (2003) phenomenological enquiry of late studentship examined personal growth and existential concerns of transition from one way of being to another. The research highlighted changes in self identity and how it can be shaped through experiences. This personal growth element paired with issues of self identity holds specific resonance to the journey of mental health service users looking to become both physically and mentally 'healthy'. The transition to a state of mental health will require challenges to their perceived identity, this could possibly occur through a self examination of their physical capabilities and the extent to which they can participate. They may experience new skills, achievement and healthy behaviour that could positively affect their identity and therefore their transition to 'health' (Brunet et al., 2013).

2.5 Possible negative effects of PA, sport and exercise

A cautionary note from the body of research is some of the negative consequences of PA. Research looking into elite athletes has found that Sports injury, competitive failure, ageing, retirement from sport and other psychosocial stressors can lead to depression and other psychological problems (Cresswell & Eklund, 2007; Peluso & deAndrade, 2005). Despite the focus on elite athletes the problems they face could possibly affect the mental health service users and as such there may be the risk that PA could magnify their current problems. Anyone can experience sports injury; this could negatively affect mood or self-esteem and add to the mental health service user's problems. Further problems of PA highlighted in the research include body dysmorphia (Greenleaf, 2011; Foster, Shorter & Griffiths, 2014); individuals can become obsessed with their body and believe that they are weak or not slim enough, although the prevalence is low. Furthermore, research conducted by Olivardia, Pope Jr, Borowiecki and Cohane (2004) provides evidence of a relationship between

muscle dysmorphia and mood, anxiety, and eating disorders. Excessive exercise can cause physical damage and socially have negative effects on relationships. Blanchard et al. (2001) found that intense exercise can be linked with mood disturbance and a general mood worsening. The evidence for negative effects of PA is far outweighed by the research that demonstrates the positive effects of exercise, though it should not be ignored.

2.6 Mediating factors

Enjoyment has been found to be a key mediating factor in affective responses to sport and exercise (Raedeke, 2007). The research showed a positive correlation between enjoyment and positive affect. This relationship is summarised in a PA specific definition of enjoyment 'enjoyment is an optimal psychological state that leads to performing an activity for its own sake' (Kimiecik & Harris, 1996 pg 256). This is an interesting definition as it places the emphasis on the individual involved having fun and enjoying themselves rather than the possible physiological or psychosocial benefits. Kwan and Bryan (2011) found that people who experienced greater positive affect had more positive attitudes and exercise self efficacy. Furthermore, they were more likely to be exercising three months later; they termed this 'stable intention'. The experiences of positive affect are correlated with greater adherence and participation.

Hamer, Steptoe and Stamotakis (2008) investigated the dose response relationship between sport, exercise and mental health. They found the intensity of the sport or exercise was a mediating factor in the benefits. They also found that that mental health benefits can be seen at a minimum of twenty minutes a week. Higher intensity PA such as competitive sport increased the dose response relationship, high intensity PA was also correlated with greater risk reduction. Further findings detail an inverse relationship between exercisers and incident depression and an association between reduced activity and emerging depression. Despite these positive findings a number of methodological concerns are raised. There is a lack of good quality studies with adequate follow up. The studies use various methods to assess mental health, inconsistent sample sizes and so rarely make adjustments for confounding variables. One of the limitations which is especially relevant to the current study is the type of activity required to improve mental health and wellbeing has not been established. If specific recommendations on activity type were made research would be better placed to inform public health policy (Hamer et al., 2008). Although there is anecdotal evidence that vigorous exercise is more beneficial and domestic functional exercise such as housework is less beneficial. However, establishing causality of such claims is difficult and raises the question of

whether social support or mastery elements contribute to benefits (Brunet et al., 2012; Eime et al., 2013).

2.7 Issues of session structure – Who? Where? How?

It is a widely held belief that it is not just the content of a scheme but also *who, where and how* it is delivered that shape its success (Crone et al. 2004). Much of the literature rarely touches upon fundamental and important issues such as; who should deliver the sessions? What exercise should the sessions incorporate? Should it be individual or group work? (Barton et al., 2012). Guidelines for a dose response relationship were proposed by Dunn et al. (2005) yet a specific, accepted and widely utilised proviso is not available for health professionals looking to implement sport and exercise provision for people with mental health problems. No Health without Mental health (HM Government, 2012) a cross-government mental health outcomes strategy for people of all ages only mentions the word exercise on one occasion in relation to PA .

There have been problems implementing a standardised provision of sport and exercise programmes for mental health service users. This could be attributed to the way in which the medical community requires data from randomised controlled trials in order to inform policy and practice. There is multitude of literature supporting the benefits of sport and exercise for mental health and wellbeing (Barton et al., 2012). Despite this the nature of the topic in question means that determining cause and effect is difficult and a defined model of provision has not yet being created (Duda et al., 2014). Where sport and exercise schemes are available through secondary and tertiary care the content of the schemes is ultimately decided by the service provider, they also rely on the funds and the drive of individuals within the organisations that provide this type of service (Pavey et al., 2011).

‘Optimal dosage for beneficial exercise prescription is still unclear. The most effective type, intensity, frequency, duration and conditions (supervised or unsupervised, indoors or outdoors, group or individual) of the activity remains ambiguous’ (Barton et al., 2012 pg 90). These issues highlight the problem of selecting which type of scheme should be used in practice. This in many cases is not the subject of the research while the research papers that do touch upon these ideas have been investigated using correlation studies and suffer from the idea of determining causality.

This is a circular problem which then holds back the creation of standardised practice (Ward & Miller, 2014).

Specific aspects of an exercise programme for mental health service users were researched by Strohle (2009) who believed to achieve beneficial effects, sport and exercise should be participated in 3–4 times week for at least 30 minutes per session. It is recommended the exercise schemes should take place over 8–14 week period (Strohle, 2009). Within this research walking and other lower intensity sport and exercise were more beneficial than high intensity activities. Strohle (2009) also found interventions that are modified to individual need or focus on a particular group are more effective than more generic interventions (Segar, Hanton & Jayaratne, 2002). Otto, Church and Craft, (2007) believed that if feedback on improving wellbeing is given during an exercise scheme it can improve dropout rates and increase adherence. Otto et al. (2007) went on to make comparisons between cognitive behavioural therapy techniques and methods of improving healthy behaviour. These include homework activities, diary taking, goal setting and general self monitoring.

A further issue raised by Thompson Coon et al. (2011) is whether the beneficial effects of sport and exercise for mental health and wellbeing are influenced by where the intervention is delivered. The key questions of their research investigated whether activity outdoors was more beneficial than activity delivered indoors in a gym style setting. The research found that green activity participants adhered to schemes for longer and reported better wellbeing. In addition, the green schemes also appealed to some people who reported not enjoying 'traditional gym exercise'. Participants also expressed feelings of escapism from city life and a connection with the natural environment.

2.8 Sport and exercise provision and support for different clinical populations

Gorczynski and Ganguli (2013) highlight the fact that people suffering more severe mental illness may struggle to understand the information available on exercise and mental health. This raises issues about where patients can access the information they require. This has key implications. If a person cannot understand the reason why they should be active and the possible benefits to their mental health, physical health and wellbeing they are less likely to participate.

Research has also examined cultural issues that may affect participation; Long et al. (2009) conducted a systematic review of black and ethnic minority communities in sport and exercise; some of the issues raised also pose questions for the provision of exercise schemes for mental health

service users generally. The areas targeted by the 'Let's Do This' scheme are deprived areas of the city, within these lower socio economic status areas the prevalence of mental health issues and ethnic minorities is high (Weich et al., 2012). With this in mind the delivery of such a scheme may need to take into account certain religious and cultural issues in order to include everyone from such a diverse area. For example Muslim women may require adequate segregated changing facilities and activities that still allow the participant to cover their skin. By thinking about such issues the attendance and diversity of participants will have fewer restrictions and as a result may increase uptake and adherence (Brodersen, Steptoe, Boniface & Wardle, 2007).

2.9 Rationale for current study

As described much of the literature within the current area of research has been approached using quantitative methodologies (Ward & Miller, 2014). The literature supports the notion of psychological benefits of PA, sport and exercise but the general findings have a number of limitations. Only a very limited number of studies suggest practical guidelines for exercise or sport with clinical populations; they rarely state which specific sport and exercise can reduce specific symptoms and which forms of sport and exercise are most beneficial for what groups. Many medical journals prescribe to a positivist epistemological view and so it is common to investigate sport, exercise and the possible benefits to mental health by quantitative means. Many of these studies have methodological problems including their experimental design; much of the reviewed literature provides correlation type data which can only imply whether these relationships follow, precede or operate independently of sport and exercise. The reviewed literature does identify the need for more qualitative research within the area of sport, exercise, mental health and wellbeing (Mason and Holt, 2012). These issues of measurement may be counterbalanced through a qualitative methodology.

The current study will redress the balance of research within the area and will provide a rich qualitative exploration of the experience of sport and exercise on the individual. Ward and Miller (2014) call for a more 3D approach if the impact of sport and exercise on mental health and wellbeing is to be understood. Strohle (2009) states that neurobiological and psychological factors might mediate, underlie or moderate the association between sport, exercise and mental health problems in a dynamic way. The effects of sport and exercise may trigger a complex system which along with physical benefits also offers psychological resilience and preventative qualities. With these thoughts in mind, the application of in-depth qualitative psychological research may be useful

in exploring how sport and exercise may effect and contribute to mental health service user's perceptions of wellbeing and their recovery process.

The research aim of the current investigation is to explore the lived experience of sport and exercise for mental health service users. Related objectives include:

1. To investigate of the perceptions of mental health service users of the effects of sport and exercise on their mental health and wellbeing.
2. To investigate the perceptions of mental health service providers regarding service delivery and the impact of sport and exercise on mental health service user's mental health and wellbeing.
3. To investigate fundamental issues of session structure.

Chapter 3 Methodology

The approach to study will use qualitative methods which will aim to redress the balance of research within the area and arguably provide a more in depth rich assessment of the influence of sport and exercise on the individual's mental health and wellbeing. By adopting a qualitative methodology it is envisaged that phenomena not touched upon by even the most rigorously designed questionnaire will be revealed. The philosophical underpinnings of the chosen methodology and issues concerning its appropriateness will be discussed.

3.1 Philosophical influences

The research aim is guided towards exploring the lived experience of sport and exercise for mental health service users. Through examining the various qualitative research methods available to the research aim, phenomenology is deemed the most appropriate to explore experience (Smith, 2008). One of the key areas of a phenomenological approach to psychology is a focus upon lived experience (Van Manen, 1990; Smith, 2008). Phenomenology is an approach to psychology heavily rooted in philosophy and various philosophic underpinnings guide the way in which the methodology is applied. The study adopted an interpretive phenomenological design which draws on the work of Van Manen (1990) to better illuminate the lived experience. Van Manen's (1990) phenomenological methodology centres' on the four existentials of the lifeworld.

This methodological stance allows a careful comprehension and examination of each participant's lived experiences of particular phenomena (Langdridge, 2007). This will allow the exploration of participant's experiences of sport and exercise and its impact upon their mental health and wellbeing. This approach like other forms of phenomenological analysis is grounded in the work of noted philosophers Husserl, Heidegger, Merleau-Ponty and Sartre (Langdridge, 2007; Smith, 1996; Smith, Flowers & Larkin, 2009; Van Manen, 1990).

3.2 Phenomenology as a philosophy

Husserl (1901/1970) a philosopher and mathematician, in his second volume of *Logische Untersuchungen - Untersuchungen zur Phanomenologie und Theorie der Erkenntnis* was interested in the fundamental issues of both logic and epistemology. One important aspect of this work is the way in which a person could come to understand their own experiences of particular phenomena. Husserl believed that if this is done with rigor and depth, then essential qualities of human

experience can be identified. Husserl believed that the essential qualities of an experience could transcend circumstance and illuminate the experience for others (Husserl, 1980).

Husserl (1901/1970) argued that we are wrapped up in natural attitude that makes us likely to categorise experience into pre-existing schemas. In our everyday life we are engaged with activities in the world and take for granted our related experiences. This engagement serves to hide the essences of experience which can only be revealed through consciously reflecting upon the experience. Husserl (1980) was keen to stress the importance of what is experienced in the consciousness of the individual and he describes this as intentionality. This in phenomenological terms is the relationship between an object of which we are conscious of and our perception of it. These objects can be a 'real' object in the world or something abstract such as a memory or a moment of imaginary thought (Langdrige, 2007; Van Manen, 1990). In adopting a phenomenological approach to the subject we strive to approach experience in its own right and attend to its individual essences (phenomenological reduction). By using a free imaginative variational method, which logically and rigorously examines essences, we may be able to reveal a level of adequate insight into experience. This involves looking at phenomena from every conceivable position by freeing the mind from its pre set schemas, stereotypes and prejudices. By approaching phenomena in this way we can start to unravel the essential features of that experience. With this probing we move away from natural attitude to a phenomenological attitude, opening the possibilities of discovery of previously hidden phenomena and discovering essences of experience (Ihde, 1986).

In order to rigorously examine every day experience, we therefore need to give equal thought to each and everything in its own right; we need to take a reflective step away (Husserl, 1980). By making this reflective step and 'bracketing off' this natural attitude (epoché)⁵ it is possible to subjectively examine the content of conscious experience and the essences of experience (Langdrige, 2007; Smith, Flowers & Larkin, 2009).

Husserl was a philosopher, not a psychologist; his thoughts and ideas have been adapted and interpreted differently by both philosophers and psychologists in order to apply them to psychological inquiry (Langdrige, 2007). The way in which the current study will subscribe to

⁵ Epoché is a term meaning the process of attempting to refrain from our natural attitude. Natural attitude is our presuppositions and biases of everyday knowledge. It is a term used by Husserl ([1931] 1967). It is sometimes referred to as bracketing (Langdrige, 2007).

Husserl's ideas is in the systematic and vigorous analysis of lived experiences of phenomena with intentionality (Van Manen, 1990). This will allow the illumination of the essential features of the phenomena under investigation. Husserl provided the platform for philosophical thinking in the area of phenomenological inquiry (Smith, Flowers & Larkin, 2009). However, the current study could be seen as one that lies in the middle ground of what is conceptualised as descriptive and interpretive phenomenology (Van Manen, 1990). Ideas are taken from Husserl and an essential structure of experience will be sought, but also ideas are taken from Husserl's scholar Heidegger, an interpretive phenomenologist.

3.3 Heidegger

Heidegger's interpretation of phenomenology is in many aspects markedly different to that of Husserl, but still is mindful of aspects of his workings such as the notion of intentionality. Heidegger (1965), in one of his most important works *Being and Time* stated that phenomenology should be predominantly concerned with hermeneutics. Hermeneutics is the theory of interpretation. Specifically in this interpretation; the examination of both visible meaning and disguised or latent meaning. The phenomenon appears and the phenomenologist can help make sense of the appearing (Heidegger, 1985; Langdridge, 2007; Smith, Larkin & Flowers, 2009). Hermeneutics forms a key part of interpretive phenomenology, especially the idea of the hermeneutic circle. This is the flowing relationship between the part and the whole; this occurs on a number of levels. To understand a part of an experience, you must look at the whole, to understand the whole you must look at the parts; this is termed mereology (Heidegger, 1985). For example, by looking at the entire experience of sport and exercise for mental health service users, parts such as the importance of coaches and support take on greater meaning. Likewise, by examining the parts of the experience such as winning a game we gain a better understanding of the entire experience.

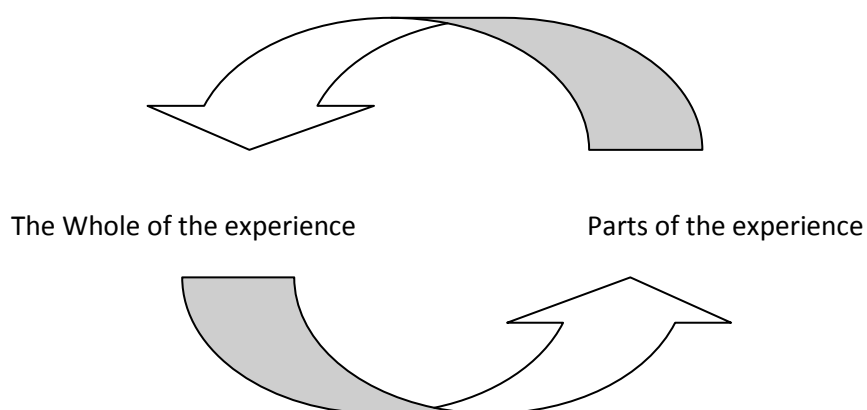


Fig. 3.1 Hermeneutic Circle (as cited in Tuohy et al., 2013)

This idea is crucial to a dynamic analytical style of thinking which can interpret and enlighten the essences and the whole experience of a given phenomena. It is also a tool in which adequacy and reflexivity can be improved through the thorough examination of how the phenomena are constructed.

