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What is the impact of health trainer interventions within a mental health setting?

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This paper relates to a single case study that was part of a larger project using a tried and tested evaluation methodology to evaluate the role of health trainers (HTs) working with groups who are considered ‘difficult’ to engage in health care. In this example, the HTs were based in a mental health centre run by a charity. The service was commissioned by a Primary Care Trust (PCT) located in the North East of England. Data collected between April 2010 and July 2011 included quantitative data from 72 service users from the National Data Collection and Reporting System. Additional quantitative data were obtained from the HTs relating to the usage of group activities and a satisfaction questionnaire completed by service users. Qualitative data included interviews with four key stakeholders, a focus group with service users, case studies and progress reports provided as part of the Centre’s annual reporting requirements for the PCT. Findings reveal that more service users aged 26–44 used the service compared with national figures. Partnership working was essential to embed the initiative into the Centre. HT interventions that were flexible, and gave service users options, encouraged mental health promotion. The success of the intervention depended less on what the HT did and more importantly on how they did it.

Keywords: mental illness; health trainer; intervention; mental health promotion

Introduction

The effectiveness of physical activity on the mind and body is a concept that dates back to an old roman proverb ‘*Mens sane in corpore sana*’ meaning ‘A healthy mind in a healthy body’ (The Everyman dictionary of quotations and proverbs, 1982). In relation to mental health, regular physical activity has been shown to help reduce mental health problems (Callaghan, 2004) and improve individuals’ quality of life and emotional well-being (Carter-Morris & Faulkner, 2003).

This paper adopts a case study approach (Stake, 1995; Yin, 2009) to explore the role of a health trainer (HT) based within a mental health centre. The HT initiative was introduced in the white paper *Choosing health – Making healthy choses easier* (Department of Health [DH], 2004) and enshrined within the white paper *Healthy lives: Healthy people* (DH, 2010) as a method to support individuals with issues such as healthy eating, physical activity and smoking cessation. HTs are a resource to local community services and either provide intervention techniques directly through one-to-one or group sessions, or refer clients on to other health services (Michie et al., 2008).

This case study is part of a larger project to evaluate the role of the HTs working with groups that are considered ‘difficult’ to engage in relation to health care. This paper focuses on the originality of the setting in which the HT was located, i.e. a mental health

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charity. Although HTs have been recruited to work in other locations, this is the only study in the UK to date of their impact on an independent mental health setting.

Literature review

Richardson et al. (2005) argue that physical activity has the ability to improve the lives of those with mental health issues in two ways: by improving health generally, and by improving psychiatric and addressing social disablement. Blank, Grimsley, Goyder, Ellis, and Peters's (2007) longitudinal correlational study spanned two years and assessed physical activity and diet alongside mental and overall health in 500 individuals from deprived English communities. A random sample of individuals from the New Deal for Communities household survey were interviewed including items from the SF-36 mental health score in 2002 and again in 2004. Overall, it was found that the more physical activity the individuals engaged in, the greater the improvement in their mental health. Blank et al. (2007) concluded that there exists a cyclical relationship between exercise and mental health that can be promoted by community-based projects that aid exercise, diet and mental well-being.

Physical activity, as an intervention to alleviate specific mental health issues, has been demonstrated by a recent meta-analysis that reviewed studies of physical activity and anxiety. Forty studies totalling 2914 patients, between 1995 and 2008, established that physical activity reduces anxiety in patients with chronic illness who would otherwise be sedentary (Herring, O'Connor, & Dishman, 2010). The authors concluded that exercise periods of over 30 min per session had the most beneficial effect. This finding echoes previous research by Petruzzello, Landers, Hatfield, Kubitz, and Salazar in 1991.

