

2 **An Ethnographic Study Exploring Football Sessions for Medium-Secure Mental Health**
3 **Service-Users: Utilising the CHIME Conceptual Framework as an Evaluative Tool.**

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Adam Benkwitz

8

Newman University

9

Mervyn Morris

10

Birmingham City University

11

Laura C. Healy

12

Nottingham Trent University

13

14 Adam Benkwitz, Sport and Health and Social Care, Newman University, Birmingham, UK.

15 Mervyn Morris, School of Health Sciences, Birmingham City University, Birmingham, UK.

16 Laura C. Healy,

17 Please address all correspondence to Laura Healy, Sport, Health and Performance

18 Enhancement (SHAPE) Research Group, Department of Sport Science, School of Science

19 and Technology, Nottingham Trent University, UK.

20

21 Corresponding Author: Dr. Laura C. Healy, Nottingham Trent University, Clifton Lane,

22 Nottingham, UK, NG11 8NS. Email: laura.healy@ntu.ac.uk. Tel: +44 (0)115 8485516.

23 **An Ethnographic Study Exploring Football Sessions for Medium-Secure Mental Health**
24 **Service-Users: Utilising the CHIME Conceptual Framework as an Evaluative Tool.**

25 Abstract

26 A key part of developing an understanding of ‘what works’ within the evolving mental health
27 recovery evidence base is finding ways of service-users (and their friends and family) and
28 practitioners working collaboratively. This interaction is slowly shifting practice, whereby
29 care is potentially co-constructed in a setting between those involved to facilitate recovery-
30 oriented processes. Increasingly, mental health services are appreciating the potential role of
31 sport. This study adds to this body of literature by providing analysis of a football project in a
32 medium-secure service context. This study also expands the methodological and theoretical
33 scope of the literature by adopting an ethnographic approach and by utilising the CHIME
34 conceptual framework as an evaluative tool. 47 participants were involved in the study,
35 which included service-users, staff and volunteers. The data demonstrated that these sessions
36 have considerable links to the CHIME processes, and can therefore be considered to enhance
37 personal recovery for those involved.

38

39 Keywords

40 Recovery; CHIME; Ethnography; Mental Health; Service-users

41

42 **Recovery Context [A]**

43 The meaning of ‘recovery’ in the context of mental health is evolving, (1, 2) slowly, away
44 from the traditional notion of ‘clinical recovery’, i.e., an outcome observed by an expert, (3)
45 to appreciate the importance of lived experience (4) in an ongoing, personal journey (5) of
46 ‘personal recovery’, i.e., a subjectively viewed and valued process. (6, 7) This acceptance
47 that each individual’s experience is different suggests that there is no blueprint for recovery,
48 (8) however, drawing on the literature pertaining to service user’s accounts, there are key
49 facets of recovery that have been systematically identified by Leamy et al. (9) as part of the
50 broader REFOCUS research programme on recovery. Leamy et al. (9) conducted a
51 systematic review and narrative synthesis that provided an empirically based conceptual
52 framework of personal recovery in mental health. 97 studies were utilised in order to identify
53 five recovery processes that are important to recovery. These processes were articulated by
54 the acronym CHIME, which comprised of: connectedness (including peer support, support
55 groups, relationships, support from others, being part of the community), hope and optimism
56 (which was having belief in the possibility of recovery, motivation to change, hope-inspiring
57 relationships, positive thinking and valuing success, and having dreams and aspirations),
58 identity (that involved dimensions of identity, rebuilding a positive sense of identity, and
59 overcoming stigma), meaning in life (that involved the meaning of mental illness
60 experiences, spirituality, quality of life, meaningful life and social roles and goals, and
61 rebuilding life), and empowerment (that encompassed personal responsibility, control over
62 life, and focusing upon strengths). The criticism of personal recovery is that it can be deemed
63 ‘complex and disordered’, (10) therefore the robust development of this conceptual
64 framework is useful to bring some order to the exploration and evaluation of mental health
65 recovery focused practice and services. (9)