3.4 Interpretive inquiry

Speech and language are the means by which we understand the world (Van Manen, 1990). Key philosopher Gadamer (1985) was particularly interested in conversation and placed it at the centre of understanding. According to Gadamer (1985) it is through conversation that things 'reveal themselves'. Self understanding is from a position based on our effective history; it both enables and limits our general understanding of the world (Van Manen, 1990). This position therefore has major implications for our interpretation of lived experience; it shows that lived experience is unique for different individuals. A key concept from Heidegger (1985) was that when we interpret anything the analyst brings with them their prior experiences, pre-conceptions and possible assumptions. Heidegger (1985) stated that because of our embodied nature in the world we are not able to 'bracket off' (or perform epoché) as Husserl (1980) advocated. We are born into a pre-existing world including society, language and culture; because of this we cannot put aside our natural engagement with the world (Van Manen, 1990). According to Heidegger (1985) interpretation is based upon fore-conception such as assumptions based on previous experience. This is an important concept in phenomenological inquiry. This concept highlights research must be conducted in a reflective manner; we must acknowledge our role in the interpretation process in order to reveal lived experience in a credible way (Langdrige, 2007; Smith, Larkin & Flowers, 2009).

3.5 Van Manen

Van Manen describes human science research as 'meaningful expressions of the active inner, cognitive, or spiritual life of the human being in social, historical, or practical contexts.' The approach aims to attach meaning to such expressions through hermeneutics (van Manen, 1990, p. 181). Van Manen believed that 'we are led by our immersion in the phenomenon we seek to thematically elucidate, and through interpretation we engage in an active process of meaning-making, producing a deeper understanding of the phenomenon' (Van Manen, 1990 pg 181). Phenomenology here places importance on unfolding existence rather than 'what it is' (Rich, Graham, Taket & Shelley, 2013). Van Manen believed phenomenology is a search for what it is to be human, though essences, description of experiential meanings and though attentive practice of thoughtfulness (Van Manen, 1990).

3.5.1 Lifeworld existentials and the current study

The current study will take an existential phenomenological approach championed by Heidegger (1980), and Van Manen (1990). The philosophical ideas discussed around van Manen's (1990) approach to phenomenology raise questions for the current study around four lifeworld existentials (lifeworld themes) rationality, embodiment (sometimes labelled corporeality), spatiality and temporality.

Relationality is the idea that we can transcend ourselves through lived relations. This is important in the current study when considering the relationships that can develop between the mental health service users and also with the mental health service providers. For example the experience of encouragement from mental health service providers and peers may directly affect how the phenomena are experienced. Relationality interactions can therefore shape the lived experience of sport and exercise for mental health service users.

We are bodily in the world, our body and its actions are often a direct reflection of our intentions. Our body within the world of sport and exercise very important. Through the lived body our natural capabilities may shape our identity and experience. This identity and experience can influence enjoyment and therefore increase participation. Interpretation of our own bodily self provides an area of focus.

In terms of spatiality, there are a number of considerations such as; how did the space in which sessions were conducted influence the mood of the mental health service user, did the setting influence the experience? For example did familiarity produce ease or boredom? How did meeting other mental health service users and new mental health service provider's impact on their experience of the sessions? Furthermore another consideration is the metaphorical space, the subjective experience of a space in life.

Temporality can relate to the vivid memories of past experience, self awareness in the present and a projection of a future self. The reflection of lived time invokes thoughts, feelings and experiences. Temporality can be subjective not just the objective time we all know and understand. 'The way we feel can influence how we experience time and moments, and conversely, constraints, freedoms, and demands placed by time can also affect how we feel' (Rich, Graham, Taket, & Shelley, 2013 pg 12). The lived time may affect the way in which the scheme is experienced. The current study looks to understand noema; what is experienced and noesis; the way it is experienced, involved in physical experience not cognition, mental processes and behaviour (Smith, 1996).

3.5.2 Operationalizing the methodology into a method

Van Manen (1990) names six research activities to practically conduct phenomenological enquiry. These activities comprise the methodological structure of the current study:

- (1) Turning to the nature of lived experience; interviews and data.
- (2) Investigating experience as we live it; interviews, data and initial interpretation.
- (3) Reflecting on essential themes; development of analysis and recognizing two essential themes.
- (4) The art of writing and re-writing; aided in reflective nature of the research and essential theme development.
- (5) Maintaining a strong and oriented relation to lived experience; reflexivity and illuminating the essential experience.
- (6) Balancing the research context by considering parts and whole; identifying structure of the experience.

The purpose of these six activities is to assist in gaining a deeper understanding of the nature or meaning of our everyday experiences. Further explanation of how these activities have been applied to the current study can be found in section 4.4.

Chapter 4 Method

A phenomenological approach was used to explore the lived experience of sport and exercise for mental health service users. This research method is concerned with trying to understand lived experience and how participants themselves make sense of their experiences. Therefore, it is centrally concerned with the meanings which those experiences hold for the participants. The phenomena were also assessed from the viewpoint of the mental health service providers.

4.1. Participants

There were 10 participants in total, each residing in localities within Leeds, West Yorkshire. There were five mental health service users. Five mental health service providers were from a variety of roles and organisations. Mental health service users participants were over the age of 18 and currently undertaking sport and exercise through the 'Let's Do This' Healthy Living Service scheme. Exact positions for the mental health service providers are not given to protect confidentiality and anonymity however they have been labelled as in management or a direct service provider.

Table 4.1 Mental health service user's information

Pseudonym	Condition	Reason for attending	Referred through
Vikki	Depression/Anxiety	To get back into exercise and meet new people.	Touchstone
John	Depression	Get fit again, lose weight.	HLS
Simon	Mild Psychosis/Anxiety	Was looking for a sport and exercise group. Enjoys sport.	HLS
Colan	Depression/Anxiety	General fitness	Touchstone
Paul	Mild Psychosis	Wanted to try some new sports and exercises. Enjoys sport and exercise.	Aspire

Table 4.2 Mental health service provider's information

Pseudonym	Position
Lynn	Manager
Mandy	Manager
Tara	Manager/On the ground provider
Bridie	On the ground provider
Ian	Manager

4.1.2 Inclusion criteria:

Mental health service users

- a) Over the age of 18
- b) Participants in the 'Let's Do This' scheme
- c) Were, in view of their key worker/mental health staff, well enough to take part in the study.
- d) Able to consent to take part in the study.
- e) Interested in the topic

Mental health service providers

- a) Over the age of 18
- b) Mental health service providers
- c) Involved in the 'Let's Do This' scheme
- d) Able to consent to take part in the study.

4.1.3 Exclusion criteria:

Participants were excluded if they did not speak English as there were not the resources to fund translators. Participants were not excluded on any other basis to allow diversity in the sample in terms of gender, socioeconomic, age (over 18) and ethnic status.

4.1.4 Recruitment process

It was deemed appropriate to interview five mental health service users and five mental health service providers to elicit enough rich data while taking into consideration constraints such as thesis word count and thesis completion date. The recruitment of mental health service users was based on suitability for interview and willingness to be involved. The choice of mental health service providers was deliberate, the sample consisted of the two 'on the ground' providers that had the most contact time with mental health service users, one charitable mental health service manager, one NHS mental health service manager and one council sports and exercise service manager. This sample was deemed appropriate to compare and contrast key issues of provision from different service perspectives. The sample also allowed the comparison of opinion between service managers who created the scheme and the individuals who ultimately delivered the scheme on a week by week basis. Purposive opportunity sampling was used. Participants were recruited from within the 'Let's Do This' scheme via the following process:

Mental health service users

1. Mental health service users were referred into the Leeds Healthy Living Service organised by the 'Let's Do This' scheme.
2. They were referred from Touchstone, Leeds MIND and Aspire based on suitability to enrol into a sport and exercise programme.
3. The leader of the scheme contacted the mental health service users and assessed the suitability of them taking part in a sport and exercise programme.
4. Between weeks 7 and 10 of the 10 week 'Let's Do This' scheme the prospective participants were approached by me. The participants were selected on their appropriateness to conduct an in depth semi-structured interview.
5. The participants in the scheme were made aware of the number of participants needed to be interviewed for the study to avoid disappointment if they were not selected.
6. The scheme members could indicate their willingness to participate in the study by verbally agreeing to participate or by returning a participation agreement form in a pre-paid envelope (part of information pack). A telephone number and email address was provided. Full written consent was obtained prior to data collection.

Mental health service providers

1. The mental health service providers involved in the 'Let's Do This' scheme were made aware of the research and asked by the researcher if they would be willing to participate.
2. The mental health service providers could indicate their willingness to participate in the study by verbally agreeing to participate or by returning a participation agreement form in a pre-paid envelope (part of information pack). A telephone number and email address was provided. Full written consent was obtained prior to data collection.
3. They were interviewed at a time and location of their choice.

Provisions were made to explicitly explain issues regarding informed consent and the participants' right to withdraw at any point prior to analysis to reduce chance of risk and conform to ethical guidelines. My contact details and those of my research supervisors were provided (work telephone, email and postal address) in the research invitation pack if they required further information (see appendix 2-6)

4.2 Ethics

The scheme received University and NHS ethical approval (see appendix 10-12).

The design of the study was also influenced by the Leeds and York NHS Foundation Trust mental health service users' research involvement group. The group advised on various aspects of the design including content of the participant information pack.

There were some minor issues highlighted through the ethics process. There was a small risk that talking to people about sport and exercise may cause upset. This was unlikely given the 'pre-screening' of mental health service users in the recruitment process of the 'Let's Do This' scheme. The screening was done by the mental health organisations they were referred from. Participants were advised throughout the recruitment process and specifically written in the information sheet that they could opt to terminate the interview at any point or move onto a different line of questioning. It was also made clear that the participant could remove their data themselves from the study up until the point of analysis (an end date was given) and that participation was not mandatory.

All anonymised transcripts were stored securely and confidentially and will be retained for a period of five years following dissemination. Participants were informed that any information disclosed which indicated a major concern to the health and wellbeing of them or others could have resulted in information being passed to the relevant authorities. In such an instance the referral to relevant authorities would have been discussed with the participant.

Prior to recruitment, Access to participants (both mental health service users and providers) was agreed with the clinical lead of the scheme.

4.2.1 Subject withdrawal: withdrawal criteria & procedures

Prior to contacting potential participants, formal organization and management agreement was sought and achieved. During the recruitment process, participants were verbally informed of their right to withdraw from the research. Participants were given information sheets and consent forms which clearly outlined their rights including withdrawal from the research. Full consent was gained from participants, before participant interviews were conducted (see appendix 2-9). Participants were again informed of their right to withdraw their data from the study before the analysis process began. If they wished to withdraw their data then it would not have been used in the analysis.

4.3 Procedure

The common method of data collection used within phenomenological research and an appropriate method of eliciting experience is the semi structured interview (Langdridge, 2007; Smith et al., 2009). This style of data collection provides structure that allows comparisons to be made across a sample, yet allows the flexibility of exploring interesting and relevant points as they emerge through prompts and probes (Smith, 2003). It is therefore considered the most appropriate data collection method for the current study. The interview schedule was informed by the research aims and the reviewed literature, its development was initially made by the researcher. The schedule was checked and recommendations were made by the supervision team. Following this the mental health research involvement panel were consulted on the appropriateness and content of the questions. As in most semi structured interviews the schedule was designed to be a starting point from which to explore further and deeper phenomena using appropriate prompts and probes. Following the completion of the schedule the researcher carried out pilot interviews. One with a mental health service user and one with a mental health service provider. The schedule was edited based on the success of the pilots and was then deemed ready for use.

Each participant was contacted to arrange an interview. Prior to the commencement of the interview, participants were given an information sheet containing some of the key aspects of the study and issues regarding how their data would be used including reassurances of confidentiality and anonymity (see append 4 & 8). The participants were then given a consent form which they were required to sign in line with NHS ethics and full BPS guidelines (see appendix 2). The participants were then interviewed in a semi structured manner using pre determined questions, prompts and probes into areas of interest (see appendix 4 & 9 for copy of interview schedule). The interviews were recorded using a digital Dictaphone. After the conclusion of the interview the participants were debriefed and presented with a debrief form (see appendix 6).

The recorded interviews were transcribed verbatim; following transcription the data was subjected to the phenomenological analysis (Van Manen, 1990).

4.4 Operationalizing Van Manen's six research activities

The process of analysis followed Van Manen's six research activities.

1. Turning to the nature of lived experience; Interviews and data.

'Lived experiences gather hermeneutic significance as we (reflectively) gather them by giving memory to them. Through meditations, conversations, day dreams, inspirations and other interpretive acts we assign meaning to the phenomena of life' (Van Manen, 1990 pg37). These experiences were revealed through the interview process, the participants offered their lived experience interpretations. It is then a task for the researcher to interpret these meanings and phenomena.

2. Investigating experience as we live it; interviews, data and initial interpretation.

'We are interested in the particular experiences of this child, this adolescent, or this adult since they allow us to become 'in-formed,' shaped or enriched by this experience so as to be able to render the full significance of its meaning' (Van Manen, 1990 pg 62). By interviewing the people who are at the heart of the phenomenon i.e. the mental health service users and the mental health service providers we can get closer to the original lived experience thereby moving towards the process of revealing the true essence of the experience.

3. Reflecting on essential themes; development of analysis and recognizing two essential themes.

'The insight into the essence of a phenomenon involves a process of reflecting appropriating, of clarifying, and of making explicit the meaning of the lived experience'. (Van Manen, 1990 pg 77). This reflection requires the researcher to uncover the essence of the experience rather than its 'face value' appearance. This is done in this study through a process of interpretation and clear description. The engagement with the text looked to move away from a rigid style of coding to allow the meaning to emerge hermeneutically, whereby the importance of the analyst in the construction of meaning is recognised. I provided a core of descriptive notes which have a phenomenological focus close to the participants explicit meaning (Smith et al., 2009). Through this process initial themes were identified.

4. The art of writing and re-writing; aided in reflective nature of the research and essential theme development.

‘The methodology of phenomenology requires a dialectical going back and forth among these various levels of questioning. To be able to do justice to the fullness and ambiguity of the experience of the lifeworld, writing may turn into a complex process of rewriting (re-thinking, re-reflecting, re-cognizing).’ (Van Manen, 1990 pg 131).

The way in which the current study adheres to these principles is through being true to the data. I approached the analysis process with a conscious attempt to reduce natural attitude by systematically examining the transcripts, giving equal devotion to each sentence allowing the meaning of what was being said to emerge and not just focusing upon my understanding and experience. Second level coding was approached in the same way, in a bottom up data led manner. The themes and sub themes that emerged are labelled in a way which is close to the data in order to keep alive the meaning of what was said and the way it was intended. The rewriting concept and all it entails helps identify thematic areas, essential themes and the essence of the experience.

5. Maintaining a strong and oriented relation to lived experience; reflexivity and illuminating the essential experience.

‘The tendency to abstraction is a common hazard of all academic activity. It is, in part, the reason for the disdain that practitioners hold for university-based theorists who have lost touch with ‘the real world’. (Van Manen, 1990 pg 138). The current study is data driven in the development of themes and through discussing the perceived essences of experience. There was a focus on the research aims to avoid an abstract ‘wandering’. By staying close to the research aims, the findings and subsequent conclusions have implications for practice, policy and research.

6. Balancing the research context by considering parts and whole; identifying structure of the experience.

This was attended to through adherence to the other five research activities and careful reflection and considerations of the hermeneutic circle.

4.5 Study quality and rigour

Rigour is the way in which we can establish trust and confidence in qualitative research findings. The way in which this rigour is achieved is a matter of much debate; for example, Lincoln and Guba (1985) propose four criteria that can help establish trustworthiness of a qualitative study. These criteria correspond to positivist investigation. However, the appropriateness of applying quantitative style criteria to qualitative research is again a subject of debate. Rigour in the current study will be achieved through adhering to the six research activities of Van Manen (1990). Through these activities the research is reflective and explicit.

4.5.1 Reflexivity

One of the key ways in which study quality and rigor were achieved in the current study was through reflexivity. Reflexivity within the current study takes upon extra importance due to my role within the research. I am the researcher, a volunteer mental health service provider within the NHS Trust and a regular participant of sport and exercise. This position raises a number of fundamental questions which could compromise the credibility of the research.

My personal lived experiences have brought me to a position where I want to investigate experiences of sport and exercise for mental health service users. My interpretation of others' experiences may be influenced by my own positioning and experience of sport and exercise. As the researcher I did not intend to take a 'god's eye view' of the phenomenon in question. I looked to minimise the effects of natural attitude while acknowledging my position as a researcher and mental health service provider.

To best encourage a reflexive approach to the research there were a number of questions I asked myself from the start and throughout the research process. For example;

Why am I carrying out the study? I have a genuine interest in the area of sport, exercise and mental health, the current study is aligned with previous research I have carried out.

What is my relationship to the topic being investigated? I am a volunteer with the Healthy Living Service, I help provide weekly sports and exercise sessions for mental health service users. I am a post graduate researcher, I have an interest in sports and exercise and its effects on mental health and wellbeing. I am both an insider and outsider. I am an insider when interviewing mental health service providers. I am an outsider when interviewing mental health service users. While conducting the interviews as either an insider or outsider I have a dual role.

Through careful reflection it is possible to minimise our own involvement in the research and at the same time acknowledge that my own being impacts on my interpretation (Van Manen, 1990).