Physical activity has also played a role in improving psychological outcomes for individuals with schizophrenia. An ethnographic study focused on a 10-week exercise programme for 3 patients with schizophrenia within an inner-city hostel, by observing and interviewing participants and the key-workers within the hostel (Faulkner & Sparkes, 1999). The 10-week exercise programme consisted of twice weekly, 30-min sessions of moderate activity such as walking or swimming. One participant withdrew from the programme but for the remaining two exercise therapy had beneficial effects. Key-workers and both participants concluded that exercise reduced the participants' auditory hallucinations, raised self-esteem and helped to improve sleeping patterns. Further positive effects of using exercise or physical activity as an intervention have been demonstrated in a recent systematic review of papers that examine the effects of physical activity on psychological outcomes for individuals with schizophrenia and affective disorders (Holley, Crone, Tyson, & Lovell, 2011). The 15 papers demonstrated that physical activity had positive effects on some areas of psychological outcomes, such as mental health and well-being, social interest, competence and self-image, as well as a reduction in levels of anxiety and tension. Because there is variation in type of physical activity intervention in these 15 studies, ranging from walking and football groups to gym work, cycling and yoga, it is important to bear in mind that individual preference for activity may play a role in yielding positive outcomes.

In addition to the reduction in psychiatric symptoms and general health gains, physical activity interventions have also been recognized for reducing social isolation for individuals with serious mental health problems (Richardson et al., 2005). Crone and Guy (2008) demonstrated the importance of physical activity for providing opportunities for social interaction by means of exploring individuals' experiences of using sports therapy in a mental health trust in the UK. Through the use of focus groups, participants reported

feeling comforted by the fact that the other people exercising alongside them were considered similar to themselves, in terms of having a mental illness. Participants self-reported an increase in energy levels as a result of exercise, and also an improvement in their mood, boosted self-esteem and feelings of accomplishment.

It has been established that individuals with mental health issues have difficulties with motivation (Crone & Guy, 2008; Faulkner & Biddle, 2001; Mason et al., 2007). Positive reinforcement and support thus play a critical role in how individuals incorporate long-term physical activity into their lives (Richardson et al., 2005). In the aforementioned Crone and Guy (2008) study, participants highlighted that the sport's therapist was confident, knowledgeable and provided effective support. Their role was regarded as pivotal for ensuring physical activity became integrated into the treatment packages for individuals. This has implications for the role of HTs working specifically in mental health centres. In line with recovery that focuses on individuals' quality of life and control of illness (Fox & Ramon, 2010), the HT approach attempts to provide an intervention led by the HT while ensuring service users participate by suggesting activities, and playing an active part in their recovery process.

A number of studies have gone as far as proposing that physical activity, as an intervention should be integrated into mental health services as a therapeutic method (e.g. Richardson et al., 2005). However, despite the wealth of research to demonstrate the positive effects that physical activity can have on mental health, it still remains an underused treatment method (Callaghan, 2004; Crone & Guy, 2008). In the absence of a national strategy to integrate physical activity into either the treatment or general lives of individuals with mental health problems, less direct attempts have been made through health promotion initiatives such as 'exercise on prescription' (DH, 2010). Faulkner and Biddle (2001) measured Clinical Doctorate Course Directors' attitudes towards prescribing physical activity as an adjunct therapy. It was found that while half the directors held positive attitudes towards physical activity being used as a mood enhancer and antidepressant, they regarded exercise as a normalizing activity carried out by professionals other than clinical psychologists. Despite the hostel in Faulkner and Sparkes (1999) study reporting positive benefits of exercise, the staff admitted they had no plans to continue the exercise programme. Saxema, Van Ommermen, Tang, and Armstrong (2005) recognize that mental health professionals are a valuable asset for the promotion of physical activity within mental health settings. Daley (2002) also suggests that physical activity as a therapy deserves attention and that mental health professionals are ideally placed to implement this.