66

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67 A key part of developing an understanding of ‘what works’ within the evolving recovery
68 evidence base is finding ways of service-users (and their friends and family) and practitioners
69 working collaboratively. (11) Arguably, this interaction is (slowly) shifting practice, whereby
70 care is potentially co-constructed in a setting between those involved in order to facilitate
71 recovery-oriented processes. (12) There is an increase in studies in mental health appreciating
72 the experiences of service-users and staff (and others). (13, 14) However, researchers
73 developing the evidence base for these types of practice need to remain mindful of the power
74 relations still present, (15) for instance, staff researchers who undertake research with
75 service-users under their care. Being mindful of this caveat, and as discussed further in
76 subsequent sections, the current study gathered data in-situ from service-users, volunteers and
77 staff members, and was undertaken by a researcher who was not a service-user, a volunteer or
78 a staff member, in order to explore differing perspectives (and potential power relations)
79 within this specific sporting context. Increasingly, mental health services are appreciating the
80 potential role of sport, physical activity and/or exercise. (16)

81

82 Mental Health and Sport, Physical Activity and/or Exercise [B]

83 Despite some notable contributions, literature on the potential for sport and physical activity
84 to contribute to recovery in a positive sense remains scarce, and often methodologically
85 flawed or vague. (17) Furthermore, as Carless and Douglas (16, p140) stated “research has
86 tended to focus on the ways exercise may alleviate symptoms, impairment, and dysfunction
87 rather than its potential to contribute meaning, purpose, success, and satisfaction to a person’s
88 life”, or in other words, there remains a dominance of the simplistic dose-response
89 relationship of certain specific exercises (e.g., see 18, 19) due to the assumed authority (20)
90 of the ‘clinical gaze’ within both health services and sport science. Often these pre- and post-
91 intervention measures ‘explain’ positives via psychological (e.g., self-efficacy, distraction,

92 self-esteem, see 21, 22) or physiological/biological explanations (e.g., see 23), which
93 increases the biomedical model focus at the expense of valuing and learning from the varied
94 lived experiences of, and providing a voice for, the people actually involved. This is despite
95 the Department of Health's (24) 'Future in Mind' policy specifically highlighting the scope
96 available for general practitioners and other professionals to offer social prescribing of
97 activities such as sport (but does not mention exercise or physical activity) to improve
98 wellbeing and mental health in children and young people. Similarly, as Smith et al. (25)
99 discussed, the Government's 'Sporting Future' strategy places emphasis on mental wellbeing
100 within the nation's sporting agenda, with the 'measure' of the link between these elements
101 being "improved subjective wellbeing". (26, p74) This limited, but potentially significant,
102 change in policy rhetoric highlights a move away from the dominance of the clinical gaze
103 towards listening to and valuing people's experiences, which could be argued to be in line
104 with the slow but steady evolution from clinical towards personal recovery. (2, 7) However,
105 the current evidence base in this area is "more complex and nuanced than is perhaps
106 commonly assumed, policy-makers and practitioners face a number of challenges in seeking
107 to provide government with evidence of the contribution made by sport participation". (25,
108 p11) An example of the complexity could include the differences between an individual
109 undertaking an exercise at a specific intensity but on their own (for example, long distance
110 running), as opposed to team sports that might involve twenty or thirty people interacting
111 together in one place but with varying levels of movement and intensity, for example, a
112 goalkeeper in football will move far less than an outfield player, but they may benefit in
113 many other ways due to the social nature of sport, as opposed to the potentially isolating
114 types of exercise and physical activity that could be undertaken. Equally as important could
115 be the context of the activity (health service or community based), how activities are run, by
116 whom and for whom, and whether they have an underpinning focus on competition,

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117 recreation or health. One such area that is developing a participant-focused evidence base to
118 explore this complexity is football for mental health projects.

