Tackling social exclusion through engagement in football: findings from the "Kickstart 2 Recovery" programme

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Abstract

Purpose – This study aims to determine whether engagement in a football programme can positively impact the recovery journey of the mental health service users involved from the perspective of the "Kickstart 2 Recovery" (K2R) programme stakeholders. There are many challenges faced by the people with mental health problems, a significant one being social exclusion. Football is a socially valued occupation in Ireland (Moran, 2019) and the K2R programme is an initiative run to combat experiences of isolation and exclusion that those with mental health difficulties may experience.

Design/methodology/approach – A descriptive phenomenological approach was taken to the study with the use of semi-structured interviews as the research method. In total, twenty one interviews were carried out and Braun and Clarke's (2006) thematic analysis was used to analyse the data.

Findings – Two themes represent the findings of this paper: the need for pathways and social inclusion, connection and flexibility. These reveal that facilitators are focused on supporting recovery but are unsure of how to overcome barriers to social inclusion. Sports partnerships and programme facilitators have a role to play in accessing community resources, challenging social stigma and creating exit pathways from the group.

Originality/value – This study reveals the challenges footballers with mental health difficulties experience when attempting to become more included in their communities and suggestions on how football programmes, such as K2R, could support their inclusion. These findings add to the body of research analysing the issue of social inclusion for people with mental health difficulties.

Keywords Mental health, Football, Kickstart, Social inclusion, Physical activity, Football group

Paper type Research paper

Introduction

There have been significant changes in the delivery of mental health services since the 1980s, with more and more services now being delivered in the community where people live and work (Davis, 2006). When the location of care changed from institutional to community-based services, it was found that individuals were still socially isolated and excluded from the society (Barton, 1998). In 2006, Ireland's mental health policy was revisited and a report on mental health service delivery was commissioned – "A Vision for Change: Report of the Expert Group on Mental Health Policy" (Department of Health and Children, 2006). It is now more than 13 years since this was published, however the issue of exclusion of those with mental health problems from society has remained (McDaid and Higgins, 2014). The housing and placement of those with mental ill health into their local environments does not automatically result in social inclusion (Davis, 2006; McDaid and Higgins, 2014) and more needs to be done to include them in their communities. Repper and Perkins (2003) state that it is important to support the building of meaningful lives for individuals with mental health difficulties through engagement in activities to promote social inclusion. One such way to promote social inclusion is to examine the role physical activity plays in managing mental health, promoting positive identity and self-esteem, trust and hope (MacKeith and Burns, 2008; Soundy *et al.*, 2015; Carless and Douglas, 2010). Physical activity engagement in team environments has been found to target

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Irish Journal of Occupational Therapy
51/1 (2023) 6–13
Emerald Publishing Limited [ISSN 2398-8819]
[DOI 10.1108/IJOT-04-2022-0016]

Received 24 April 2022
Revised 21 September 2022
9 December 2022
Accepted 2 March 2023

Irish Journal of Occupational Therapy
Volume 51 · Number 1 · 2023 · 6–13

social inclusion and enhance the recovery process (Curran *et al.*, 2017).

Literature review

Social inclusion and football programmes

Football is an example of a team sport that has been used to support a sense of inclusion for people with mental health difficulties. Football has allowed mental health service users the opportunity to engage in a team sport that is free from the social exclusion and stigma that they often encounter in their community settings (McGale *et al.*, 2011; McArdle *et al.*, 2012; Moloney and Rohde, 2017; Mason and Holt, 2012; Brawn *et al.*, 2015; Darongkamas *et al.*, 2011; Lamont *et al.*, 2017; Friedrich and Mason, 2018; McElroy *et al.*, 2008). However, it is currently unclear from the existing literature whether social connections extend beyond the football group programme to other aspects of the person's lives. For example, Moloney and Rohde (2017) state that providing opportunities for footballers to socialise after sessions by engaging in a cup of tea and chat can promote social connections and act as a bond for the group. However, it is not clear if improvements in social connections went beyond the programme itself to the wider community. Similarly, Lamont *et al.* (2017) found that a "walking football programme" did support the recovery journey of individuals but not necessarily their social inclusion in the wider community.