Methodology

Given the issues emerging from the literature, this study aimed to use a recognized evaluation strategy as part of an overall case study approach to provide a comprehensive evaluation of the HT contribution to a mental health centre. Warr, Bird, and Rackham's (1970) evaluation strategy was employed to evaluate the HT contribution across four levels. These consisted of *context evaluation*, which considered the organizational issues of implementation, *input evaluation*, which focuses on the types of input delivered by the HT and how these were received, the service users' *reactions* to the interventions, and any *outcome* revealed in changes in their behaviour.

In accordance with a case study approach (Stake, 1995) a mix of both quantitative and qualitative methods were used to capture the complexities and uniqueness of the HT role. Data collection and analysis spanning the different levels of the evaluation framework was

important for triangulation to increase the validity and credibility of the findings in the single setting (Denscombe, 2007). In this study, the approach used fits with what Denzin (1970) describes as a method triangulation; where the mix of methods are used to study the same phenomenon.

Quantitative data were collected from the National Data Collection and Reporting System (DCRS) during 1 April 2010 to 1 July 2011 and a short satisfaction questionnaire was designed to elicit service users' satisfaction with the HT's intervention. This was developed with service users for the larger project as a whole and was piloted to check relevance of the questions to those in a mental health setting. DCRS data were obtained for 72 service users with a diagnosed mental illness and who were seen by the HT. The satisfaction questionnaire was completed by nine service users. Additional quantitative data were ascertained from two progress reports produced by the HT, which included a breakdown of the groups run by the HT and the average attendance by service users.

Qualitative data were collected in relation to the organizational context in which the role of HT was introduced, particularly as the role was unique to a third sector organization. Four interviews were conducted with key stakeholders, including the HT, the two managers of the Centre and the commissioner for the HT initiative. These interviews collected information regarding the HT's approach, key partnerships, how the implementation of the initiative was experienced and important lessons that had been learned throughout the implementation process. A focus group was undertaken with three service users who volunteered to participate and the HT, and the four stakeholder interviews were re-analysed to gain an understanding of the HT input. All interviews and the focus group data were analysed using a grounded theory approach (Strauss & Corbin, 1998), where the data were read and re-read and subsequently grouped into themes and sub-themes. These were cross-checked by both researchers to ensure the validity and reliability of categories.

Two case study reports prepared by the HT with service users were used as illustrative examples of the impact of interventions. These impact case studies formed part of reporting requirements for the commissioners.

Findings

Context evaluation

Clientele

Of the 72 service users referred to the HT service between 1 April 2010 and 1 July 2011, 50 were males and 22 females. Service users' demographic characteristics are summarized in Figure 1, revealing that the majority were between the ages of 26 and 45 years. Twenty-one had one-to-one sessions only, while thirty-one engaged only in group activities and twenty began with a one-to-one session and later joined a group. All service users were referred to the HT through one of two routes: either as a self-referral from within the Centre, or by their Care Coordinator or Support Worker from external organizations.

The percentage of appointments made by service users aged between 26 and 45 years was significantly higher than those made nationally (DCRS Hub Report May 2011). See Table 1 for a summary of comparisons.

Organizational input and construction of the HT role

The HT role was commissioned through a partnership arrangement between the local PCT and the independent centre, both located in the North East of England. The successful implementation of the HT role depended upon this partnership and support from a

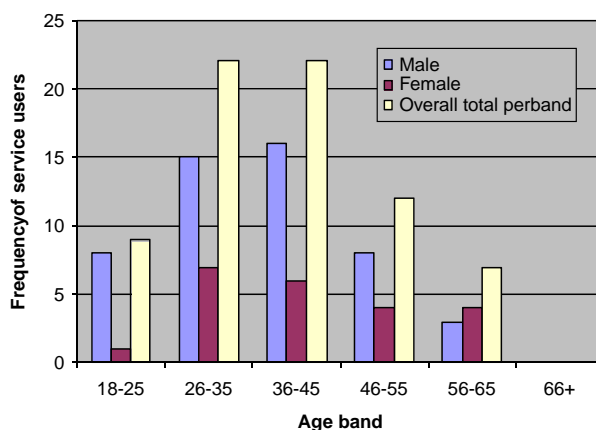


Figure 1. Service user demographic information.