119

120 Football Specific Projects [B]

121 There has been an increase in the use of football (in various formats) to aid recovery, most
122 often in partnership with football clubs, (27) however, literature on initiatives that are located
123 and run solely by mental health services is limited. Furthermore, research that centres on
124 medium-secure service-users and staff is rarer still. Rather than a distracting predominance
125 on dose-effect style studies, the nature of a team sport like football brings the social
126 interaction and group dynamics to the fore. (28) Therefore, existing studies have highlighted
127 the importance of moving away from exercising for periods of time at certain intensities and
128 instead raising issues like: football being a site and topic to break down barriers, for example,
129 talking to new people or opening up about health concerns, (29-31) football projects tackling
130 stigma, (4) or helping people to (re)discover their identity (17) and recover personal and
131 social roles. (32)

132 Qualitative literature has also focused on the beneficial function of football to initially engage
133 with people, then to have something to talk about (football), which builds rapport and enables
134 participants to discuss issues and challenges. (33) This is especially important to engage ‘hard
135 to reach’ populations within a mental health context. Research suggests that men’s reluctance
136 to seek support can further exacerbate distress and can often lead to suicide, (34) and initial
137 studies have suggested that football can be useful to engage these often ‘hard to reach’ male
138 demographics who are most at risk. (35-36)

139

140 **Summary of Literature and Rationale for Study. [A]**

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141 Whilst the existing literature is a solid starting point, it could be argued that further
142 development of this evidence base is required, with consideration given to four areas
143 specifically. Firstly, the context within which the project is delivered is potentially important,
144 as it should not be assumed that projects that are delivered in the community by football clubs
145 are synonymous with projects delivered within a therapeutic, mental health worker delivered
146 context (e.g., the 'It's a Goal' project, 31, 37), or considered to be identical to a project that
147 involved qualified football coaches and then a therapeutic programme running alongside. (4)
148 Secondly, Magee et al. (4) were critical of the projects they studied as they retained a heavy
149 biomedical model approach, which is often part of time-specific projects that inevitably
150 become affixed with targets and outcome measures. Mental health services could take note of
151 this small but significant idiosyncrasy, and scholars should be mindful of the underpinning
152 aims (and therefore, potentially 'outcome measures') and the sustainability of sport projects,
153 for instance, considering whether they are genuinely recovery focused. Thirdly, from the
154 information available, methodological approaches in this area appear to be limited to generic
155 questionnaire data and/or interviews, there is a lack of researcher involvement actually at the
156 sessions (participant observation), which could be a key omission if the aim is to explore
157 what goes on at projects. Finally, the existing literature often lacks a coherent theoretical or
158 conceptual approach to develop analysis and inform future work.

159 Therefore, addressing those four points, this project aimed to add to this body of literature by
160 (a) providing analysis of a sporting project that aimed to improve mental health within a
161 certain context, which (b) adds to the qualitative data exploring lived experiences. This study
162 also contributes by (c) expanding the methodological and theoretical scope of the literature
163 by adopting an ethnographic approach and by (d) adopting the CHIME conceptual
164 framework, which aims to draw together the recovery-focused literature and the relevant
165 sport-specific studies.

166

167 **Methodology [A]**

168 In terms of the broader research context for this study, the emergent priority is the
169 development and evaluation of interventions to support the five CHIME recovery processes.
170 (9, 11) It therefore follows that if recovery is subjective and best judged by the person living
171 with the experience, (3) then initiatives should be evaluated by exploring and providing a
172 ‘partial interpretation’ (38) of those lived experiences. This approach aligns with the
173 underpinning philosophical assumptions of this study, of a relativist ontology (assumes
174 numerous subjective realities) and a constructionist epistemology (our understanding is based
175 on appreciating multiple social constructions of knowledge). (39) Therefore, this study
176 adopted a qualitative approach to explore *what it is like* (40) to experience the football
177 sessions for those involved (service-users, staff and volunteers). This study has gained unique
178 access to an ongoing NHS Mental Health Foundation Trust football project, which has been
179 running for several years (as opposed to being a specific, finite project). Therefore, this can
180 be considered a naturalistic study that seeks to explore and further understand the relationship
181 between football and mental health for those involved (service-users, staff and volunteers) in
182 order to inform policy and practice.