This dialogue of reflexivity enabled me to construct a phenomenological account that was rigorous. I aimed to be true to the experience and the reading and re reading of the data developed themes that were as close to the experience as possible.

4.5.2 Further establishing trustworthiness

The research focus and subsequent construction of the interview schedules was invariably influenced by my position as someone who participates in sport and exercise and also volunteers delivering sport and exercise for mental health service users. The interview schedule construction drew on a combination of these experiences, past studies and theoretical understanding. The prompting and probing involved in a semi structured interview is guided by research aims. The findings from the study are presented with enough contextual information to allow the reader to relate the findings in the analysis to their own experience. This is important when considering the application of research findings and authenticity (Langdridge, 2007).

The research considered a number of additional techniques used to further establish trustworthiness, this included triangulation. Investigator triangulation can be defined as the use of more than two researchers in any of the research stages in the same study. It involves the use of multiple observers, interviewers, or data analysts in the same study for confirmation purposes (Hussain, 2009). This was applied in part through the active role the supervision team engaged in during the analysis process. Other elements of triangulation were considered including data triangulation, theoretical triangulation and analysis triangulation. Despite the merits of such techniques the application of these was not considered appropriate for the current data set. The focus was upon the lived experience of the individuals so the theoretical and data triangulation would not have enhanced the data collected.

Another technique considered was respondent validation. This is where feedback is obtained from the participants about the accuracy of the data they have given, and also the researcher's interpretation of that data. In addition, feedback after the completion of the research project on the interpretation of all the data that has been obtained and interpreted can provide another type of validation (Torrance, 2012). This is another way in which trustworthiness can be established. The time constraints of the research project dictated that using these techniques would not be possible. These demands included the length of time to secure NHS ethical approval, data collection, transcription and analysis all required to be completed in a one year timeframe. A shorter modified version of the research project is being created to present to the Healthy Living Service and research participants, from this feedback will be sought.

Chapter 5 – Analysis

This chapter details the combined analysis of the data from the interviews with the mental health service providers and the mental health service users. Although the findings are combined they are still delineated. The analysis of the mental health service providers was phenomenological in nature but with less application to the lifeworld existentials. This was a conscious decision based on the aims and objectives of the research project and the main purpose being to elucidate the lived experience for the service users. As such, the consideration of the existentials allowed me as the researcher to feel more able to understand, interpret and step into the experiences or life worlds of the participants.

The analysis reveals a number of intertwined and independent in-depth themes (see fig. 5.1). The issues surrounding these themes are highlighted and debated. The chapter culminates with a discussion of what are considered the main findings as related to the lived experience of sport and exercise, from the perspective of both mental health service users and mental health service providers.

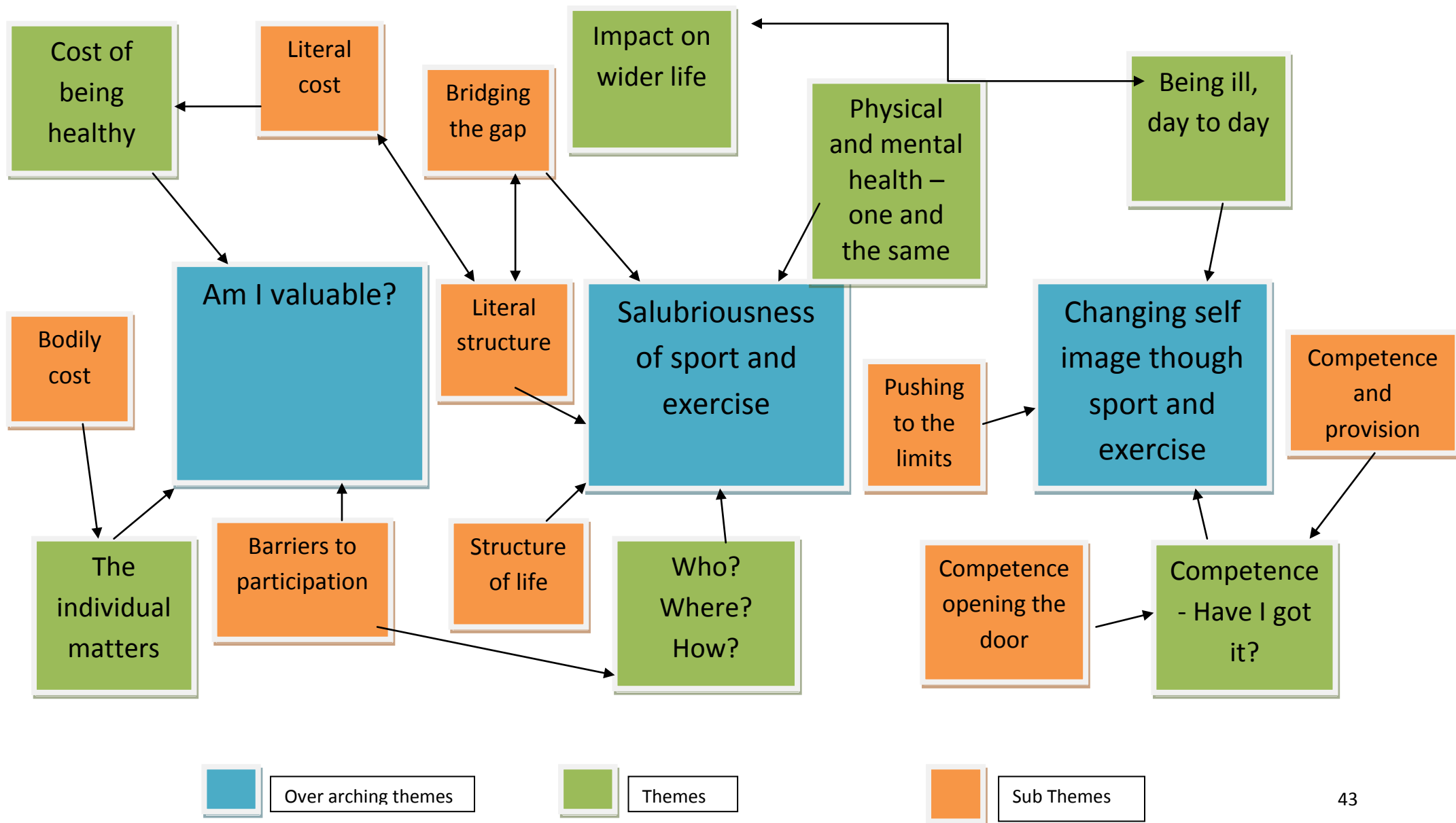


Figure 5.1 Diagram of themes and their interaction

5.1 Salubriousness of sport and exercise

Salubrious means conducive or favourable to health and wellbeing. Here the term is used to express the interaction between structure, wider life effects, physical and mental health and how they are perceived to benefit the individual. To get a salubrious effect it requires the engagement of the whole person. This includes the debate around whether physical and mental health are the same which is a key issue given the aims of the 'Let's Do This' scheme (Vreeland, 2007).

5.1.1 Impact on wider life

The importance of family relationships in terms of sport and exercise relates to lived relations and was touched upon by mental health service user John. He talks of how his active lifestyle has impacted upon the way his children act and present themselves;

'I did it to give something back to teach the kids what it's like to walk along Hadrian's wall or do the three peaks, challenges to themselves and also for my sons, they are all out doorsy kids not indoors kids and they have done a lot. For example we went on holiday to Cuba and he spent two weeks diving to get his masters, it's just giving them things that I didn't get to do till I went into the army you know so that's it basically' John.

The impact sport and exercise can have on social lives as described here, presents elements of the lived experience in terms of relations, time and space. Reminiscing about previous adventure holidays, a returning to the moment and ruminating over what that meant to the individual is conveyed really well through John's further talk of his family relations;

'where you are outside, they were all young boys my lads, I have two lads and a daughter and I got into the scouts anyway and basically learnt to rock climb, used to take these all over, canoeing holidays and do stuff within the scouts but with my boys and the walking is exactly the same thing...I've stopped smoking since July I've not had a cigarette and I was doing 30 maybe 40 a day but what I do, I did a lot of physical work with my sons both of them have got their own business which is like gardening work and physical stuff, paths and so I used to go and help them for two or three days a week and then spend two or three days in my shed so I had a bit of fitness coming in because I knew the way I had been I've always been able to eat what I want because id just burn it straight off, go walking or whatever but now I don't exercise as much as I should but I'm still packing in 2000 calories a day and it's got to go somewhere and it goes on your stomach, but every day I have got to walk with the dog, the kids bought me that so I go out the house to walk. We go usually on a weekend just for 10 mile or something and then have some lunch somewhere and do that sort of thing and the work with my boys' John.

Johns work life is described in terms of sport and exercise; this could be understood as functional exercise. The quote is also punctuated by health messages, for example stopping smoking and calorie intake. Media and

government messages are frequently focused upon smoking and the obesity crisis, some of these messages could have had an impression on the participant.

He also mentions dog walking as a way in which the family relate and interact with each other. The idea that his family decided to buy him a dog to encourage him to engage in healthy behaviour is of interest. The participant was given something to care for that could not look after itself; this responsibility has helped increase sport and exercise participation without a direct intervention. The introduction of a pet was not to motivate exercise, it was bought to give their father a reason to leave the house, yet the outcome was exercise. The benefits of dog walking and physical health is well documented (Cirulli, Borgi, Berry, Francia & Alleva, 2011; Schofield, Mummery, & Steele, 2005)

5.1.2 Physical and mental health – One and the same

Within the literature review the endorphin hypothesis is explored (Lahti et al., 2013). This has resonance with a simple but interesting comment was made by Simon;

‘What type of feelings does it give you?

Like a high, endorphins, endorphins being released’ Simon.

The lived body experience in this instance may have been influenced by the knowledge the participant has acquired. This is not to say the endorphin hypothesis is supported or refuted, what is particularly interesting is that the immediate conceptualisation of sport or exercise is its effects on mental health and in particular neurochemical changes. These neurochemical changes are not observable for the participant yet it is the first thought that comes to mind when thinking of exercise. The knowledge Simon has acquired has lead him to believe that a series of chemical changes will occur in his brain when he exercises. This is interesting from a phenomenological point of view as his preconceived ideas of exercise and the benefits he believes that are attached to that exercise affect his lived experience. This type of education may be commonplace; highlighting a culture of not only providing sport and exercise but also an education on why it is important.

‘P - when I was younger I had adrenaline rush, you know when you’ve done something, you’ve run 10 mile or whatever, or played 3 games of squash, you get that adrenaline rush, but as you get older, well I haven’t had it

R – So it’s harder to get that?

P – Yeah it’s harder to get that fix, so you, like when I was younger I’d be out every night doing something. I’d finish work and go play squash or go swimming or go football training 3 nights a week, you know?

R – So there was always something?

P – Yeah but as I've got older it gets harder and harder to actually physically say 'I've got to go play football tonight' and you would just say I'm not bothered I'm a bit achy you know.

R – Is that because you feel achy or is it because you struggle to find somewhere good that can provide for different ages? You know because at the minute I can do whatever I want I can play wherever. What is it like as you get older finding provision?

P – Its hard having the motivation, that's the big thing' John.

Here John speaks of time; he speaks of his past participation showing that he has been actively participating in a range of activities. At one time point in the past he remembers feeling a physical high from sport and exercise, he talks in terms of 'a fix', this is interesting as it is a term commonly used to describe drug use. The terms 'high' and 'fix' demonstrate the importance sport and activity/exercise had at this time of his life, it was something he needed, craved and felt elation from. For John the way in which he used to experience sport and exercise is different to how he experiences it now. When John speaks of current participation he speaks of it in negative terms. This is a demonstration of how we can experience similar things differently through the passage of time.

John speaks in purely physical terms in the beginning of the conversation. As the conversation develops he moves on to talk about motivation which is a psychological concept. Here, for the Colan through the lived body, sport and exercise leads to a physical benefit, getting this benefit is mediated by a psychological construct which has altered over time. For Colan there is a direct connection between his physical and mental health.

'There are some days you're not well enough to leave the house, simply because of the way your brain is functioning at the moment' Colan.

In these quotes it appears the participants still place themselves in previous version of themselves. Their current mental health condition is a separate happening or occurrence, almost like the mental health condition stands alongside them. They understand that their current mindset is not how it should be; it is effecting what they experience though being present bodily by restriction placed by their current mental state. Here the mind and body are for the participants operating independently. They are physically able to leave the house or to try something new yet their current mentality is preventing these experiences. Mandy speaks of her experience of sport and exercise and makes a direct connection between physical and mental health;

'When you have a busy job and lots going on in your life sometimes it's hard to fit it in but actually I prioritise it because I know it makes me feel better physically and mentally. If you have a stressful job or whatever I know if I haven't been for a couple of weeks I might start to get aches and pains, not that I don't in my sport but they are different. I might get a bad back from sitting at a computer all day or neck but I feel, I think if I don't go stress effects me and I think my mood is effected especially in this type of job I think you are more aware of it' Mandy.

In Mandy's case the more active she is, the better she feels mentally. She goes as far as saying without sport or exercise she feels deterioration physically and mentally. Some participants see a link between their physical and mental health.

5.1.3 Who? Where? How?

The mental health service providers discussed a range of experiences that have led them to provide sport and exercise for mental health service users. The desire to encourage healthy behaviour in the service user's recovery path seemed to emanate from their positive experiences of sport and exercise. The influence of family behaviours and how they were raised had made them view sport and exercise as an essential aspect of their everyday life.

All service providers reported to participate in sport and exercise but had also played in teams and joined clubs outside of school sport in their youth. This is an interesting finding not previously explored in the literature in the area. Whether or not it is important for mental health service providers to have an interest in sport and exercise and furthermore whether this interest impacts upon how they deliver interventions.

'yeah I think I've been quite lucky actually, from a young age I've always been into sports because my mum made me do it when I was younger so I guess I've grown up with a lot of health and fitness as part of my life from quite a young age. I used to do quite a lot of swimming and gymnastics and a lot of sports at school. I also have a military background as well so I was involved in a lot of fitness training from a young age' Tara.

What is evident here is that the early encouragement from family and school settings has created a lifelong journey involving sport and exercise, both personally and professionally. The service providers have naturally and organically moved into their workplace roles. Their affinity for sport and exercise and its importance in both their work and personal life is highlighted in the quote below from Tara.

'also have a military background as well so I was involved in a lot of fitness training from a young age and then before I went to uni I was doing personal training qualification working with members of the public training them on weight loss trying to get them fit and that kind of thing. That was my actual job for about ten years doing personal training' Tara.

This affinity for sport and exercise is paired with a passion for making a difference and striving to deliver. The strength of feeling is evidenced in the words such as 'love' 'real research' and 'damaging' in the quote from Ian.

'Just good luck with it, I would love to see what you are doing have an impact on people taking it up, lots of people are shouting this culture needs to change. I'd like to see some real research being done around sedentary lifestyle and how damaging that is on people's health' Ian.

The mental health service user's reasons to participate in sport and exercise extended much further than simply being told to participate by their key worker or being referred in through an organisation or service, the reality is much more complex. The positives of participation tied in closely with the reasons why they participate. There were many reasons given for participation, some were as you would expect such as enjoyment, achievement and the physical benefits as described in a multitude of the reviewed literature (Barton, 2012; Duda et al., 2014; Strohle, 2009).

'I enjoy going out and I enjoy going to play sports'

'Yeah I liked working towards a goal, a team effort, say if you score a goal or something in the football all the team congratulate me, it's a team effort.'

'R – What are the main feelings it gives you?

P – More energy and tiredness seem to go away' Simon.

Interestingly, these commonly perceived reasons to participate were found to be mediated by some issues not reported in previous literature and theory. One interesting topic of debate for service providers was how schemes are structured and created. The question of contention was whether the success of a scheme is reliant on a bottom up style, utilising enthusiastic pro active individuals who create their roles from their own interests and observations or a top down system based on careful management assigning individual workers for purpose. This debate is of great interest when you consider the inception of the current scheme. It was developed based on a pilot scheme set up by a member of the healthy living service using some left over funding. It was their personal interest in sport and exercise that led to the scheme being created not a scheme driven by top level management and policy. This style of scheme development is specifically targeted; it has been developed in a local area with a specific group and evolved its aims.

'when I started about three years ago there was money available, physical activity is something that service users always ask for and want to be involved in and because the team is so small it's very difficult to be able to provide additional sessions based on what we do here so when I first started there was a little bit of money from NHS Leeds to run a pilot group of sessions in the sports centre's once a week at three different locations which is what we did for about 6-8 months, it started from that really and that was a way of providing physical activity for the service users that was free. We assessed them before they went into the sessions as well so it was managed by our service when we ran the trial' Tara.

One of the issues of structure which the service users and providers agree upon is the idea that the service should be adapted to the service users, this shows the importance of the coaches and their ability to change or modify sessions to best serve the mental health service users. For the mental health service providers lived time is especially important, drawing on past experiences and moments both in the sense of previous sessions

delivered and also their own experiences of sport and exercise. The importance of mental health service provider coaches in a scheme was seen by all participants as a vital element.