Table 1. Comparisons between appointments in The Mental Health Centre and National appointments in terms of age (DCRS Hub Report, May 2011).

Age band	Mental health centre statistics (%)	National statistics (%)	Significantly higher or lower than national statistics
< 18	0	1.69	No
18–25	12.5	10.51	No
26–35	30.56	16.62	Yes
36–45	30.56	20.20	Yes
46–55	16.67	19.89	No
56–65	9.72	17.00	No
Over 65	0	14.08	Yes

collection of wider networks that were established by the HT, once in post. These relationships have been fundamental to ensuring the wide range of activities provided by the HT and have led to increased referrals from outside the centre (43 referrals from 8 separate organizations during the study period).

The amount of people that are engaging and the amount of referrals that are coming through and what it has brought for us is better partnership working than we have ever had... I think it is really positive that some of the services are working together and loving it. (I1)

We didn't really have a common theme working with the psychiatric hospital other than referring on to secondary care and to primary care. We now have somebody interlinking who is working with people on Sections, etc. (I1)

The HT had established 13 successful partnerships that were key to providing a range of activities targeted at healthy lifestyle behaviours and for generating referrals. These partnerships included mental health services such as specialist horticulture services and local hospitals, housing associations, and sports/physical activity services such as local gyms and sports clubs. The links proved essential to provide a diverse range of activities and have led to the HT project being regarded as a flagship initiative within the Centre as a whole:

It is our best project and that's no disrespect to the other projects because the other projects we've got are good, but it's doing the best for the people in a short space of time than any other project that has been done at the centre. (I2)

Due to the sheer impact the project has made, stakeholders struggle to see a future without the HT at the centre:

It is very hard to see the future now without a health trainer at the centre I would say, and that's just after less than a year in. (I2)

Commitment has been a key factor in the project's success:

We have committed resources from the centre. The minibus goes out quite regularly to wherever the cycling, badminton, or the 5 a side football may be ... We've included it in our timetables; it's part of our services now. (I2)

While the HT project is deemed to be invaluable within the current services, potential hindrances have been noted further afield. Nationally it is recognized that the HT service needs to establish a standardized level of competency for the role:

I think that HTs in the future may be funded outside of PCT. They would still be called health trainers but they wouldn't be health trainers ... So for me I want to ensure that the best practice remains throughout the health trainer arena and ensure they are all practicing the same way so there is a standardised way of working ... It only takes one person to have a negative experience, and it may be because that particular health trainer hasn't worked in the same way as other health trainers. (I1)

Input evaluation

Delivery of the role

The focus group with service users and the interviews with stakeholders yielded a description of the key attributes considered important in a HT. These were flexibility and commitment, and have been key to the success of the HT within the mental health setting:

The fact that he was getting up at 5/6am in the morning to go swimming with somebody is extraordinary. (I3)

The HT reported that practical workshop sessions were particularly effective for people with mental health issues because they were put off by sheets of paper such as the behaviour change diary:

With the Healthy eating workshops I can do a traffic light system, but what really works the best is demonstrating ways to make healthy food. It's best to get service users to actually make something as the nutritional value content labels may be hard to read for some. (I4)

This is reflected in how the stakeholders have adapted ways of collecting demographic and progress data about people using the service. At the very early stage of the project, nationally developed paperwork was being used with service users in a very formal manner. It was concluded that this needed to be changed to be effective. Information is

better collected whilst out and about with service users as opposed to a formal setting. (I4)

Data confirm that the HT provides a selection of physical activities for service users. Activities currently on offer include (numbers in brackets indicate average attendance of service users per session):

- (1) Group walks (12);
- (2) Cycling group (8);
- (3) Gym group (4);

- (4) Football group (10);
- (5) Aerobics/circuit training class (4);
- (6) Badminton group (12);
- (7) Boxercise group (8).