183

184 **The Football Sessions [B]**

185 Sessions run each Tuesday morning for 90 minutes, in a well-equipped indoor football arena
186 in the centre of a large city, and are run by an occupational therapy team based within a
187 medium-secure unit. The sessions are attended by service-users from numerous medium-
188 secure units across the city, who have been authorised to be chaperoned by members of Trust
189 staff in order to travel to the venue and partake in small sided games of football. There are
190 two features of the sessions to note, firstly, there are also service-users and former service-

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191 users who attend who have transitioned out of the medium-secure setting and are engaged
192 with accommodation services or who are back in the community (and still engaging with
193 services). Secondly, several members of Trust staff, and also volunteers, play football as part
194 of the sessions alongside service-users, all of whom were eligible to be part of the study as
195 they had lived experience of the sessions. Each week there are between 40-50 people present
196 at the sessions, with usually between 30-40 people who play football, as some staff members
197 (chaperones) do not play and there are also some service-users who attend but for various
198 reasons do not play, instead there are seating areas next to the pitch for them to spectate.

199

200 Research Design [B]

201 A research design was required that was flexible enough to engage with the complexity of the
202 context, given the involvement of varied demographics, given diagnoses, periods of time
203 engaged with various services, as well as the involvement of staff and volunteers, which are
204 challenges that have been highlighted within sport and mental health settings previously. (16,
205 41) There were also the expectations to inform future practice of social inclusive, non-
206 stigmatising activities (42) that aid recovery and provide a voice to participants. (43) This
207 inclusivity began at the start of the research project via ‘co-production’, as participants
208 (service-users, staff and volunteers) were involved in discussions regarding the nature of the
209 research. Including participants was both beneficial to the quality of the study and also a
210 stipulation for gaining full NHS ethical clearance, which was gained in addition to the lead
211 researcher’s institutional ethical clearance. Central for the participants was the need not only
212 for the researcher to interview them (provide a voice), but also to attend the sessions regularly
213 to see what they entail. These methods, along with the underpinning philosophical
214 assumptions and the need for flexibility to explore the complexity led to an ethnographic

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215 research design being adopted, which included participant observation and semi-structured
216 interviews.

217

218 Procedure [B]

219 As the sessions were already established, and as the study aimed to explore the lived
220 experiences of everyone involved (service-users, staff and volunteers), the recruitment
221 process began by briefing those present at the sessions on the study, giving them participant
222 information sheets and initially asking them to consider being part of the participant
223 observation data collection. As attendance fluctuated, and in order to attempt to inform
224 everyone who attended prior to data collection beginning, this briefing period lasted for three
225 weeks. During this period, participant information sheets were passed electronically to staff
226 members who were known to accompany service-users to sessions but who were not present
227 at the football sessions for the three weeks during the briefing period. Trust staff were also
228 asked to pass information to anyone due to start attending sessions for the first time during
229 the data collection period, and the researcher's contact details were provided to facilitate any
230 discussions that were required. Those individuals that did not consent to be part of the
231 participant observation were informed that they could continue to attend the sessions as
232 normal, and that the researcher would not collect data (i.e., take any field notes) that related
233 to them in any way. Once all reasonable steps had been taken to inform attendees about the
234 study and written informed consent was gained from participants willing to take part in the
235 study, the researcher attended the sessions as a participant-as-observer, (44) in the sense that
236 the researcher attended sessions, played football, sat and watched others play, and had
237 informal conversations with other attendees, but was known to be a researcher (i.e., the
238 researcher was participating in activities but not researching 'covertly'). After several months
239 of participant observation, and once initial themes began to emerge, participants were

240 purposively sampled (45) for semi-structured interviews in order to explore emergent themes
241 in more depth, with a new participant information sheet and informed consent form being
242 signed.