'The coaches have the ability to adapt things like tempo and exercises but for someone who has never been before you wouldn't see that you would just perceive a room full of fit people doing an aerobics class and where do I fit in, so I do believe there is a need for a total beginners class that would pick up all types of people... I think once the timeslot is in place then it is down to the people that deliver the session, there are factors that could happen so for instance we didn't have the sports hall but it was organised that we would go in another room so this is not a big deal, we have those facilities so we don't ever really have to miss out as long as the instructor turns up and does what they are supposed to do then everything is going to be ok' Bridie.

Service providers spoke in terms of the mechanical and practical structure coaches provide whereas the service users spoke of the coaches in terms of the psychological structure and support the coaches provide by using words such as 'care' and 'trust'. Hodgson, McCulloch and Fox (2011) also interviewed mental health service users and found the importance of coaches was a key aspect of service provision.

'I can go to the gym, I have the dates there where I can go and there will be someone there I trust. I'll go on certain days when I know she will be there, I can go every Wednesday and she will be there' Ian.

'Really like the coaches both Debbie and you and the program you have designed and how you care for the group' Vikki.

Ian speaks of trust and with a certainty that the coach will be there to be a part of his recovery; this sentiment was echoed in research by Ussher, Stanbury, Cheeseman and Faulkner (2007) who found mental health service users would exercise more with the support of a caring professional. The creation of the 'Let's Do This' scheme has placed these people together; this relationality is overflowing with interpersonal experience.

'One gentleman that had balance issues and he has progressed an awful lot, he has got stronger which has helped with the balance. We have got one lady who keeps going from strength to strength, her flexibility was there already but her cardio is getting a lot better' Bridie.

'I've found my coordination has got better, one of the coaches worked on shooting and saving the ball with me' Paul.

This shared experience is also felt in contrasting ways;

'the way I see it is the badminton is doing me good, I can stop whenever I want, I don't have to do it but I enjoy going and its goal I actually set myself to get out of the house and physically go and do it' Ian.

'We do a before and after for the gym so people report how they feel when they come and before they do the exercise and then report how they feel after like tiredness, low motivation, low mood and low they feel when the leave like normal, high energy. Pretty much everybody reports feeling better after doing some exercise even a 10 minute session helps peoples mood' Tara.

The difference in what sport and exercise means to each person is clear; much more personal meaning is attached to Ian's quote. Ian explicitly states that he enjoys sport and exercise and enjoyment is an integral factor for continued participation for Ian. He states he does not feel like he is required to do it, but he wants to do it. Because he enjoys the sport and exercise the secondary benefit for Ian is that it gets him out of the house. Whereas Tara's quote although positive and caring is tinged with targets and outcomes. It demonstrates what is important for each person out of the same lived human relations. Both want positive outcomes but for different reasons.

The staff and coaches implementing the sessions raised a number of practical questions regarding the structure of each session. Currently the structure lies in the hands of the person implementing the sessions. The questions include whether elements of competition should be included. Levy, Nicholls and Polman (2012) believe competitive sport can improve mental toughness, mental toughness can aid in emotional and life control as well as interpersonal confidence, all of which could be considered beneficial to a person's mental wellbeing. Elements of competition and competence draw on experiences through the lived body.

'I think in the vast majority of cases it needs to be non competitive when you think of mental health community I think getting people out walking and gardening are really important steps and they are not competitive activities' Ian.

'I really like the team games especially football, I like playing to win' Paul.

The contrast between Ian and John's comments is enormous. Paul may have certain mental health issues but they do not change the experience of competing and winning for him. The following quote from Tara suggests that service users should not have restricted activity type and choice purely on the basis that they are service users; it needs to be a careful and considered process.

'We have done bits and pieces in the past but we have gauged from the service user if that will be appropriate or not, there is some people that are really quiet and reserved that won't really do very much and so doing something like that might deter them from coming to the session. But then we have done things with service users like basketball and little drills and things like first to ten and things like that, little bits of competition are ok if it's in a controlled environment but it is about gauging the service user as well I think' Tara.

Elements of competition were included in the sessions attended by participants, this may have altered how the service user felt, interacted and experienced the scheme. In the following quote from Paul the perception of how he feels through his bodily actions is important. He is feeling and sharing competition through this sporting interaction with the world and it is influencing the way in which he experiences the situation.

‘One of the weeks I beat everyone at indoor curling, it was the first time I’d ever played it as well, it was good playing something different, I even beat the coaches’ Paul.

Another structure issue raised is whether the sessions have team or individual activities? This falls into the realm of relationality. The quote below from Lynn shows the difficult balance that needs to be considered in relation to conducting team and individual sport and exercise sessions for mental health service users;

‘I guess with mental health issues there could be a point in time where you only want to concentrate on yourself and do something within your own space and you’re not interested in interacting with others, so then a group thing might not be necessarily meaningful to them but at a later stage maybe it will and you might get to a point where you want to be more social and let people interact with you so it’s a difficult one’ Lynn.

‘R - Have you made any friends through the group?

P - I have made two friends Paul and Colan and two coaches’ Vikki.

Research suggests that team sport improves health and wellbeing citing the relationships and bonds between team mates benefiting people psychologically (Sabiston et al., 2013). The issue may be more complex when dealing with a clinical population. The mental health service user may simply be unwell and not be open to new relationships, although this is contrary to the quote from Vikki who appears to have developed four relationships through the sport and exercise scheme.

Another practical question posed through the literature in relation to service delivery is whether the activity should take place indoor or outdoor. This lived space is also an important consideration to be made. The space we find ourselves in can affect how we feel and experience things’ therefore setting is important. Should it be the same space each week to bring consistency or changed to deliver different experiences? Research has highlighted the therapeutic elements of outdoor activity (Thompson Coon et al., 2011) yet much of the provision I have explored here is delivered indoors. Van de Berg, Maas, Verheij, and Groenewegen (2010) found in human geography research that people who live within a high green space environment suffer less from stressful life events. This demonstrates the effect the lived space can have on life experiences. The service providers generally could answer these questions yet their answers did not always align. The disparity between the answers may be because of a lack of informed direction through research and policy. The location, venue and its space of the scheme however appeared to be conducive to working, engaging and enjoying.

5.1.4 Structure of Life

Structure is not just important in the sense of how the scheme is set up but is also important in the literal structure it can provide to a person's life. This was expressed by both the service users and service providers.

The quotes echo one another;

'Also if someone has been unwell for a while they probably have limited structure in their life so it's about having a regular session every week so when they wake up on that morning they have purpose they have something to do so that's helping them get back into a structure if they're going to a walk with Tara on one day then coming to the lets do this on another that's going to help with that' Lynn.

'I like that it is at the same time every week and I know when to come, that structure' Vikki.

'It's set for Friday so I know I make sure I'm there, I try to go in the gym after as well so that's my Friday afternoon' Colan.

The structure the scheme provided could be considered a demand or a freedom on the mental health service users lived time. The quotes provided suggest that the current scheme offered a freedom by providing a safe space to engage in healthy behaviour during that time period every week. It could also be considered a demand in terms of the cost of being healthy which will be discussed in more detail in 'the Individual matters' thematic area. The reference to group and social side of the group was also raised by research conducted by Hodgson, McCulloch and Fox (2011), they found that structure of a scheme including the regular timeslots and familiarity helped develop social confidence. The points highlighted in the analysis from both the mental health service users and mental health service providers demonstrate the importance of structure in a number of ways, from the literal structure of the scheme through to the structure a scheme can provide in a person's lifeworld from a temporal perspective.

The service providers are vastly experienced and knowledgeable in their field but without concrete direction on how best to provide sport and exercise for mental health service users they are 'just guessing' at the type of activity to provide as demonstrated in the quotes below;

'blimey, now you're asking. I wouldn't know actually. I'm not an expert in these types of things, erm but I don't see why there can't be, I don't see why. I think it depends on the group you have got in front of you. Some people will really thrive on that and some people won't like it at all' Mandy.

'that's a difficult one for me because our whole ethos is about choice and being driven by the service users but I also think there is an element of encouraging people and pushing people, because people can often underestimate what they can achieve' Ian.

This again feeds into the issues that have been the focus of the analysis such as individual differences of the participants and the difference in opinion of the service providers on scheme content. To some extent this has

been addressed within this scheme which aims to provide taster sessions of a variety of sports and exercises in which the service user can experience things they might not have tried or heard of before. Yet the questions of exactly what to provide remain largely contentious or unanswered even from the people delivering the service.

The future of service provision is discussed by all the participants who raise a number of points which could greatly improve service provision and therefore the health and wellbeing of mental health service users. One of the key contentious issues was that of policy.

‘they wanted to improve their physical health and mood they generally weren’t looking to lose weight to get fit, that was just a by-product and that’s how we marketed it as well we wanted it to be accessible to them and of it not to be intimidating and be a whole fitness thing it was more about being social and being active and using activity as a form of them improving their physical health which is what most people wanted and why they got referred in, If I think about our own trust we talk about it a lot but we don’t do nearly enough about it so I’m not sure whether it is the gulf between the evidence coming out and being able to put it into practice and I think that is a problem with lots of areas. The gap between research and practice can be big. They can be quite slow to react. I do think we know the research is out there but it seems to be lost in getting through, like you say it’s either really slow or it never arrives’ Mandy.

And

‘If you look at the NICE guidelines for example schizophrenia it mentions one thing on lifestyle whereas that needs to be as strong as medication, I think that would be ideal because the evidence is there and it is in the department of health when they did physical activity policy. It was the first time in the last one that they mentioned about mental health and mood and dementia and that is probably the first time it has been mentioned in a government policy. The evidence is there, it’s about them making that more mainstream now’ Ian.

Mandy and Ian are almost exasperated by the lack of a direct link between research findings and practice. The mental health service providers have taken an active interest in published research and are seeing discrepancies between what they are reading and the body of knowledge compared to what they are seeing within their services.

5.2 Am I Valuable?

Can we put a price on health? The question is complex; within the question are a number of different arguments and viewpoints which have evolved from the data.

‘Yeah if you don’t have people coming the funding goes, but if people don’t know about it, how can they go. As I said yeah some days you might not get anybody turn up but other days you might get 10 people, or you might get 2 people. But 10 people or 2 people that makes a difference in that person’s life’ John.

An important consideration is the value an individual places on themselves. Within the quote John is acutely aware of issues surrounding funding. This fear of funding cuts is one which could cause feelings of low worth. The service user may think they are not worth the funding provision. John almost pleads for funding to continue. The value of making a difference in one person's life is immeasurable for that individual, placing them in a subjective space of health as opposed to a space of negative feelings towards themselves. Making a difference in a person's lifeworld in a real and lasting way through healthy behaviour is priceless to the individual; despite this resources have to be seen to be effective in order to continue, so John's fears are rational and real for him. The treatment of mental health patients should be on a par with treatment of physical health conditions where suitable 'post op' care and rehabilitation is offered. This message is endorsed in the Annual Report of the Chief Medical Officer (2013) which goes on to state; 'Whilst there is a wealth of robust evidence for public health approaches to mental illness prevention and mental health promotion, England needs a better defined, policy-relevant focus on these concepts.' This value is also outlined in the document; it clearly states the financial implications of mental health issues in the UK economy as up to £100 billion per year, accounting for 70 million sickness absence and 23% of the national disease burden. While these figures are enormous, the investment in mental health service has fallen. This could go some way to explaining the fears of individuals like John. He is valuable but the squeeze on mental health services puts his recovery path in jeopardy from funding cuts. This sends the message from government that John is not as valuable as a physical health condition patient.

5.2.1 The cost of being healthy & Barriers to participation

One interesting point raised by two of the service providers was the experience while delivering schemes that a free service is not necessarily the best way to increase and encourage participation.

'We offered all our participants a free three months leisure pass. The problem being with it was quite a low take up, I don't know if you have found this in your experience but if you give something for free sometimes people don't see the value in it. So I think that's what brought me here kinda around the lifestyle stuff. It's important to think about these types of things on how to engage people within sports and exercise especially in people with mental health problems' Mandy.

'I don't know how much you know about GP referrals and referral schemes as well for people with health problems again there is a very low take up. Often in the past they were free to people with both physical and mental health problems but really low take up. I think some research came out as well that if you charge a fairly nominal fee for it the take up actually increases because people are buying into it both mentally, intellectually, they are making an investment financially so it's a bit counter intuitive, one of the barriers to people is financial because it can cost five quid to go swimming or whatever to access a gym. But also we have to think about what you are offering because not everybody wants the gym do they. So you have to think about what you are offering' Lynn.

This quote demonstrates the delicate intricacies of providing a service. Financial constraints for service users are one of the key barriers to participation yet free services are not always well received. A free service is also very resource intensive to the provider financially and in time. These nuances could make the difference between the success and failure of a scheme getting and keeping a healthy number of participants while delivering a cost effective service.

‘well it falls down to putting value on your health, one of the things is though even when we put schemes on in more deprived areas it doesn’t get filled up with local people it’s the ones from LS17 who see a good thing and go for it, the only thing is I have to take peoples addresses and if the people attending aren’t from the catchment area even if the group is full the funding will get cut. So it just falls down to motivation really and I find those working and busy people have more motivation than those who don’t work and do anything’ Bridie.

Another issue raised here is that by encouraging payment for a service, people are not only investing in their health but are also using skills which are vital in everyday society. The acts of making payment and interacting with staff are important skills. They may seem like basic skills but after moving from an institutional setting they are vital in building confidence and becoming an active part of society. Perkins and Slade (2012) researched the recovery process for mental health service users; they highlight key elements in this transition: hope, control and opportunity. Here the description of opportunity is most relevant, ‘The chance to do the things that you value and participate in as an equal citizen in all facets of community life.’ (Perkins & Slade, 2012). By doing what ‘normal’ people do such as using the local community leisure centre the transition back to society is being achieved.

Chow and Priebe (2013) conducted research into psychiatric institutionalisation and commented on ‘adaptive behaviour’ and ‘social withdrawal’ both of which contribute to the loss of independence and responsibility. This may have a detrimental effect on management of everyday demands. Therefore the practice of such skills may be of benefit to the mental health service users in order to function within a non institutional setting. Although this is in contrast to findings from Paul

‘I haven’t got much money so coming to these sessions is a big help to me. I like the gym and stuff like that but I can’t afford to pay a fiver every time. I’m looking forward to getting my Leeds cards though, i will probably go more then’ Paul.

The financial costs are a barrier that are sometimes overlooked, if someone has been ill for a period of time the likelihood is that they will not have worked within that time. The financial implications of being ill could reduce participation.

5.2.2 Bodily Cost

The cost of being active is not purely about the finances involved in being active, further issues emerged, one of the costs is being active can demonstrate a lack of ability or competence

‘You go with the mindset to go and do circuit training and before if I was in the army or before I had my heart attack or even just after I would’ve pissed this but then you go you get a shock after you have been sat on the sofa for four months you can’t do it, I was two days in bed with it, I couldn’t physically walk’ John.

Here John is talking about his bodily capabilities in a negative way, if the participant had remained inactive they would not have realised to the extent their ability to be active had been reduced so significantly. This realisation can negatively impact self worth and self image and exasperate the current psychological problems, in this case depression. The last thing a person with depression needs is further ‘proof’ that they are not good enough. Through our experiences within the world through our body and relationships over time we build an image of ourselves. By taking an inactive person and engaging them in activity we may reveal a more accurate likeness to that person, working with a more accurate self perception may help in the recovery process for the service user.

5.2.3 The individual matters

One issue that resonates throughout the analysis of the service providers is that they are all acutely aware of the fact that each service user is an individual with their own needs, targets and aspirations. This is also expressed by the mental health service users. The importance of the individual is a challenge to mental health service provision. Mental health services need to be cost effective and sustainable. The difficulty for mental health service providers is balancing funding costs, outcome and delivering a service which is effective and impacts upon the most people. While these are important issues for top level service management, a balance needs to be struck where the individual needs mental health service users are met. A further consideration for the structure of mental health provision is given the importance of the individual should we be setting prescriptive guidelines as all? The psychosocial outcomes may be more important than the physiological hence no need for generic prescribed program to be rolled out across the country for everyone.

‘They will all have different personalities, you might be in a group where people are not competitive and want a bit of fun and try it and laugh when they haven’t got very good technique or something like that or you might have some people in the group that are so competitive whizzing the shuttlecock down in front of you in badminton every time so you haven’t got a chance to get there and hit it back which would put some people off. There are all these things; it’s very complicated isn’t it!’ Lynn.

'I don't have to do it but I enjoy going and its goal I actually set myself to get out of the house and physically go and do it. That's the mindset when you don't want to go out because you're scared of going out 'Ian.

The individuality of the mental health service users needs to be addressed by the coaches and staff implementing the scheme. McAllister (2010) points to the idea that recovery should be focused on from a service user point of view that take into account their wider wellbeing. The individual needs are important in delivering a service which is well received, engaging and effective. For example elements of competition and other issues of scheme structure that could be altered or implemented in a way which could suit the service users. In the following quote Bridie talks about introducing untried activities to the group, this flexibility could be seen as strength through its reactive changes to mental health service user feedback. It could also be considered a weakness due to this type of provision not being based on any evidence.