The range of activities and the fact that they offer opportunities for all tastes and abilities were welcomed by service users:

There are all levels of ability, like football and badminton cater for everyone. (SU2)

Reaction evaluation

Out of the interview and focus group data, five categories of service users' reactions to the HT interventions emerged from the thematic analysis. These included changes to HT's lifestyle, motivation required by service users, positive attributes of the HT, delivery of the role and service user perceptions of benefits of physical activity.

The role has been of significant benefit to the HT encouraging him to make changes in his own lifestyle:

It's definitely improved my health just from the advice that I am giving out and from the group activities that I organise, for instance group walks and such. (I4)

The service users indicated that prior to the HT service being implemented within the centre, exercise was an interest that was not pursued due to a lack of motivation. Service users highlighted that the HT generates the needed enthusiasm and motivation to exercise:

I've always wanted to do exercise because I need to lose some weight and get a bit fitter, so I'm glad he's come along as it gives me the spur to do that. (SU3)

It was reported that the HT continually instils enthusiasm in service users from the beginning and throughout, of which they are appreciative.

I think even the days when I don't really want to do the activities, you find if you get yourself along at the end of it you feel lifted and feel like you've done something. So you can go home and relax easier and sleep better. (SU2)

The HT's attributes were regarded as a positive influence for service users. Service users indicated that they appreciated the HT's easy going but enthusiastic manner and in particular does not place service users under pressure to participate in activities:

He's just generally laid back, easy going and facilitative. He doesn't put you under any pressure. You don't feel like you have to do things. You don't feel like you have to come when you don't feel like it, like when I feel lethargic. You're not obliged to go bike riding. He's very easy about that. (SU3)

In terms of the perceived benefits of physical activity, two important benefits highlighted by service users were seen as the social and health aspects of exercising. The social benefits of attending physical activities were deemed important as service users highlighted that it can be difficult to socialize with other people, and therefore exercising with individuals who suffer from similar illnesses helps to reassure service users. Furthermore, it was regarded as beneficial to make friends and feel less isolated:

Outside of here we've been given the opportunity to make new friends and do things other than what we do here ... it's an incentive, and you don't feel so alone or so isolated in the world. (SU3)

I'm comfortable with people in here because I know them, but, when I went to another place with the HT group and there were other groups of people it made me anxious. But I still found something that suited me. (SU1)

With respect to health service, users felt positive after conducting exercise and displayed knowledge in relation to physiology:

It has helped improve things like depression and to release chemicals in exercise, is it endorphins? (SU2)

Service users indicated that attending physical activities have increased enthusiasm for other activities.

The cycling got me thinking 'what else can I do' rather than I can just do this. It is nice to vary it so it is not just one thing and doesn't become boring and repetitive. (SU3)

Outcome evaluation

The 72 service user issues from the DCRS are represented in Figure 2. Four service users wanted to eat more healthily and two wanted to quit smoking. However, the majority of service users ($n = 66$) wanted to increase physical activity (86%). Of these 66 service users, 47 were male and 19 were female.

From the DCRS data, a total of 36 service users reported having achieved their goals (50%) with a further 9 saying that their goals were 'on-going' (12.5%). This demonstrates that at least half the service users are making positive progress with the HT.

Sixteen service users achieved their goal but later relapsed (22.2%), while only six had not reported achieving their goal. These six were subsequently discharged from the HT service. Five service users did not attend the appointment with the HT (6.94%).

Satisfaction questionnaires

Response rates for completed forms were low (9 out of 72 service users), which may be due to literacy issues or a reflection of service users' aversion towards form filling, as indicated by the interview data and experiences of staff:

Service users could be put off by paperwork because '*People can be in delusions, afraid and/or paranoid*'. (I1)

However, despite the low response rate the completed forms demonstrated a positive result. Seven service users indicated that they were 'definitely happy' with information received from the HT and the remaining service users were 'mostly happy' (one service user) or 'unsure' (one service user). Eight service users revealed that they had acted on the advice given.