243

244 Participants [B]

245 There were 47 participants who consented for the participant observation data collection (36
246 service-users/former service-users, nine Trust staff members, two volunteers), which lasted
247 for 46 weeks. There were seventeen semi-structured interviews undertaken (ten service-users,
248 five staff and two volunteers). The study did not seek to access any medical or case files, and
249 did not ask staff about their specific roles. This was due to the study having an inductive
250 approach that focused on the experiences of those attending without the potential distractions
251 of the ‘clinical setting’, which is in line with a personal recovery philosophy. (9) As with
252 other football for mental health projects, the majority of participants were male (three were
253 female), as football remains a contested site where gender relations continue to be
254 reproduced, maintained and resisted. (46) More broadly, in this context, this could be
255 partially viewed as a positive, as football projects can attract ‘hard to reach’ men who are
256 known to under-use health services. (36, 47-48)

257

258 Findings [A]

259 Participant observation data (from 47 participants) and interview data (from seventeen
260 participants) were initially analysed thematically (45) through an inductive process, with first
261 order themes identified and sub-themes developed through an interplay between data and
262 theory throughout the ethnographic process. (49) For this article, and in a similar manner to
263 Brijnath, (50) an additional step was taken to code data in line with the CHIME framework
264 (9) in a deductive process, which meant that the data coded under one code name were

265 categorised into two or three sub-components within the overall analysis. This was done in
266 order to both evaluate the football sessions against the well-established and evidence-based
267 CHIME framework and to also locate the current study within the broader recovery literature.
268 Table 1 provides an overview of the key themes from the initial inductive analysis, all of
269 which were apparent throughout both the participant observation and interview data, before
270 the discussion section focuses in more depth on the deductive analysis in order to explore the
271 CHIME framework processes within this specific context.

272 *INSERT TABLE 1 HERE*

273

274 **Discussion [A]**

275 It is useful when considering the discussion of the CHIME processes to be mindful of the
276 extent that service-users in medium-secure units, and those transitioning back into the
277 community, might experience in their daily lives the opposite of these processes, in other
278 words, feeling isolated (rather than having connectedness), feeling hopeless (rather than
279 hopeful), lacking a sense of identity (rather than retaining a sense of their identity), and so
280 forth. The following sections are based on the CHIME framework (9) and are structured in
281 order of importance and relevance based on the interpretation of data in this study.

282

283 **Connectedness [B]**

284 The participants frequently discussed the importance of the social elements of the sessions, as
285 they facilitated interactions (and friendships) that otherwise would not occur. This was
286 especially significant for those from medium-secure units, as service-users highlighted that
287 they would probably not have got out of bed if they did not have the sessions to attend, and
288 for some it was the only time in the week that they left the unit. It was evident from the
289 participant observation that there was a strong element of community and connectedness

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290 amongst participants, with a welcoming and friendly culture that was very much valued, as
291 Marty (Volunteer) suggested:

292 I've been here for a very long time, I've seen the change in people. They've made a
293 lot of friends. They feel here they can get involved, where years ago they were very
294 quiet, shy. They involve their self with other people, talk and communicate. Look at
295 'Gerald' for example, when he first came, he was very quiet. He never got involved.
296 He couldn't even touch a ball. You look at him now and he's fantastic. He's cheerful.
297 He's happy. When you see him, he shakes your hand and he gets on with people. It
298 wouldn't have happened if he couldn't come here and see everyone.

299 This supports previous studies, highlighting the social benefits in terms of shared experiences
300 (30, 51) with others that provide something to talk about (football) as well as an opportunity
301 to talk and connect, (16) which is deemed important in recovery (9, 11) especially for those
302 involved in medium-secure units who might be, or feel, isolated.