'I would like to introduce some team games but I'm not so sure how well that would be received, that's something that I would have to research because I've not done it in this field before so I'm not sure how they would react to that. In may even though we have got a small group I'm hoping to start doing some kettle bells just to open up another field of exercise, we will try it and if it doesn't work it doesn't work but if it does we can incorporate it even if one person likes it because we do circuit type things and we can leave it in there' Bridie.

Finding an effective way to engage different people may take a more novel approach. Some service users may be adamant that they do not like sport and exercise so it requires a skill to engage people in healthy behaviour. They are motivating mental health service users, focusing on elements of experience allied to the activity.

'maybe they enjoy looking at gardens in the spring so you go for a walk in the park maybe it is something different the focus isn't on being physically active it's on something they enjoy doing that happens to involve being active. Maybe you have in your resource day centre things like skittles something like that, they're having a game but they are being physically active, the focus isn't on them being active but you know they are doing certain movements and exercising their muscles. Not in a strong way but they are doing something, so there is a role for that' Lynn.

Yet interestingly another viewpoint emerged for one of the service providers.

'Yeah for us because you wouldn't be in the community unless you were well enough, so from that side of it. It would be safe, that's why we would have the referral before they go in. But in terms of different backgrounds you could get that anywhere so it will bring people together with common cause and interest without having to look at the other things. You wouldn't necessarily have to say you had a mental health condition if you went for a swim or the gym because it wouldn't be an issue; they would be going for that activity. The benefits are going to be different depending on what they have come for I think. So I wouldn't see that as an issue because you are trying to normalise a healthy lifestyle and a physically active lifestyle' Lynn.

This viewpoint demonstrates that the individual does not have to focus upon their condition. The sport and exercise participation almost 'cloaks' their identity of being a mental health service user. This could help with

the transition back to society. It allows the mental health service user to take part in 'normal' healthy behaviour without the potential stigma of their condition affecting the experience.

The mindset and action or construct of being healthy should transcend their particular problem. Being active and taking part in a class does not require the participant to divulge personal information so why should their condition be an issue?

'To be honest it was good to just get out and play some badminton and tennis and not think about being ill' Simon.

'My problems are my problems; I had my accident a long time ago. It's my business really; you don't want a sign above your head saying I've got a problem' Colan.

This position is important in the fact that it shows normalising healthy behaviour can help people on their journey to health and day to day management of condition. Of course there are individual needs within people yet the point is individual or segregated provision may not be the best course of action;

'It's not necessarily what you do to people it's their experience of it. So it's how people treat them or engage with them that is almost as important as or if not more than the interventions provided I'd say. That's why it's so important to get their experience of things' Ian.

5.2.4 Barriers to participation

Through the interviews a number of practical questions were raised about specific issues around the importance of the individual. The sub theme which holds most resonance with the mental health service users was the barriers to participation.

'There are many barriers. Services put barriers in place but also there are barriers around the individual which we find all the time around motivation, anxiety and accessibility, finances all those pose barriers for people, we know that. But there is also the barriers around making it less scary from the service point of view and more tailored to people with mental health needs, around how they advertise it these are all things' Mandy.

The confidence to get to the facility and that's a big thing generally within mental health and that's also one of the reasons we set up this project' Tara.

The issue of changing mood day to day is one which is generally out of the control of the mental health service providers

'Our people don't need a reason, anymore reason than they already have to drop out' Tara.

One of the key points highlighted in Tara's quote is the importance of increasing and improving confidence of the participants so they felt able to access local sports and leisure centre

'You need a gym teacher who knows what you're going through or has an idea what you're going through' Paul.

'Once you get there you know it's going to be alright, you've met somebody you know, who you trust so if anything goes wrong she will help you' Simon.

'I can go every Wednesday and she will be there, except this Wednesday but someone else is coming in and how I am now I'm getting a little better, I don't need that comfort blanket of someone I know with me' John.

The development of the participant through these statements is very clear. The confidence instilled in them through developing relationships and trust is of a huge significance to the participant.

'That's the mindset when you don't want to go out because you're scared of going out' Colan.

To develop the confidence to attend a session with a stranger at a local leisure centre when previously they were at a point due to the condition that they could not leave the house is astonishing. For the participant the structure the session provides and the knowledge that someone would understand their condition and needs was very important in developing their confidence. The role of the sport and exercise group takes on an importance in the recovery from mental illness by building confidence and trust.

5.3 The changing self image through sport and exercise

The changing self image through sport and exercise emerged through the data. The mental health service users in some instances used sport and exercise as a gauge of their self image, this included looking to their past levels of participation in comparison with their current levels. This was done through pushing themselves to their limits. The process through which self image changes is not a simple one. The way in which people self image changes through sport is affected by the struggles dealing with mental health issues on a day to day basis.

5.3.1 Being ill day to day

One of the key issues raised by both the service users and service providers was the notion of a day to day existence. This is an interesting point in terms of temporality. The way in which the mental health service users are experiencing the world seems to be influenced by the demands and passage of time. This presents difficulties when the overall goal for the mental health service users and providers is the return to health. The implications for the lived time of the service user are that they do not know when they will be well. Only limited plans can be made personally, in their recovery and professionally in their work life. This day to day illness reinforces the importance of structure and support as discussed earlier. This demonstrates its importance as an

essential element of the experience of sport and exercise for mental health service users. In the first quote John make a reference to the passage of time. It is particularly interesting as when he is feeling good, time moves quickly yet if he is not having a good day, time does not move as quickly. Here it also demonstrates that there are periods of wellness within the gloom of depression and that wellness is experienced at a faster pace.

‘You know some days I’ll come up and go out there and go in my shed and do what I’ve got to do and be busy all day and think where has the time gone and then other days I won’t, ill just think why am I going out there I can’t be bothered so you end up sat watching television, that’s the nature of the illness’ John.

And

‘It all depends on what frame of mind you have at that time. With depression some days you just don’t want to go but you have to force yourself to go, and once your there you’re okay. Depending, you know if you’re a bit iffy about going out you force yourself to go’ Colan.

And

‘I think in general their mood is an issue and it can be variable day to day as well so managing their mental health day to day is a big issue, one day they may feel really good then another they are completely down then the whole routine goes out the window, that’s one issue’ Tara.

The service users have a limited temporal window in which their experiences of sport and exercise will be more likely to be well received; this has implications for how we should help people become healthy. It is how that healthy or unhealthiness experienced. This relates to conceptualisations of what healthiness or unhealthiness means. You can have health in illness.

From the viewpoint of the service providers, the implementation of sport and exercise to help with recovery assisted in a number of ways, for example;

‘Definitely, there is one gentleman that had balance issues and he has progressed an awful lot, he has got stronger which has helped with the balance. We have got one lady who keeps going from strength to strength, her flexibility was there already but her cardio is getting a lot better’ Bridie.

While the next quote shows the extent to which sport and exercise can impact upon a person’s life.

‘she said the exercise helped her manage the symptoms both mentally and physically she then attended Scotthall sessions for a couple of months and from that it just improved her confidence really because she was doing things outside the session that we hadn’t asked or recommended her to do, she started biking, she started a volunteer job and she was biking to work as well and doing walking in between the sessions, which was really good for her and helped improve her physical health as well. I think she lost weight; she wasn’t looking to lose weight. It just happened because she started exercising and doing a little bit more. That was a really good example, when she was here she was very poorly, when I saw her at the end after she had done the community she was like a completely different person which was really nice to see’ Tara.

The quote demonstrates that sport and exercise has encouraged motivation in other spheres of the person's life. The impact of sports and exercise on the wider lifeworld of a person is evident. This shows the salubrious effects sport and exercise may possess.

Sport and exercise can also offer further benefits to institutionalized mental health service users. The opportunity to leave a ward can form the highlight of a person's week. This could raise the question of whether it was the chance to leave the ward or the exercise which benefitted the patient, yet this stance misses the point that regardless of the reason for the benefit, the fact would be that they had engaged an otherwise inactive person in healthy behaviour. By engaging in such behaviour the mental health service user is taking a step in the right direction to recovery.

'they are there for a long time and they are usually detained on the ward under the mental health act so them coming to sessions is a big improvement and it was something that the service users said that they really enjoyed actually getting out and coming to the sessions, they were asking about the sessions themselves to staff and to myself when I was there last time. I guess that shows the value that they put on that because they didn't have anything else that they could engage in on the ward' Tara.

The journey may not always be straight forward, John attended regular weekly sessions and through the confidence he gained at those sessions he joined a regular public circuit class;

'I did that thing on a Saturday and it wiped me out you know, I couldn't do it' John.

The effects of a setback such as this could have a damaging effect on a person who is already low on confidence or self esteem. A negative experience of sport and exercise could be detrimental to a person's long term health if it discourages participation (Cresswell & Eklund, 2007).

5.3.2 Pushing to the limits and self image

The theme of pushing to the limits emerged and demonstrated itself a key way in which a person challenges their self image through sport and exercise;

'I like when we did the aerobics, I felt like I was gonna die at the end but it felt good' Vikki.

'I try to go on a Saturday and do circuit training and it nearly killed me' John.

'I had my heart attack in July. I finished my heart attack and went and walked a mountain two days after I had got out of hospital which I wasn't supposed to do but I did it to prove a point' John.

'I just felt a bit of a fraud because I could get on the bike and hammer it or get on the rowing machine and get my heartbeat up to 120 and all the nurses would shout at me for doing that because you are not

allowed to do that and so I stopped going to go to another gym to do it sort of an advanced one but I had a bit of a do' John.

In the first instance Vikki has pushed herself to the limits but enjoyed the feeling which is in stark contrast to the second quote in which John tried to push himself, this resulted in a situation where he had gone too far. This idea of pushing yourself to the limits is closely linked to self image and its changes through illness. It almost seems like John is fighting against his current state. In the first quote the participant is still in their old mindset of competence, confidence and prowess yet in the second quote when they attempted to push themselves the result was one of realisation of their physical limitations which require an adjustment in self image.

In the third quote the idea of pushing to the limits takes on a significant role, the participant looked to push himself in such a way to prove that he wasn't ill physically despite the obvious warning signs displayed by his body in the form of a heart attack.

'I was going and I would turn up in shorts and a t-shirt to thrash myself and that was what I did every week but when you are doing it with people who are 70 or massively overweight people that you expect to have a heart attack and you are still bashing yourself about having one because why me? I just felt a bit of a fraud because I could get on the bike and hammer it or get on the rowing machine and get my heartbeat up to 120 and all the nurses would shout at me for doing that because you are not allowed to do that' John.

By doing such an activity it was defiance and an unwillingness to accept a change in John self worth and self image. The idea of being unwell was rejected in his mind. The struggle to accept a changing self image in which they can't compete or do to the same level must be particularly difficult for someone who has been very active their entire life. Here John speaks of exercise in quite negative terms such as 'thrash' and 'bash', it conveys a feeling of a trying to exercise to a level beyond his means. This is further evidenced later in the quote; John describes how the nursing staff were concerned about his actions. By pushing himself to near breaking point he is trying to reconnect with his past and return to a state where he was in control both physically and mentally.

'I used to enjoy football, I used to play a lot of football and do a lot of training for football because it was semi pro so that was it, work wise you had to be fit when you were running up or down buildings you needed to be reasonably fit' John.

'I used to play lots of badminton and table tennis, I suppose I was fit then but age catches us all up, but it's good to get back into it' Colan.

John was a fit and healthy semi pro footballer and member of the army. His work, leisure and even holiday time have always been filled with sport and exercise of some description; much of which were generally outdoors. The shock to move from that to the limitations imposed by a heart attack was very difficult for him to come to terms with. The current scheme has looked to rebuild some of that lost confidence through the supported

sessions. The basic levels of fitness it has provided will hopefully be a platform from which Colan can further improve both his physical and mental health in the future.

5.3.3 Competence – Have I got it?

Through the analysis process competence has been shown to be important in the process of changing self image. The mental health service user participant can be caught between past perception of their competence, their current level and their aspirations for the future. The term competence here is used to illuminate the perceived ability of an individual to perform a given sport or exercise to a certain level. The level in question seems to vary among the mental health service users. For Simon, the level he reflects on is the basics of point scoring in a team game. In contrast, Vikki and John speak of how competence in a particular sport has allowed them to compete at a higher level. The ability to perform in a sport seems to be related to feelings of enjoyment despite differences in competence level. Competition can be seen as a motivator for some and barrier for others linked to perceived competence. You need to feel you have at least a chance of winning rather than feeling humiliated, for example if you were last one picked for school team you see competition as a bad experience. Perceived competence is a key concept in taking part and enjoying the experience (Hodgson, McCulloch and Fox, 2011). The importance of this idea is that by coaching and improving someone's competence level we may be able to improve the experience for the individual and ultimately what they get out of that experience.

'I studied in secondary school I joined a school team especially running and the javelin, there was a small group for training and I represented the school at javelin in the regional games' Vikki.

'R- If you think back to when you played basketball, is there any standout moments or memories?

P- Yeah I scored a basket, slam dunked it yeah, it was a really good feeling' Simon.

'For the sports, the team sports it's all about winning isn't it. I used to enjoy football, I used to play a lot of football and do a lot of training for football because it was semi pro so that was it' John.

From these statements a range of meanings emerge, for each person, competence and the related enjoyment arises in different ways. On a basic level, the competence required to score a point in a team game creates an immediate feeling of enjoyment and even a boost in self esteem. Through the lived body, Simon has interacted with the sporting world. He has used his physical attributes to leap through the air and smash that ball through a hoop. This is not something that everyone could do and it has brought him joy. Enjoyment and affective response in general is important for adherence but may be particularly important for mental health service users due to notoriously high dropout rates. By being able to experience a success even on a basic point scoring

level his bodily competence has provided Simon with an instant increase in felt self confidence, self efficacy and self worth;

'Say if you score a goal or something in the football all the team congratulate me, it's a team effort' Simon.

5.3.4 Competence opening the door

The competence in the javelin for Vikki has opened up another world to her, training and competing at a regional base to represent her school and town. This lived space would not have existed in the participants life were it not for the participation in sport and exercise. The experiences and achievements which occurred in this lived space of the regional training camp were felt in a positive way. This type of competence requires further training and dedication to reach but the effects have the potential to be more poignant and long lasting in the participant's world through the opportunities it can provide;

'I was very proud to represent my school and my city at that competition and I could show my talent on that stage' Vikki.

The feelings of enjoyment through competence for Vikki develop even further into a sense of pride (Williams & DeSteno, 2008). The level of competence allowed the participant to join a particular lived space involving a small group selected based on their ability. This has given a Vikki a moment in her life to reflect upon in which she had positive feelings of sense of self worth. When sport and exercise was mentioned to Vikki this was the first vivid memory which was recounted and the first thing that the participant wanted to talk about. She looks to convey her level of prowess and competence.

In the quotes below John's competence has led to playing football as a semi professional. Johns lived body has allowed him to experience the world in a unique way. These unique experiences are delivered in a multitude of ways. Firstly through relationality; John refers to 'we' in both quotes, being a part of something, forming identity and belonging through his relationships with the team.

'I was never brilliant at it but I wasn't bad, I made the first team but I might not have made Borussia Dortmund, we used to go all over' John.

'R – You seem like you have done loads of stuff and activities are there any experiences that really stand out?

P – Winning the championship in Germany, that was like a Sunday league championship that was big, we went to Austria for that and won it' John.

In the second quote the emphasis is on the concept of winning and the enjoyment that can come with success. His enjoyment in this sense had become entirely result dependent. Here competence has allowed John the chance to become part of a team which has achieved a level of success. This experience is vivid in the memory of the participant and was the first thing recalled when asked about previous experience of sport. This is an experience in John's lived time in which he was younger, talented and successful. The enjoyment of winning and this vivid experience at a semi pro level was only possible through a high level of competence. In order to succeed in sport there are other things that are required in combination with competence, things such as effort, dedication and motivation. Yet without a certain level of competence the most motivated and dedicated individual will still struggle to succeed in the highly competitive world of sport.

5.3.5 Competence and provision

What we do see through the data is that competence and the meaning of competence is multifaceted and subjective. Through Simon's earlier quote in which he speaks of 'slam dunking' a basketball it seems that teaching an individual a sporting activity to a basic level where they can score a point or influence a game is enough to create enjoyment. Whereas through John's quotes we see that on a higher level of competition competence still influences enjoyment although it seems more result dependent. These points raise issues which are important for provision and participation. Kilpatrick et al. (2005) highlight competition and challenge as very important factors in motivation to participate in sport and exercise. While Hamer, Steptoe and Stamotakis (2008) note the magnified health benefits of competing at a higher intensity such as competitive sport. In contrast, Strohle (2009) found positive effects of sport and exercise for mental health in participants walking on a treadmill, which is non competitive and classified as low to moderate intensity. The 'Let's Do this' scheme included a range of sport and exercise activities both competitive and non competitive; the sessions included a range of intensities. The sessions also included team games and individual activities. This was done to offer the participants a chance to experience a wide range of activities to help them discover which was the most appropriate/beneficial for them.