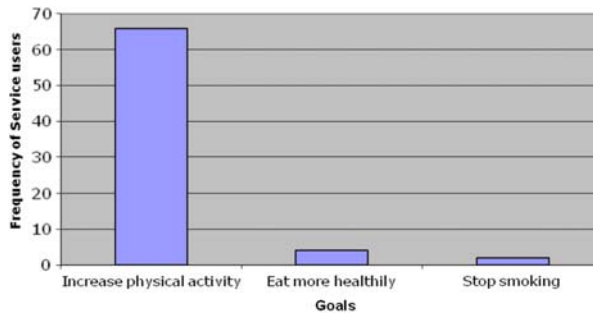


Figure 2. Frequency of issues discussed with health trainer.

Case studies

Service users had started to integrate sport into their daily lives:

It has led me to do stuff on my own. I've just discovered badminton and I really love it so I also play with my support worker and I've also got my family involved in it. (SU2)

In some instances, the integration had widened to family and friends of service users:

A few of my nieces come along to the leisure centre where I live and my mum is in her sixties and even she comes along, and probably will continue to. It's excellent. (SU2)

The following two impact case studies demonstrate the change in two service users' behaviour subsequent to the HT intervention. These two case studies were provided by the HT as part of reporting procedures for the commissioners.

Case study 1: client case study

Client case study: B.M.

Referral details/background

B.M. was a self-referral to the Centre after having been discharged from Hospital. B.M.'s goals were to improve mobility, increase physical activity and lose weight.

Client's programme

The HT's first aim with B.M. was to attend the gym and reinforce the exercises that had been given before his discharge from hospital to improve his motor skills. B.M. wished to use the static bike so the HT introduced 5-min sessions at first and after three months, B.M. was able to complete 30-min sessions with no complaints of pain in his knees. B.M. also began to go for walks with his family on weekends.

Approximately four months after being referred, B.M. had decreased the use of his walking stick as his balance had improved, and furthermore the HT had noticed increased mobility in both of B.M.'s knees.

The HT organised a bike ride in August 2010, and after encouragement B.M. completed the full bike ride and therefore completed one of his long-term goals.

B.M. today

B.M. now attends the biking and gym groups and occasionally attends the circuit/aerobics class.

B.M. has lost 2 inches from his waistline. Family and friends have commented on his weight loss that has boosted his confidence.

B.M. exercises on a regular basis at home, and although he takes his walking stick out as a precautionary measure, he does not need to use it as he is able to walk for approximately two miles along the walking tracks near his home.

The above examples from the case study data and the service users' dialogue demonstrate the significant impact of the HT intervention on service users' daily lifestyles. B.M., R.W. and SU2 have demonstrated increased independence in their lives by including activities such as badminton and healthy food shopping in their time outside of the centre.

*Case study 2: client case study**Client case study: R.W.**Referral details/background*

R.W. was referred to the HT by his care coordinator to provide input into improving his diet and increasing his confidence in the kitchen.

Client's programme

R.W. was not including enough fruit and vegetables into his diet. After establishing that spaghetti bolognese was one of his favourite dishes, the HT took the client to a local supermarket to cost ingredients for R.W. to attempt to cook the meal from scratch. The HT had ensured that R.W. was fully risk assessed by his occupational therapist and deemed safe to use the cooker.

In the following session, R.W. bought the required ingredients that included three vegetables of his five-a-day requirement. While out shopping the HT talked about finding cheaper options when buying ingredients, and so the total cost of ingredients was under £4.00.

R.W. had been given step-by-step instructions to cook bolognese from scratch. Despite requiring verbal prompts, R.W. was able to make four batches of bolognese.

R.W. Today

The HT continues to work with R.W. around healthy eating. R.W. is now able to cook spaghetti bolognese with no prompts, although he has not cooked it without the HT being present. R.W. has also cooked a variety of healthy meals with the HT but still lacks the confidence to cook independently on a regular basis.