303

304 An issue that comes with increased connectedness in this context, which was highlighted
305 previously in a football project, (4) was the competitive nature of football and how it could
306 lead to violence in sessions. However, it was noted that participants frequently praised these
307 sessions and the 'culture' that meant there was very little conflict, violence or "aggro that we
308 don't wanna see here" (Garth, Service-user). Some suggested the reason for this was the
309 interactive, collective nature of the sessions, as staff and service-users played together and
310 were considered, generally, to be equal, or as Jermain (Service-user) put it "on the same
311 level, everyone is the same out on the pitch, no matter where you came from or whether you
312 are staff or usually locked-up". Another factor is the long-standing nature of the sessions, as
313 they have been running, in various forms, for more than a decade, with some participants
314 being involved for that period of time. Therefore, there is a well-established culture or habitus

315 (52) that guides the behaviours, which is especially useful to inculcate new-comers to the
316 sessions.

317

318 Empowerment [B]

319 The nature of medium-secure units means service-users have limited empowerment, but these
320 football sessions demonstrated that this does not always have to be the case. The data
321 supported a number of the sub-themes of the empowerment processes that Leamy et al. (9)
322 identified as being important for recovery, with the most recognisable being ‘maintaining
323 good physical health and well-being’. It was reported frequently in the interview data that
324 participants were mostly sedentary during the rest of the week, but that these sessions gave
325 them a chance to be active. The general sedentary behaviour of service-users raises questions
326 about other service-users who do not attend these types of sessions, and whether provision
327 (options more appealing to personal tastes than football) should be made more readily
328 available, especially on wards where opportunities and, therefore, choices and empowerment
329 are extremely limited. For Jimmy (Service-user), the opportunity to be active was
330 appreciated:

331 You’ll always see me running, in the game I’m running all the time, non-stop. It’s the
332 only chance I get so I get sweating. It’s good for my heart, and my weight, ‘cause I
333 didn’t always look like this. But it’s hard, when I’m not here, to run around at all.

334 Being empowered enough to be able to make a choice (53) is important for ‘regaining
335 independence and autonomy’. (9) Participants appreciated how service-users can choose to
336 attend (albeit, if that is an authorised option for them), can be team captains (and choose their
337 teammates), and can choose to attend and not actually play (for instance, there is one service-
338 user who never plays football, but attends almost every week and in the short time gap
339 between games will run a lap of the pitch). This empowerment and taking control of decision

340 making transcends just those experiences of service-users in medium secure units, as
341 participant observation made it possible to witness over time how the sessions provided a safe
342 and familiar space for people as they progressed on their recovery journey, (5) a journey that
343 sometimes involved participants who had previously returned to the community becoming
344 more ill and finding themselves back in secure care, but they benefitted from the on-going
345 sessions and the connections they retained, as Greg (Service-user) explained:

346 I was feeling a lot better a while ago, but I had some troubles again. But you know
347 what, I only missed like four weeks or something [of the football], and they let me
348 keep coming, so that really helped to see the guys. Them people are my friends, it's
349 like coming home. Some of these guys here I've known through the footie for five or
350 six years, we wouldn't have that otherwise.

351 The football sessions appeared to be a useful tool for the process of regaining independence
352 and autonomy for transitioning service-users who were out of the units or wards, as there
353 remained a support network for them to cohere around whilst they made decisions and
354 recovered their autonomy, for instance, choosing to attend, considering organisation and
355 timing, making transport arrangements, and so on. The final element of the empowerment
356 processes that were evident was how the positive and supportive culture encouraged
357 'focusing on strengths'. (9) In sessions this included supportive remarks, encouragement
358 'from the side-lines' from spectators, cheering when someone scored, and generally making
359 people feel good about their footballing ability, which service-users reported contrasts with
360 experiences of some of the language and interactions in clinical settings. This positivity is
361 considered important for recovery processes and making positive changes, (3) which shall be
362 discussed in the following sections on hope and identity.