A range of activities was included in the scheme delivered in a 'taster' style. This created an opportunity to develop mental health service users' basic skills. The coaches then looked to signpost individuals to groups and classes where a particular activity could be pursued if they enjoyed the session. From a service provider perspective the onus is on gauging the needs of the participants and being able to tailor sessions to the needs of the individual participants. This resonates with the work of Hodgson, McCulloch and Fox (2011) who found that overcoming issues of competence or inadequacy as they termed it was an important factor through the scheme. The coaching offered by staff mediated this issue.

‘You know the staff, its important the staff on the ground know about our population and how to make adjustments for our population because it will stand or fall on how the sessions are delivered’ Mandy.

Here Mandy highlights the importance of the staff and coaches rather than the competence or motivation of the mental health service users. She states the success of sessions will stand or fall based on competence of the coaches. This is a very clear and direct assessment of the value of a good coach.

Chapter 6 - Discussion

The aim of the current investigation was to explore the lived experience of sport and exercise for mental health service users. There were three additional objectives, they were; to investigate perceptions of sport and exercise on mental health and wellbeing; to investigate the perceptions of mental health service providers regarding service delivery and finally to investigate fundamental issues of session structure. Thus the study asked mental health service users and mental health service providers involved in the sport and exercise scheme to describe their lived experiences of sport and exercise. Using an interpretive phenomenological perspective, these descriptions were analysed to elicit the meaning of the phenomenon utilising Van Manen's (1990) six research activities.

The chapter includes a summary of the main findings of the study and a discussion around what is considered to be the essential nature/structure of the experience. The chapter also includes reflection on the methodology, considers the strengths and limitations of the study, the possible implications of the research and future recommendations.

6.1 Insight through visual representations of the experience – the essential themes

There appears to be two essential themes running throughout the data analysis the 'Intermittent health breaking through heavy clouds of illness' and 'The cycle of recovery'. The hermeneutic circle was instrumental in the recognition and development of these essential themes. It was only through considering the parts (such as individual words, turn of phrase, themes and sub themes) in relation to the whole (the phenomenon of interest) that I began to question the way in which I could better illuminate the lived experience. Meaning making is a difficult process yet through reading and re-reading the shared experiences and through using imaginative variation techniques, I developed a mental picture of the lived experience. I thought of the way in which I could use language to provide a fuller, richer interpretation of the essential structure of what had become a mental representation. Then through much deliberation and returning back to the whole and parts of the data and interpretations, I realised that I could not only describe the essential themes I had visualised but I could also show the reader these mental pictures.

6.1.1 Intermittent health breaking through heavy clouds of illness

The journey to health is not always quick or straight forward, the chance to leave an institutional setting to engage in sport or exercise can beam a bright light in an otherwise dark time. With no idea of whether you will be well enough to engage with your own recovery it must feel bleak. I imagine the experience as a cloudy day punctuated by sunny spells, as a dark period breaks into bright sunlight everything must begin to feel better and positive, only for the cloud to return and once again fill life with dullness and dreariness.



Fig 6.1 Intermittent health breaking through heavy clouds of illness

‘Through hope and expectations we have a perspective on life to come or through desperation and lack of will to live we may have lost such perspective’ (Van Manen, 1990, pg 104) The cloud of mental illness is much like rainclouds, on the day and time you see the rainclouds the darkness can be all consuming, yet when the sun breaks through, hope of a brighter time returns. This is how the experience of being ill day to day was portrayed. This temporal window of periods of health in unhealth revealed that mental health issues can remove you from the ‘normality’ of everyday time and instead place you in a timeframe dominated by illness. You can no longer plan or operate on planned basis because you do not know if the next day will be raining. The

cloud metaphor extends further; we are helpless in controlling the elements as we are sometimes helpless in controlling illness.

‘we know the space in which we find ourselves affects the way we feel’ (Van Manen, 1990, pg102). The lived space you occupy is not always a pleasant space, sometimes the same space can be experienced in different ways based on other factors. The experience of structured sport and exercise offered an enjoyable experience in one ‘safe’ space for the mental health service users. The ever familiar dimensions of the scheme paired with a developing relationality with staff and other service users alike offered the intermittent sunny spell. This feeling of belonging with the lived other and shared experience can bring about a positive perception on the self.

6.1.2 The cycle of recovery

The term 'cycle of their recovery' was used to represent the journey to health the mental health service users were making. It occurs at different times with different people, with some it takes longer than others.



Fig 6.2 The cycle of recovery

The shops in the high street represent 'normal everyday' life or the lived space of normality. The water is the mental health condition which is affecting every aspect of the 'normal everyday life' causing difficulty making the journey. The bike is the scheme and support provided. It doesn't make the journey easy but it helps make the journey possible. The support provided helps the mental health service users achieve and be an active part of their own recovery, increasing self worth and a positive self perception. The waterproof coat represents the

person's natural psychological resilience, it can only do so much, without the added support of mental health service intervention they would soon feel the flood water of mental illness. This temporal awareness of the self includes an understanding that they are not in a state of full mental strength. They may need help on the journey. Being on the journey with someone else facing the same difficult struggle promotes a sense of belonging and offers a feeling that they are not alone, they are not the only one. It is through these lived relations that a sense of belonging and feelings of being a valued member of a scheme develop. The struggle in the cycle of recovery is tough but it is not impossible.

'Phenomenological research, unlike any other kind of research, makes a distinction between appearance and essence, between the things of our experience and that which grounds the things of our research. In other words, phenomenological research consists of reflectively bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of our natural attitude of everyday life' (Van Manen, 1990, pg 32)

6.2 Essential Nature of the Experience

The essential themes hopefully illuminate further the lived experience of sport and exercise for mental health service users. To uncover what I consider to be the essential structure of the experience, further engagement was needed with the six research activities (Van Manen, 1990); musing repeatedly over the derived themes and essential themes I have tried to understand and convey the experience of those who live it.

As proposed by Van Manen (1990) a single thematic statement has been constructed based on my total analysis (see figure 6.1 which displays the themes and essential themes, i.e. The total analysis). 'In determining the universal or essential quality of a theme our concern is to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is.' (Van Manen, 1990 pg 107).

The lived experience of sport and exercise and its impact on mental health and wellbeing for service users can be expressed therefore in the following statement:

Being within a structured sport and exercise setting environment fosters a sense of belonging. The relatedness of sport and exercise activities heightens a positive perception of the self, a notion of self worth and a temporal awareness of self identity. The embodied experience of being a valued member of a sport and exercise group can create relational connections that can promote the management and recovery of mental illness.

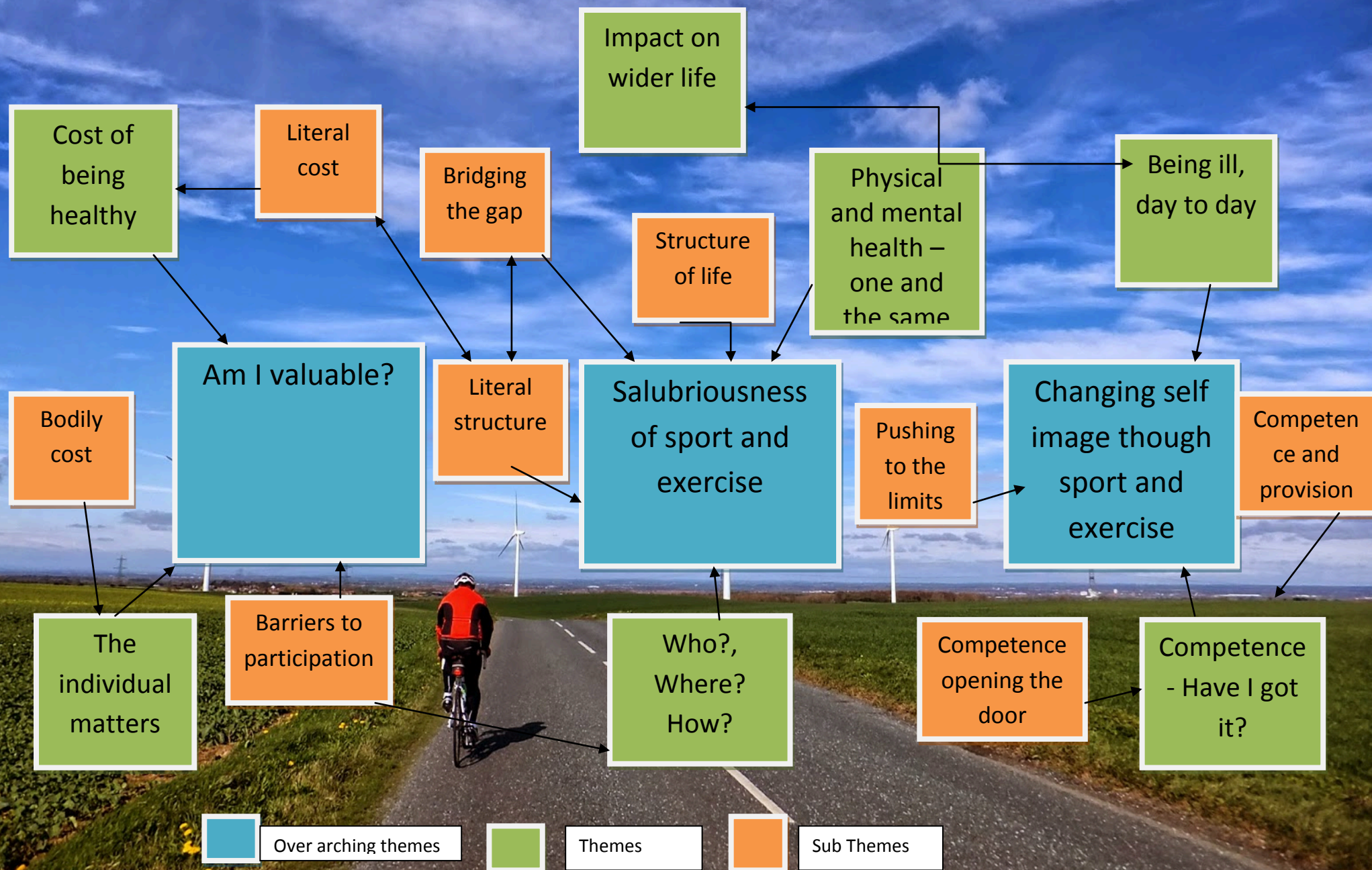


Fig 6.3 Essential themes underlying the whole experience.

6.3 Reflexive thoughts

Uninvited Guest

Feel broken down, my body aches
My heart it bleeds from past mistakes
Can't stop the tears, they fall like rain
The words are spinning 'round my brain
So scared and feeling so alone
The coldness fills my every bone
No food, no sleep, can't think at all
Each way I turn, another wall
This darkness haunts my very soul
My world seems dead I've lost control
The only weapon is my pen
Depression has moved in again

(Vicky, Family Friend Poems, 2007)

The participants of the current study are real people with individual conditions greatly affecting their lives. If we keep their struggles in sight, the current study takes on greater meaning.

Van Manen (1990) details six research activities and these activities provided a methodological structure for the study. Van Manen (1990) also advocates a use of the arts to express and convey meaning. In aligning my procedural methods with these activities I could engage deeply within the research process of interpretative phenomenological inquiry. The mental health service users revealed a great deal surrounding what sport and exercise meant to their past, their present and their hopes for the future. The essence of the experience is given in the language of the stories told. This methodology was effective in eliciting meaning in a way which could be presented to the reader to understand the experience. The analysis process when dealing with in depth semi structured interviews is one which takes lots of time, care and effort yet the process is positive and rewarding.

Phenomenology is not just a methodology to be used in psychology; it is a way of examining the human condition guided by profound philosophical thinking. It rejects the subject-object dualism that is central to the positivist ideals which continue to be the dominant force in modern psychology. Through my active role within the 'Let's Do This' scheme, when analysing the data I could picture the engaging nature of the sessions. These

memories of mine helped in my interpretation of the data, they added a different dimension to the life-worlds on the page and helped me illuminate the described experiences for the reader. However, within the analysis process I found myself wanting to report every part of the data to do justice to the given experiences, I found all of what participants had to say to be important and meaningful. The guidance from an experienced supervision team helped me step back and look at the parts that generated most meaning in terms of the project aim. Through this process and collaboration and development of the thematic analysis, the essential nature of the lived experience of sport and exercise for the mental health service users came to light.

The way in which schemes are delivered cannot be underestimated and the effects they can have on their participants. The mental health service provider's analysis offered a unique opportunity for the same experience to be told from two opposite ends of the clinical spectrum. This offered insight into the commonalities and divergence of opinion and experience of sport and exercise provision for mental health service users.

The adequacy of the phenomenological investigation (Ihde, 1986) relies on the extent to which the researcher develops insight and intuition in order to think in a phenomenological manner. We as researchers must overturn presuppositions to establish new perspectives, through this we can seek to make new discoveries. This relates to adequacy, in that with careful meticulous probing, we may discover what is there and available for discovery, but not often seen. The issue of adequacy focused me on adhering to the principles of phenomenology which is experimental in nature (Ihde, 1986). The foundation of adequacy is apodicticity, if we can return to a phenomena and fulfil the experiential claim we can evidence that it is a repeatable experience. Through this we can make tentative generalisations. The experiences investigated in the current study are worldly and relational. So by making tentative generalisations, we may be able to understand experiences, not just a unique phenomena but as essential features which can be experienced by others, therefore giving us insight into the way in which lived experience is manifested (Langdrige, 2007; Smith, Larkin & Flowers, 2009).

6.4 Strengths and Limitations

The current study has a number of strengths and limitations. Firstly, I am a novice researcher which could be highlighted as a weakness. This may be counterbalanced by my active role volunteering within the area of study. This experience offered me the type of insight rarely afforded in research of this type. The extensive and wide reading within the subject area and hands on experience of service delivery place me in a position of strength from which to investigate the experiences of the participants of the study.

Phenomenology is a philosophy not a methodology (Langdridge, 1997) so using Van Manen's (1990) six research activities helped make the transition of philosophical theory to a methodology. The experience of the supervision team helped guide me through the methodological process and the application to the phenomena under investigation. They challenged my interpretations to achieve a level of credibility in my findings.

From the perspective of the service providers I wanted to view the experience from a number of different positions, from management through to on the ground service delivery. I believe this cross section of service providers offered a more rounded assessment of sports and exercise provision for mental health service users. In terms of the mental health service users', one potential limitation that may be pointed out is that a voluntary participation in a sports and exercise scheme may only attract people with a natural affinity for sport and exercise and therefore their views may be biased towards the positives of this type of experience (Stubbe et al. 2006). I would counter this limitation with the premise that the study was to enlighten the experience of sport and exercise for mental health service users, so to investigate participants with no interest or little affinity for the subject in question would have been inappropriate. Although this may be a participant group for future research to see how we can engage this group in healthy behaviour.

One of the main strengths of the investigation was discovering all the work many professionals undertake with little or no encouragement from high level management and policy. The people in the roles of service delivery in this service contribute a great deal to the mental health service user community in this demographic area with a good network between local services. The work they undertake further highlights the need for additional funding to be able to do their jobs to the maximum potential and therefore benefit the mental health service users.

One potential limitation is the small sample size, yet small homogeneous participant samples allow an in depth investigation of similar and differing experiences between participants (Smith, Larkin & Flowers, 2009). Phenomenological inquiry places emphasis on experience and essences of lived experience. It is idiographic by its very nature. (Langdridge, 2007; Smith, Flowers & Larkin, 2009). Given the aims of providing a rich in depth exploration of the lived experience of sport and exercise for mental health service users, the number of participants selected was appropriate.

Another perceived strength of the research is the participant sample group. The selected participant sample of mental health service users could be perceived as a vulnerable group. This type of sample can be difficult to firstly gain access to and secondly to have willingness to be a part of research. The dual role of researcher and mental health service provider along with the content and structure of the 'Let's Do This' scheme' perhaps

aided the readiness of users to participate. Following the interviews many of the respondents discussed how they enjoyed being part of the research process. This enjoyment and engagement with the process can only have helped their openness in sharing their lived experiences.

6.5 Implications

A direct list of implications for practice, education and research is inappropriate for an interpretive phenomenological study. What the study can hope to do is deepen the understanding of the phenomenon. This study has combined the illumination of experience of individuals receiving sport and exercise on their recovery path with the experience of people delivering such services. However, the findings of this research do have some practical implications for sport and exercise provision for mental health service users. The findings are from a small number of participants and as such claims made for practical application are not statistically proven yet the unique experiences from the user and provider may resonate within other similar settings and services. The research can provide a platform for further research and provide recommendations for practice based on the experiences reported.

Sport and exercise can have an important role to play in the lives of mental health service users. The way in which the service is delivered can impact this role. Structure is important both literally and mentally. The 'Let's Do This' scheme offered a freedom by providing a safe space to engage in healthy behaviour during that time period every week. The literal structure and scheme content was also important, the mental health service users and mental health service providers differed on opinion over including competitive elements. The coaches and staff are key in delivering a service which recognises that the individual is important. The research found a number of strengths of the service currently being delivered. These included the contribution of the staff; both in the management of the scheme and the flexible delivery. Coaches were respected for their sport and exercise expertise and were able to change or modify sessions to best serve the mental health service users. Mental Health service users' had trust in their coaches, they felt they were understanding of their conditions and cared. This demonstrates the importance of placing the right staff in the roles of service delivery. In some cases these relationships were potentially considered of greater importance than the content of the session.