R.W. has met his initial goals by increasing his confidence in cooking healthy meals, shopping for ingredients and food preparation. However, R.W. has requested that he spends longer working with the HT to build up further confidence.

Furthermore, R.W. has expressed an interest in swimming and attending the bike rides. The HT intends to work with R.W. to help to increase his physical activity.

Discussion

All service users receiving intervention from the HT had a similar background of a diagnosis of mental illness, whether they had been referred from an external organization or self-referred from the mental health centre where the HT is based. Feedback reinforces that service users feel secure and supported being in the company of others with similar difficulties. This echoes previous research that highlights the importance of being with others this client group can trust and with whom they feel safe (Crone & Guy, 2008). Data confirm that physical activity can help to reduce isolation in clients with mental health issues (Richardson et al., 2005), and that service users enjoyed exercising and socializing which supports independence beyond the service.

From the interviews and focus group, motivation was identified as a barrier to service users engaging with the HT interventions and with undertaking physical activity in general. A lack of motivation is a characteristic of psychotic illness as well as other mental health problems (Murray et al., 2008) and lethargy, an on-going issue for some service users. Although sometimes a struggle, service users reported feeling better after

exercising which supports Anderson and Brice (2011) who advocated that mood enhancement can occur after a single session of exercise. Crone and Guy (2008) similarly found that individuals with mental health issues often reported a lack of motivation as a barrier to exercising, but once overcome, enjoyed participating in physical activities. However, it is of note that a small proportion of service users were either discharged, did not attend, or achieved a goal and later relapsed. This could reflect a lack of commitment to exercise and/or lifestyle change generally or the fluctuating nature of mental illness.

This study demonstrates that with individuals with mental health issues, the success of the HT intervention depends less on what you do, but more on how you do it, with flexibility being the key. The HT's client-centred approach was considered vital for success of this pilot. The HT demonstrated flexibility with service users and offered a service in line with the needs of the individual taken at a pace determined as comfortable. The HT approach fits in with the new meaning of recovery by creating a sense of collaboration between the service user and the HT in order for the service user to live well despite illness and be in control (Fox & Ramon, 2010). It is the nature of the interdependence that allows for service users to build on their strengths and enjoy their life. The HT approach allows for service users to be a part of their recovery process, and aims for them to incorporate physical activity into their daily lives.

Establishing successful partnerships has contributed to the essential stability of the activities over time. Planned and regular activities ensured that service users had a consistent service that provided support for their needs. This echoes previous research that suggests having a purpose or structure to daily life is a very important part of building or restoring self-esteem in service users (Fox & Ramon, 2010).

Of significance was that this study documented a higher attendance of service users in the 26–44 age group than the national profile of HT clients. This may be due to one of two reasons. First, because individuals with mental health problems have more general health issues than the average population (smoking, dying younger, alcohol or drug misuse) (DH, 2010), they present with more health needs. Second, because employment rates are currently lowest for individuals with mental illnesses or nervous disorders, depression or anxiety (Office for National Statistics, 2011), they may have more time to access a HT service.

Limitations of the study include the small numbers and the difficulties in gaining questionnaire data about satisfaction with the intervention from the sample of service users. This demonstrates the potential methodological issue of collecting progress data from service users who are put off by sheets of paper and being questioned in what they may see as an investigative manner. Stakeholders confirmed that being too insistent or assertive with service users could feed into symptoms of paranoia and promote disengagement rather than the opposite.

Despite the limitations of this study, those who participated agreed that physical activity makes a positive contribution in the lives of individuals with mental health issues and therefore should be promoted as an intervention alongside other mental health promotion initiatives. Recommendations cannot be made regarding the specific activities that an individual with mental health illness should undertake, as these should be based on personal choice. Where appropriate, interventions are best introduced and sustained in collaboration with a mental health service in order for a coordinated approach to aid recovery.

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