363

364 Hope and Optimism [B]

365 Previous football and mental wellbeing studies, for instance, Lewis et al., (36) found via
366 quantitative data analysis (often using the Warwick-Edinburgh Mental Wellbeing Scale) that
367 participants felt more optimistic following involvement in such a project. The current study
368 goes beyond this questionnaire and survey data to provide some qualitative elucidation to
369 what this optimism or hope might actually entail, whilst providing a voice for the
370 participants. It was evident that there were elements of being involved in the sessions that
371 encouraged participants to feel more hopeful and optimistic about the future in terms of the
372 short, medium and long-term. In the short term, service-users felt that they really benefitted
373 from having something to look forward to each week, as Ricky (Service-user) outlined: “it’s
374 the best bit of my week that’s for sure. If I’m honest, like, it’s the only good bit of the week
375 mostly, keeps my health going. I’d come every day if they ran it”. Ryan (Staff) echoed this
376 from a staff perspective:

377 These guys look forward to coming, absolutely. I can speak about the patients who I
378 work with, and they talk about it all week, especially if they've had a good
379 performance and scored some good goals. They don't shut up about it [laughter]. They
380 keep telling us how brilliant it is, and it gives them a real focus, and I think that gives
381 us as staff something to work with.

382 In the medium term, participants appreciated how (perhaps indirectly) the sessions enabled
383 them to see beyond their current circumstances and feel more hopeful about their own health
384 and personal recovery. This was mainly due to the incorporation of service-users who had
385 transitioned through the stepped process and had either moved from medium to low-secure
386 units, or into service accommodation or back into the community, but who still attended the
387 sessions. From spending time with the participants, and seeing these transitions occur, it was
388 possible to see the personal relationships and communication present that gave people hope
389 that things could change. As Jon (Service-user) stated: “It definitely gives me a bit of hope,

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390 because I see people come here that aren't even in secure services anymore. People that I
391 know that have got out and they've come back and still chat to me and that, do you know
392 what I mean? It makes you see what you can do, like, and be better". Hardeep (Service-user)
393 also explained: "it gives people hope seeing others that are now back in the community.
394 Some people that have moved on from here, they come back, and I think that's really good,
395 but for them its good, too, so they have somewhere familiar to come, they aren't just on their
396 own out there". There was also the benefit for being optimistic moving forwards about the
397 therapeutic relationships between staff and service-users, as Jasper (Staff) explained:

398 It's beneficial for everybody involved. Even the members of staff who aren't involved
399 in actually playing can see their patients in a different light, because there are a lot of
400 patients who are stuck on the ward day in, day out and they come here and they're
401 completely different. It's like seeing a completely different person at times.

402 Almost on a weekly basis, service-user participants expressed what can be interpreted as a
403 longer-term hope of getting well and 'being a footballer' or just joining a local team once
404 they are back in the community, which shall be discussed in relation to identity in the next
405 section.

406

407 Identity [B]

408 A common theme amongst service-users was how they had played football a great deal prior
409 to becoming ill. During the participant observation data collection there were very often
410 discussions about the teams they had played for or the level they had reached, and it was
411 frequently followed by a reflection of how pleased they were that these sessions were
412 available to them to 'recover' that 'old' part of their identity, whilst providing hope that this
413 could be enhanced further in the future. In addition to being an important element of their
414 perception of self (16) and giving life value and meaning, (54) there is potentially a benefit to

415 their social identity in that playing football again affords them cultural capital, (55) which is
416 valued in this different ‘field’ (52) (i.e., in a football arena in the town centre) that contrasts
417 so markedly from their usual social environment (being in a unit or on a ward) that does not
418 value such capital, and therefore can make that person feel undervalued. Furthermore,
419 service-users, volunteers and staff appreciated the dynamic of everyone playing together, as
420 Sean (Service-user) stated:

421 The power dynamics aren’t that obvious, everyone’s on one level. I can’t praise it
422 enough. It’s good that here I’m better than the staff [at football] and we have more of
423 a laugh about that, whereas the rest of the time I’m just ‘Sean’ the patient.