The way in which the scheme supported mental health service users in 'bridging the gap' between a mental health setting and being back in the community was another important finding. Sessions are important both physically to build up a basic level of fitness and mentally to offer guidance through times of self doubt. This type of finding can provide knowledge which is useful for those designing and delivering sport and exercise schemes for mental health service users. The findings also raised possible areas of future research.

6.6 Recommendations for further research

There are many effects of sport and exercise on mental health service users that we do not fully understand. Research which can help with understanding these effects can only be beneficial to people with mental health problems. Such research calls for longitudinal, mixed method, pragmatic designs (Morgan & Goldston, 2013). The following topics build on some of the findings of the current study:

The role competitive sport can play in mental health

How competence is implicated in the enjoyment of sport

Service evaluation of barriers to participation

The wider effects of sport and exercise on the lifeworld of people with mental health problems, such as how changes in identity can occur through challenging personal limits and the bodily and literal cost of participation.

The investigation of changing self image through sport and exercise.

6.7 Unique contribution

Few studies have approached this research area using interpretive phenomenological inquiry. I am unaware of a study which has merged the perspectives of mental health service users and providers in a specific sport and exercise scheme. The in depth exploration of perceptions, convergences and divergences of these two groups makes the nature of the sample unique.

The research project has shed light on the complex issues involved in delivering a sports and exercise scheme for mental health service users. These include the way in which competence, self image through sport and exercise and the concept of day to day illness impact on the journey of health for people with mental health problems. Specific details on the appropriateness of scheme structure, based on the experiences of mental health service users and the mental health service providers offers new insight.

6.8 Connectedness to recent policy initiatives

The findings on the wider effects of sport and exercise on mental health are important in relation to the 'No Health without Mental Health' (Department of Health, 2011) policy. This key policy document lacks a focus on the possible benefits of sport and exercise on mental health and wellbeing. Provision is developing but it is sparse and disjointed (Happel, Platonina-Phung and Scott, 2011).

The 'Improving Access to Psychological Therapies' (IAPT) policy (Gyani, Shafran, Layard & Clark, 2011) comments on the positive effects of sport and exercise but only advises on self help on the need to engage in healthy behaviour. It fails to follow recommendations on how to deliver sport and exercise groups. IAPT is many patients first contact with a psychological service and as such, offering some form of sport and exercise to their clients would be beneficial.

The bottom up scheme style of the 'Let's Do This' scheme and its structure appear to be working but questions are raised with regard to its transferability to other geographic areas and different mental health service users. Greater emphasis on sport and exercise and mental health is required in key government policy in order to effect change on a local and wider scale. Issues of how policy and funding is or should be directed to similar schemes are also raised. This holds implications for future scheme creation and current policy documents as such 'A Healthy City', the physical activity strategy for Leeds 2008 to 2012 'Active Leeds' and NICE guidelines 'Public health outcomes framework for England (2013).

6.9 Conclusion

This study demonstrates the value of phenomenological research in the area of sport, exercise, mental health and wellbeing. It provides an exploration of the lived experiences of sport and exercise for mental health service users. The 'Let's Do This' scheme looked to help the transition between leaving mental health services and developing a regular routine to promote recovery. The 'Let's Do This' scheme helped mental health service users on their journey to health by removing barriers such as cost. It offered a supported service in a local community setting. Having access to the resources and flexibility to help mental health service users when they are ready is important. A fluid service which can be utilised when the service user feels ready may be an effective way of structuring sport and exercise to get the best results for the individual participant. Through their described experiences of the 'Let's Do This' scheme the participants have provided a window into their life-worlds and how their lived experiences can be effected through engaging in a sports and exercise. The insight provided through the mental health service user interviews should not be underestimated, as they provided a frank honest assessment of the services they deliver. The combined analysis of the lived experiences of the two groups provide a unique awareness of the key issues that can effect service delivery and the way sport and exercise is experienced by individuals with mental health problems.

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Appendix 1 - Permission to study letter

Dr Alison Rodriguez
FAO Luke Pickard
University of Huddersfield
Queensgate
Huddersfield
HD13DH
tel 01484 473639
Date: 05/01/14

Dear Service manager

In accordance with our previous correspondence, I am seeking confirmation of permission to approach clients and staff involved in the 'Let's Do This' scheme to become participants for study.

The research aims to explore mental health service users' experiences of sports and exercise. The focus will be upon their experiences related to any perceived sport and exercise in their lifeworlds. Participants will be encouraged to discuss activities both related and not related to the 'Let's Do This' initiative. A further objective is to explore the sports and exercise experiences of participants when participating in structured activities, organised through mental health and general recreational services.

The method of data collection will be individual semi structured interviews with mental health service users to understand their experiences of sport and exercise. Service providers will also be individually interviewed. The participants' lived experience of sports and exercises will be discussed. Data analysis of the transcripts will use interpretive phenomenological analysis (IPA) (Smith, 1996). Interview will be conducted both in Scotthall Sports centre and on site at the Becklin Centre. Transcripts will be coded and subsequent themes and possible master themes developed.

The findings from the study will be reflected in further research, policy planning. The research will inform policy and provision of sport and exercise for mental health service users. This is essential to aid in coping and recovery from mental health problems. Participants will be interviewed and their data analysed and presented in my MSc project entitled; Mental health service users' experience of sport and exercise and its effects on mental health and wellbeing.

Enclosed are the information sheets and letters that will be given to service providers and users upon your approval.

Yours Sincerely

Luke Pickard

Appendix 2 - Participants Consent Form

Title of Project: Mental Health service users' experiences of sport and exercise and its effects on mental health and wellbeing

Name of Researcher: Luke Pickard

**Please initial
to confirm**

- I have read and understood the information sheet (version 3, 24/02/14) for the above study. ☐
- I have had a chance to ask any questions about the research and information I provide ☐
- I understand that I can withdraw myself from the interview at any point and do not need to provide a reason ☐
- I understand I can refuse to answer any question during the interview ☐
- I understand I can withdraw my information at any time before analysis and know how to do this ☐
- I agree to the interview being digitally audio recorded ☐
- I understand my information will be kept anonymous and confidential (except in issues discussed in the information sheet) ☐
- I agree to the data being transcribed verbatim and the use of some quotes in the final write up process. ☐
- I give permission for my interview to be used in Luke's project report and subsequent dissemination, on the basis that it will be kept completely anonymous. ☐
- I agree to take part in this study ☐

Name of Participant

Signature of Participant

Date

Name of Researcher

Luke Pickard

Date

Signed

Appendix 3 - Consent to Researcher Contact – Service user

University headed paper

Dr Alison Rodriguez
FAO Luke Pickard
University of Huddersfield
Queensgate
Huddersfield
HD13DH
tel 01484 473639
Date:

Dear.....

I am a Masters Degree student at the University of Huddersfield investigating mental health service users' experiences of sport and exercise and its effects on mental health and wellbeing. This involves investigating personal experiences of sport and exercise, the effect of sport and exercise on individuals' lives and thoughts and feelings related to sport and exercise experiences.

As a member of the 'Let's Do This' scheme I believe you may be interested in taking part in an interview to discuss how sport and exercise has had an impact on your life

If this study interests you and you may wish to take part, please read the enclosed information sheet and return the form either in a session or in the SAE. If you have any questions/require further information please e-mail me directly (U0358207@hud.ac.uk) or contact my supervisors (a.m.rodriquez@hud.ac.uk) for further information.

Yours sincerely

Luke Pickard

.....

I have read the the enclosed information sheet and I am happy to be contacted with respect to participating in an interview

.My name is:

My contact phone number is:

Signed.....

Appendix 4 - Participants Information Sheet Service User

On university headed paper

Title of research:

Mental health service users' experiences of sport and exercise and its effects on mental health and wellbeing.

Researcher Name: Luke Pickard

Researcher contact details: U0358207@hud.ac.uk

Supervisor's name at the University of Huddersfield: Dr Alison Rodriguez and Ms Kiara Lewis

Supervisor's contact details:

Alison Rodriguez a.m.rodriguez@hud.ac.uk 01484 473639

Kiara Lewis kiara.lewis@hud.ac.uk 01484 473218

My name is Luke Pickard and I am a Master's Psychology degree student at the University of Huddersfield. I am conducting a study looking at mental health service user's experiences of sport and exercise and its effects on mental health and wellbeing. As part of this research, I am planning to interview mental health service users and providers who currently undertake sport and exercise sessions. I would like to invite participants to discuss their personal experiences and opinions around this topic. Before you decide to take part you need to understand why the research is being done and what it would involve for you. Please read the following information carefully.

If any aspect is unclear, do not hesitate to ask questions or request further information. Take time to decide if you would like to take part.

You have been invited to take part in this research investigating lived experiences of sport and exercise. During the interview you may be asked about your:

- a) Current and past involvement in sport and exercise.
- b) Opinions of how sport and exercise effects your life.
- c) Experiences and thoughts regarding the wider issues involved in participation of sport and exercise.

This will help us to understand how different types of sport and exercise can effect people's lives and experiences. This could help with the development of exercise programmes and guidelines on what type of sport and exercise can help improve people's mental health and wellbeing.

After you have read the information sheet, if you wish to participate and have had the opportunity to ask questions and feel comfortable with the study, you should complete the form entitled 'consent to

researcher contact'. You can leave your name and contact number and I will then contact you to arrange a mutually convenient time to meet for the interview at Scott Hall Sports Centre, Leeds or the Becklin Centre, Leeds. When I meet you for the interview I will check that you understand the aims of the study and if you have further questions. I will ask you to confirm that you have had enough time to consider taking part and then I will ask you to sign a consent form to show you have agreed to take part. The participation in this research is completely voluntary and you can withdraw at anytime up until the interviews are analysed, without giving any reason or having an effect on the services provided/received within the 'Let's Do This' scheme.

What will happen to me if I take part?

You will be involved in a one-to-one interview with me in a private room at the Scott Hall Sports Centre or the Becklin Centre based in Leeds. The interview will be in a semi structured style. This means that although I will have prepared a set of questions which every participant will be asked, I may ask you to go further into detail or ask you certain different questions depending on your previous answer and what you may want to add. For example, I may ask 'How do you feel before sport and exercise?' If a participant answers that they feel excited, I may ask 'why and what sort of things create these feelings'. You will have the opportunity to contribute to the interview and discuss issues I may not have considered that are relevant to sport and exercise in your own life. The interview will be digitally audio recorded with your permission and should take no longer than one hour.

What are the disadvantages of taking part?

The time it would take to participate in the interview. Depending on the nature of your responses, the interview will last approx 40-60 minutes.

What are the possible benefits of taking part?

You may enjoy talking about your experiences of sport and exercise. The findings of all the interviews I conduct will enable me to consider the impact sport and exercise has on the individual lives of others.

Will my taking part in the study be kept confidential?

Any information you give during the interview will be kept completely anonymous. This means that only I will know your name or that you have taken part. To keep the research anonymous you will be given a false name (pseudonym), this will be used to protect your identity. The words from your interview may be used in the study report or for presentation purposes but no one will know these are your words, again because all interviews will be anonymised so no name will be attached to any words.

Any information disclosed which indicates a major concern to the health and wellbeing of you or another, may result in information being passed to the relevant authorities. It is envisaged that such an instance would be rare; the referral to relevant authorities will be discussed with you.

Any information you give will be kept as confidential as possible. Only I will listen to the recording of the interview and whilst people at the University will read my project report, they will not know any names or other personally identifying information of people who participated.

Following the interview the information received will be transcribed word for word in preparation for analysis.

Some direct quotes that you have said may be used in the write up of the study, although as previously stated your name will not be used alongside the quote and instead the pseudonym will be used.

A member of the healthy living service mental health team located near to the place of interview may be called to assist in the event you require support.

If you have any further questions please ask me before the start of the interview.

What will happen if I don't want to carry on with the study?

You may refuse to answer any questions during the interview or stop the interview at any point. You have the right to withdraw yourself from the interview and you can ask for your interview not to be used in the study.

If you become distressed at any time during the interview in the first instance the interview will stop, at which point we will discuss whether you would like to carry on with the process, if the issue cannot be resolved by me, a member of the healthy living service mental health team located near to the place of interview may be called to assist in calming the situation. They are trained mental health professionals who have extensive experience of dealing with situations of this nature. If this unlikely situation occurs the interview will be terminated and any data you have given up to that point destroyed.

If you would like to complain about any aspect of the investigation please contact the clinical lead of the Healthy Living Service via any of the contact methods given below, Sue Davies

Tel - 0113 3056817 Fax - 0113 3056628 email - susan.davis8@nhs.net

Or the academic supervisor Dr Alison Rodriguez

Tel - 01484 473639 email - a.m.rodriquez@hud.ac.uk

In order to withdraw your information you should contact me and your data will then be destroyed. This will have no impact upon the service provided within the 'Let's Do This' scheme. Please note withdrawal of data will not be possible after the analysis process has begun. Data cannot be withdrawn after analysis has commenced

What will happen to the results of the study?

The interview will be recorded and transcribed word for word as I will need to analyse all our talk. The analysed findings will be reported in my project. After my project has been submitted and marked, all recordings will be destroyed. Anonymised transcripts may be kept for further publication purposes and stored in line with the Data Protection Act (1998).

The study will be published in a relevant sport, exercise, mental health and wellbeing journal. The study may also be presented at academic conferences.

If you would like a copy of the final report please inform me after the interview and I will take your full contact details to later forward you the report.

Do I have to take part?

You are under no obligation to take part in the study, it is completely voluntary. If you do not wish to take part it will not affect the provision provided on the 'Lets' Do This' scheme.

Debrief

Thank you for taking part in the study: Service users experience of sport and exercise and its effects on mental health and wellbeing

This research was carried out for the purpose of a project for a Masters of Science by research. It is aimed at evaluating the impact of sport and exercise on mental health service users and providers lives.

If you wish to withdraw your interview please do so before the analysis process has begun and your interview will be destroyed and will not be included in the report.

If you require any further information or would just like know the outcome of the report please do not hesitate and contact me on U0358207@hud.ac.uk

If any of the issues discussed have lead to any distress psychological support can be found by contacting the Becklin Centre, Healthy Living Service 0113 305 6607

If you would like a copy of the final report please contact me via email with your postal details or email address and it will be sent out following completion.

Thank you very much for taking part.

Luke

Further information

E-mail- Luke Pickard U0358207@unimail.hud.ac.uk 07506200445

Supervisor- Alison Rodriguez contact details: a.m.rodriguez@hud.ac.uk 01484 473639

Supervisor – Kiara Lewis contact details: kiara.lewis@hud.ac.uk 01484 473218

Appendix 5 - Semi-Structured Interview service users

Brief

Hello..... How are you feeling today? As previously explained the following interview will be about you and your experiences of sport and exercise. It should take no longer than one hour and you can stop the interview at any point. I will be recording the interview using this device (show them). Feel free to ask questions throughout at any point.

1 -I'd like to start by talking about your previous experiences of sport and exercise.

Can you explain them? What makes that stand out?

2 -What sports or exercise can you first remember taking part in?

Why was that? An early experiences stand out? Any other activities

3 -What other sports or exercises have you engaged in?

What can you remember about that?

4 -For what reasons have you participated in these?

Can you explain other reasons?

5 -In the past, what if any, sport or exercise groups or clubs have you been a member of?

What made you join? Why didn't you join?

6 -Have you enjoyed your past involvement in sports and exercise?

What was enjoyable? Why? Any Moments stand out?

7 -Do any experiences stand out? Any clear memories?

Any others? What makes that stand out?

8 -Can you explain these?

Any others? What makes that stand out?

I'd now like to talk about your current participation in sports and exercise.

9 -What groups are you part of?

Any others? Why did you join? How does it feel to be part of that?

10- Do you enjoy the groups?

Why? What was your favourite experience?

11 -What sports or activities do you enjoy?

Any reason? Why?

12 -Is it your choice to get involved in the groups?

Who suggested the group? Were you happy to attend?

13 -Do you like the individual sports/exercises or team sports/exercises?

Why? Any experiences effect that choice?

14 -Do you like the exercises or the sports?

Why? Do you enjoy both?

15 -Do you feel you have enough choice in the group activities?

Why is that?

16 -Are there any sports or activities you think should be included in the group(s) you attend?

Any others?

17 -What would make the group(s) better for you personally?

Can you expand on that?

18 -Do you enjoy being active?

Why? How does it make you feel? Why is that?

19 -Without everyday restrictions how often would you like to participate?

Would you like more provision?

20 -What benefits do you feel from exercise?

Does it change your feelings? How do you feel after?

21 -Any negative effects of exercise?

Any injuries? Any other experience stand out? Why?

22 -How do you feel when you win? Can you give examples?

Can you give me an example?

23 -How does losing a sport make you feel?

Can you give examples?

24 -How did you hear about this group/other organised activities?

Is information easily available from services?