424 This is in line with the more collective, solidarity-enhancing activities that have been called
425 for by Leamy et al. (9) and McKeown et al., (30) which highlighted the benefits of flexible
426 inter-personal relations in settings that contrast with the ‘mainstream’ mental health service
427 settings and relations with practitioners. This significance is perhaps intensified in medium-
428 secure units where these relations and power dynamics are especially manifest, as Onken et
429 al. (53, p10) suggested the “interaction among characteristics of the individual (such as hope),
430 characteristics of the environment (such as opportunities), and characteristics of the exchange
431 between the individual and the environment (such as choice), can promote or hinder
432 recovery”, therefore services could benefit from reflecting on service-users’ hope and identity
433 when considering opportunities and choices.

434

435 Meaningful [B]

436 Although the data suggested that this element of the recovery processes framework was
437 discussed the least by participants, there was a strong consensus of football being meaningful
438 and the sessions meaning a lot to them in terms of their health and ongoing recovery.

439 Participants felt particularly strongly when asked ‘what if the sessions stopped?’. Put simply

440 by Megan (Service-user): “If the sessions weren’t on I think I might fall back into depression.
441 A lot of people would be lost without this, I think. I know I would”. These sentiments were
442 echoed by staff members Lewis and Mikey: “for some of the guys who come, it’s the only
443 physical exercise they do. It’s the only social thing they do” (Lewis, Staff); “I dread to think,
444 mate [what would happen if the sessions stopped]. I dread to think. They say to me ‘What
445 would I do on my own on a Tuesday?’, they all love football and want to come here” (Mikey,
446 Staff). A functionalist perspective (56) would highlight the function of sport of being the
447 ‘hook’ that brings people together, in order for additional benefits (such as the other CHIME
448 recovery processes) to be enabled. The obvious limitation in a practical sense for services is
449 that not everyone likes football and facilities might not be available, however other sports
450 could be offered and despite the limited funding there is a growing body of evidence that is
451 highlighting how sport can really influence people’s personal recovery, so these opportunities
452 arguably should be made available.

453

454 **Academic and Practical Impact [A]**

455 In an academic sense, this study has attempted to add to the limited, but growing, evidence
456 base in this area in four specific ways, by exploring sport in a specific mental health context
457 (that has not previously been studied); whilst focusing on the lived experiences of those
458 involved; via an ethnographic approach; the analysis of which is underpinned by the CHIME
459 conceptual framework. (9) In terms of mental health practice and impact, the findings and
460 report produced for the Trust that runs the sessions has led to a documented increased
461 awareness (especially at a senior management level) of the benefits of the sessions for staff
462 and service-users, as well as a formally reported appreciation of the benefits for recovery
463 from taking part in sport. This has subsequently led to funding being secured for future
464 football sessions (that was not previously forthcoming) and has also contributed to a strategy

465 being implemented to increase sport and physical activity across the Trust, so more people
466 are benefitting from the sessions on a continuing basis. Considerations outside of the CHIME
467 analysis here could adopt a critical approach and point to elements such as the gender divide
468 during sessions, (46) competitive sport causing conflict (4) or the predominance of the
469 biomedical model that still underpins services. (2) However, this study explored the lived
470 experiences of those involved in the sessions, and these experiences were overwhelmingly
471 positive. Even when probed, the only negative comments related to frustrations that funding
472 was precarious (which caused anxiety about sessions not continuing), wanting to have more
473 sessions during the week available and wanting to play for longer during sessions. The data
474 demonstrated that these sessions have considerable links to the CHIME processes, and can
475 therefore be considered to contribute to personal recovery for those involved. Therefore, this
476 study has responded to the challenge of Leamy et al. (9, p451) to use the CHIME framework
477 to develop an evidence base that “simultaneously helps mental health professionals to support
478 recovery and respects the understanding that recovery is a unique and individual experience
479 rather than something the mental health system does to a person”.

480

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483

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