25 -Would you recommend sport and exercise to other service users?

Why? Any other reasons>

26 -Do you take part in activity groups for non service users?

How do these compare?

27 -Any things that stop you participating?

Mood? Finance? Provision? Transport? Worry? Fear?

28 -When you feel not so well does sport and exercise help?

Why is that? How does it affect you? Any examples?

29 -Why do you participate?

Can you explain that?

30 -How do you feel before sport and exercise?

Can you give examples?

31 -How do you feel during participation?

Examples?

32 -How do you feel after participation?

Can you give examples?

33 -How do you feel if you can't participate?

Can you give examples?

34 -How often do you think about sport and exercise?

What do you think about? Why is that?

35 -Do you consider sport and exercise to be an important part of your life?

Why is that? Can you explain further?

36 -Do you compare yourself to other participants?

In what ways? Similar or different?

37 -Do you view yourself differently during participation?

How does it make you feel? Why? Any examples?

38 -What have you achieved through sport and exercise?

Any wins or achievements stand out?

39 -Have you made friends through sport and exercise?

What made the friendship? Why?

I'd now like to move on and ask some questions about your future with regards to sport and exercise.

40 -Will you continue to take part in sports and exercise after the group sessions of the lets do it scheme have finished?

Why is that? Such as?

41 -Will you keep in touch with any friends through the group sessions?

Was it a good place to meet people? Why?

42 -Have the sessions given you confidence to use local sports facilities

Alone? Together with friends made on this scheme?

43 -What sport and exercise do you plan to stay involved with?

Why is that? Any experiences?

44 -What benefits do you believe sport and exercise will give you in the future?

Why? Why not?

45- Is there anything you would like to add?

I hope to use these questions as starting points from which further more explorative questions could evolve. I also hope to engage participants in considering the effects of organised (via mental health initiatives) versus unorganised activity. I will also consider the impact for example of formal sport type activities such as football or tennis against more recreational types of sport and exercise such as free swimming or walking. Where possible participants will be asked to explore their lived experiences.

Thank you for taking part in this interview. Would you like to ask me any further questions? (Give debrief letter).

Appendix 6 - Participants Debrief Form

Thank you for taking part in the study: Service users experience of sport and exercise and its effects on mental health and wellbeing

This research was carried out for the purpose of a project for a Masters of science by research. It is aimed at evaluating the impact of sport and exercise on mental health service users and providers lives.

If you wish to withdraw your interview please do so before 01/05/2014 and your interview will be destroyed and will not be included in the report.

If you require any further information or would just like know the outcome of the report please do not hesitate and contact me on U0358207@hud.ac.uk

If any of the issues discussed have lead to any distress psychological support can be found by contacting the Becklin Centre, Healthy Living Service 0113 305 6607

If you would like a copy of the final report please contact me via email with your postal details or email address and it will be sent out following completion.

Thank you very much for taking part.

Luke

Appendix 7 - Consent to Researcher Contact – Service provider

University headed paper

Dr Alison Rodriguez
FAO Luke Pickard
University of Huddersfield
Queensgate
Huddersfield
HD13DH
tel 01484 473639
Date:

Dear.....

I am a Masters Degree student at the University of Huddersfield investigating mental health service user's experiences of sport and exercise and its effects on mental health and wellbeing. As a service provider, your experiences of providing sport and exercise for mental health service users may provide insight into the provision of sport and exercise and the related effects on service users.

I believe you may be interested in taking part in an interview to discuss how sport and exercise has had an impact on service users.

If this study interests you, please read the enclosed information sheet and return the form to me directly or return in the SAE. If you have any questions or require further information please e-mail me directly (U0358207@hud.ac.uk) or contact my supervisors (a.m.rodriquez@hud.ac.uk) for further information

Yours sincerely

Luke Pickard

.....

I have read the enclosed information sheet and I am happy to be contacted with respect to participating in an interview.

My name is

My contact phone number is:.....

Signed.....

Appendix 8 - Participants Information Sheet Service Provider

On university headed paper

Title of research:

Mental Health service users' experiences of sport and exercise and its effects on mental health and wellbeing.

Researcher Name: Luke Pickard

Researcher contact details: U0358207@hud.ac.uk

Supervisor's name at the University of Huddersfield: Dr Alison Rodriguez and Ms Kiara Lewis

Supervisor's contact details:

Alison Rodriguez a.m.rodriguez@hud.ac.uk 01484 473639

Kiara Lewis kiara.lewis@hud.ac.uk 01484 473218

My name is Luke Pickard and I am a Master's Psychology degree student at the University of Huddersfield. I am conducting a study looking at mental health service user's experiences of sport and exercise and its effects on mental health and wellbeing. As part of this research, I am planning to interview service users and providers who currently undertake sport and exercise sessions. I would like to invite participants to discuss their personal experiences and opinions around this topic. Before you decide to take part you need to understand why the research is being done and what it would involve for you. Please read the following information carefully.

If any aspect is unclear, do not hesitate to ask questions or request further information. Take time to decide if you would like to take part.

You have been invited to take part in this research investigating lived experiences of sport and exercise. During the interview you may be asked about your:

- d) Current and past involvement in sport and exercise.
- e) Opinions of how sport and exercise affects your life.
- f) Experiences and thoughts regarding the wider issues involved in participation of sport and exercise for mental health service users.

This will help us understand how different types of sport and exercise can affect people's lives and experiences. This could help with the development of exercise programmes and guidelines on what type of sport and exercise can help improve people's mental health and wellbeing.

After you have read the information sheet, if you wish to participate and have had the opportunity to ask questions and feel comfortable with the study, you should complete the form entitled 'consent to researcher contact'. You can leave your name and contact number and I will then contact you to arrange a mutually convenient time to meet for the interview at either Scott Hall Sports Centre, Leeds or the Becklin Centre, Leeds. When I meet you for the interview I will check that you understand the aims of the study and if you have further questions. I will ask you to confirm that you have had enough time to consider taking part and then I will ask you to sign a consent form to show you have agreed to take part. The participation in this research is completely voluntary and you can withdraw at anytime up until the interviews are analysed, without giving any reason or having an effect on the services provided within the 'Let's Do This' scheme.

What will happen to me if I take part?

You will be involved in a one-to-one interview with me in a private room at the Scott Hall Sports Centre or the Becklin Centre based in Leeds. The interview will be in a semi structured style. This means that although I will have prepared a set of questions which every participant will be asked, I may ask you to go further into detail or ask you certain different questions depending on your previous answer and what you may want to add. You will have the opportunity to contribute to the interview and discuss issues I may not have considered that are relevant to sport and exercise in your own life and that of the mental health service users. The interview will be digitally audio recorded with your permission and should take no longer than one hour

What are the disadvantages of taking part?

The time it would take to participate in the interview. Depending on the nature of your responses, the interview may last 40 to 60 minutes in length.

What are the possible benefits of taking part?

You may enjoy talking about your experiences of providing sport and exercise for service users. The findings of all the interviews I conduct will enable me to consider the impact sport and exercise has on the individual lives of others.

Will my taking part in the study be kept confidential?

Any information you give during the interview will be kept completely anonymous. This means that only I will know your name or that you have taken part. To keep the research anonymous you will be given a false name (pseudonym), this will be used to protect your identity. The words from your interview may be used in the study report or for presentation purposes but no one will know these are your words, again because all interviews will be anonymised so no name will be attached to any words.

Any information disclosed which indicates a major concern to the health and wellbeing of you or another, may result in information being passed to the relevant authorities. It is envisaged that such an instance would be rare; the referral to relevant authorities will be discussed with you.

Any information you give will be kept as confidential as possible. Only I will listen to the recording of the interview and whilst people at the University will read my project report, they will not know any names or other personally identifying information of people who participated.

Following the interview the information received will be transcribed word for word in preparation for analysis.

Some direct quotes that you have said may be used in the write up of the study, although as previously stated your name will not be used alongside the quote and instead the pseudonym will be used.

If you have any further questions please ask me before the start of the interview.

What will happen if I don't want to carry on with the study?

You may refuse to answer any questions during the interview or stop the interview at any point. You have the right to withdraw yourself from the interview and you can ask for your interview not to be used in the study.

In order to withdraw your information you should contact me and your data will then be destroyed. This will have no impact upon the service provided within the 'Let's Do This' scheme. Please note withdrawal of data will not be possible after the analysis process has begun.

What will happen to the results of the study?

The interview will be recorded and transcribed word for word as I will need to analyse all our talk. The analysed findings will be reported in my project. After my project has been submitted and marked, all recordings will be destroyed. Anonymised transcripts may be kept for further publication purposes and stored in line with the Data Protection Act (1998).

The study will be published in a relevant sport, exercise, mental health and wellbeing journal. The study may also be presented at academic conferences.

If you would like a copy of the final report please inform me after the interview and I will take your full contact details to later forward you the report.

Further information

E-mail- Luke Pickard U0358207@unimail.hud.ac.uk

Supervisor- Alison Rodriguez contact details: a.m.rodriguez@hud.ac.uk

Supervisor – Kiara Lewis contact details: kiara.lewis@hud.ac.uk

Appendix 9 - Semi-Structured Interview service providers

Brief

Hello..... How are you feeling today? As previously explained the following interview will be about you and your experiences of providing sport and exercise for mental health service users. It should take no longer than one hour and you can stop the interview at any point. I will be recording the interview using this device (show them). Feel free to ask questions throughout at any point.

1-What is your sporting/exercise background?

What made you interested in sport/exercise/related work? Any reason? Any experience?

2-Have you always participated yourself?

Can you give me a little history?

3-What sports or exercise do you currently enjoy?

Why is that? Any examples?

4-How has sport and exercise effected your life?

In what ways? Why? Any experiences?

5-Are you still active?

What do you do? Anything else? Why?

6-What is your position within the scheme?

7-How do you encourage participation within your centre?

Can you elaborate?

8-What are your qualifications to provide physical activity for service users?

Any others? Professional? Personal?

9-How did you get involved?

What do you get out of it?

10-Why did you get involved?

Any other reasons?

11-What are your drives to provide this provision?

Why is that? Any other reason?

12-How do you think the mental health service users benefit from physical activity?

Why/in what ways? Similar to you?

13-In your opinion what are the specific benefits of sport/exercise for this population?

Why? Can you explain further? Give examples

14-What barriers do you think there are to mental service users participation/provision?

Why? Who/what causes that? Any examples?

15-Can you recall any specific positive experiences of service users?

Any others? Examples?

16-Can you recall any negative experiences of service users?

Any examples?

17-Do you believe sport and exercise can help the mental health and wellbeing of service users?

Why? Any examples/experiences?

18-Who decides the activities?

Why? Do you have a range of activities? Any you would like to learn?

19-What activities do you think are most/least appropriate for service users?

Why? Any others? Examples?

20-Do you think the activities should be competitive?

Appropriateness? Why?

21-Do you prefer to provide team games or individual games?

Reasons why? Examples?

22-Do you prefer to provide exercise or sport?

Reasons why? Examples?

23-Do you have choice and freedom to tailor the activity to the service users needs?

Can you give examples? Reasons?

24-What other (recreational) services are you aware of for this population?

How do they compare to sport/exercise in effectiveness?

25-In an ideal world what would you provide for service users in terms of sport and exercise?

Why? What else?

26-How do you manage service users who do not want to take part in a specific activity?

Any other techniques? Any examples?

27-How would you cope with a distressed service user?

What else? Any examples?

28-Has providing sports and exercise had a positive effect on you?

In what way? How does it make you feel?

29-Should more effort be made to encourage engagement?

In what ways? Personal? Professional? Ideas?

30-Should it be a compulsory part of recovery?

Why? Any others ideas

31. Do you have anything further to add?

Any questions? Related experiences to report?

I hope to use these questions as starting points from which further more explorative questions could evolve. I also hope to engage participants in considering the effects of organised (via mental health initiatives) versus unorganised activity. I will also consider the impact for example of formal sport type activities such as football or tennis against more recreational types of sport and exercise such as free swimming or walking. Where possible participants will be asked to explore their lived experiences.

Thank you for taking part in this interview. Would you like to ask me any further questions? (Give debrief letter).

Appendix 10 – NHS Ethics Approval

NRES Committee East Midlands - Northampton

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839521

05 March 2014

Mr Luke Pickard
Human and Health Sciences
University of Huddersfield
Huddersfield
HD13DH

Dear Mr Pickard

Study title:	Service users experience of sport and exercise and its effects on mental health and wellbeing
REC reference:	14/EM/0096
IRAS project ID:	141929

Thank you for your email of 4th March 2014, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Rebecca Morledge, NRESCommittee.EastMidlands-Northampton@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
REC application	141929/565587/1/673	12 February 2014
Evidence of insurance or indemnity		07 August 2013
Interview Schedules/Topic Guides	Semi-structured interview - service users, V3	14 February 2014
Interview Schedules/Topic Guides	Semi-structured interview - service providers, V3	14 February 2014
Investigator CV	Luke Pickard	
Investigator CV	Dr Alison Rodriguez	
Investigator CV	Kiara Lewis	
Other: Permission to study letter	2	14 February 2014
Other: participant debrief form	2	14 February 2014
Other: Consent to Researcher contact - Service provider	2	14 February 2014
Other: Consent of researcher contact - service User	2	14 February 2014
Other: Lone Working Procedure	2.0	31 March 2013
Participant Consent Form	2	14 February 2014
Participant Consent Form	3	24 February 2014
Participant Information Sheet: Service Provider	2	14 February 2014
Participant Information Sheet: Service User	2	14 February 2014
Participant Information Sheet	3	24 February 2014
Protocol	2	
Protocol	3	24 February 2014
Response to Request for Further Information		26 February 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments •
Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

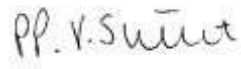
14/EM/0096

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Ken Willis
Chair

Email: NRESCommittee.EastMidlands-Northampton@nhs.net

Enclosures: *"After ethical review – guidance for researchers"*

Copy to: *Nigel King, University of Huddersfield*
Dr Alison Rodriguez, University of Huddersfield
Mrs Sinead Audsley, Leeds and York Partnership NHS Foundation
Trust

Appendix 11 – Research and development approval



Leeds and York Partnership **NHS**
NHS Foundation Trust

Our Ref: 2014/476/L

Research & Development North Wing, St Mary's House St Mary's
Road
Leeds LS7 3JX
E-mail: sinead.audsley@nhs.net
Direct Line: 0113 295 2387
FAX: 0113 2954466

Dr Alison Rodriguez University of
Huddersfield Queensgate
Huddersfield
HD1 3DH

06/03/2014

Dear Dr Rodriguez

Project Title: Service users experience of sport and exercise and its effects on mental health and wellbeing
REC Reference: 14/EM/0096

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within **Leeds and York Partnership NHS Foundation Trust**.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol	3	24 February 2014
Participant Consent Form	3	24 February 2014
Participant Information sheet	3	24 February 2014
Participant Information sheet: Service Provider	2	14 February 2014
Other: Permission to study letter	2	14 February 2014
Other: participants debrief form	2	14 February 2014
Other: Consent to Researcher contact – Service provider	2	14 February 2014
Other: Consent to Researcher contact – service user	2	14 February 2014
Other: Lone Working Procedure	2.0	31 March 2013
Interview Schedules/Topic Guides	3.0	14 February 2014

Interview Schedules/Topic Guides	3.0	14 February 2014
REC Approval Letter		05 March 2014

This approval is granted subject to the following conditions:

- You must comply with the terms of your ethical approval (where applicable) Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform the relevant ethics committee and us immediately.
- You must comply with the Trust's procedures on project monitoring and audit.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care¹(RGF). Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator²**. They should **also** be reported to:

- The R&D Department
- the Research Ethics Committee that gave approval for the study
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

Projects sponsored by organisations other than the Trust are reminded of those organisations' obligations as defined in the Research Governance Framework, and the requirements to

¹ _____ Details _____ from:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

² SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Sinead Audsley', with a long, sweeping underline that extends to the right.

Sinead Audsley
Research Governance Manager

Cc Luke Pickard
Nigel King, University of Huddersfield

Appendix 12 – University ethical approval



6 January 2014

TO WHOM IT MAY CONCERN

Name: Mr Luke Pickard - University of Huddersfield
Research Project: "Service users lived experience of sport and exercise and its effects on mental health and wellbeing"
Reference: SREP/2013/86

Mr Luke Pickard, the holder of this letter, is a Research Student at the University of Huddersfield, where he is currently pursuing a Master of Science by Research on the above topic within the Centre for Applied Psychological Research.

Mr Pickard's research has been through the School Research Ethics Panel (SREP) and his project was approved on 6 January 2014.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

If you require any further information in relation to this letter, please do not hesitate to contact me.

Yours faithfully

A handwritten signature in black ink, appearing to read 'K. Ousey'.

Dr Karen Ousey

Chair, School Research Ethics Panel (SREP)
School of Human and Health Sciences
Direct Tel: +44 (0)1484 473462
Email: K.J.Ousey@hud.ac.uk

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Patron: HRH The Duke of York, KG

Vice-Chancellor: Professor Bob Cryan DL MBA DSc CEng FIET FHEA