Other studies have suggested that the establishment of sports partnerships and the setting up of sessions in local sports centres had enabled the aim of social inclusion to be better met (Hargreaves and Pringle, 2019; Benkwitz and Healy, 2019; Friedrich and Mason, 2018). However, there is a difference between engagement in community-based activities and the facilitation of social inclusion into the broader community. Magee *et al.* (2015) state that football programmes tend to promote social interaction within the group itself but do not appear to facilitate a carryover into the community setting or with other individuals outside of the group. They call for the incorporation of exit pathways from clinically supported football programmes into football clubs and other local football resources for clinical groups to better bridge the gap between individuals and their communities. An existing example of this would be the creation of links between community football and mental health service-based football (Curran *et al.*, 2017; Darongkamas *et al.*, 2011). There is a tendency for links such as these not to be forged (Ramon *et al.*, 2007) despite this being in line with best practice in the area of mental health recovery (Bryant *et al.*, 2014; Garverich *et al.*, 2020; Health Service Executive, 2017; Roe *et al.*, 2007; Davidson *et al.*, 2006).

Social connections and interactions made within football sessions have been shown to have a positive influence on self-esteem and hope and studies have found that individuals could be re-integrated into their communities by fostering these connections (Brawn *et al.*, 2015; McElroy *et al.*, 2008). Other studies have identified that maximising the accessibility of football interventions for service users is vital to facilitate social connections but again it is not clear if these connections extend outside of the group environment to the whole community (McGale *et al.*, 2011; Mason and Holt, 2012; Curran *et al.*, 2017; Magee *et al.*, 2015; Townsend and Polatajko, 2007). Repper and Perkins (2003) describe true social inclusion as access to roles, responsibilities, activities and resources needed for recovery to maintain social integration or discover new ways to integrate into the community. There appears to be a disparity in existing studies examining football interventions about whether the social skills learnt in these programmes and the connections made within the group setting are transferable to the community environment.

"Kickstart 2 Recovery" programme

Although Ireland has traditional sports such as Gaelic football, soccer is also seen to have both social and cultural values within Irish society (Moran, 2019). In 2017, the Football Association of Ireland released the "Football For All Strategy 2017-2020" initiative which aims to replicate a sense of community for those who are often isolated or excluded from mainstream football. A programme called "Kickstart 2 Recovery" (K2R) was designed in 2011 to specifically target mental health service users who experience the challenge of social exclusion and who are at risk of being isolated. Key outcomes of K2R are personal identity affirmation, social and leisure skill development, improving physical health and overall health promotion and community integration and inclusion. The programme is typically delivered once a week in 6–12-week blocks and the session content includes introductions, warm-up, skill drills, matches, cool down and feedback. The group is facilitated by a Football Association of Ireland coach and an occupational therapist.

Study need and aims

At present there is only one published study examining the K2R programme (Moloney and Rohde, 2017). This study was completed as part of a larger study aiming to add to the body of knowledge and address a number of apparent literature gaps examining the ability of football programmes to meet recovery outcomes, such as reducing social isolation and increasing social inclusion. The purpose of this paper is to explore whether connections made between participants of football programmes, such as K2R, transfer to environments outside of the group setting from the perspective of different stakeholders. These findings will then be discussed in the context of the wider challenge of social exclusion and whether programmes such as K2R can play a part to combat it.

Methodology

Research design

This qualitative study used descriptive phenomenological research methods that allowed the perspectives of the individuals who had exposure to football interventions to be explored and described. Three semi-structured interviews guides were created and reviewed with two occupational therapists within the study site, one for footballers, one for coaches and one for health-care professionals (HCPs). Feedback was applied to the interview guides which were then used to conduct the interviews with the study participants consisting of three footballers, six HCPs, six occupational therapist facilitators (OTFs) and six coaches. The option of phone or face-to-face interview was offered to all participants.

Participants

Three footballers were recruited from two sites within the same service catchment area. Inclusion criteria for this group were that service users needed to be within the study site catchment area, complete a Physical Activity Readiness Questionnaire and obtain clearance from their general practitioner to participate in the programme. Two footballers chose face-to-face interviews and one chose to do a phone interview (authors' own work; Tuite, 2022) (Table 1).

Six HCPs took part and were recruited from two different sites within the same service catchment area as the footballers. This group consisted of clinicians who had made referrals to the K2R programme but were not actively involved and included two occupational therapists, one consultant psychiatrist, two nurses and one cognitive behavioural therapist. The role that corresponds with each participant will not be indicated as they were encouraged to discuss their perceptions of the programme free from the values and obligations of their roles. All HCPs chose to do their interview face to face (authors' own work; Tuite, 2022) (Table 2).

In total, six Football Association of Ireland coaches took part in the interviews and had varying levels of experience facilitating the group. Whether the group was based in a rural or urban area is indicated as this was said to be an important factor in determining the engagement of footballers with the programme. Four coaches chose to do their interview face to face and three chose phone (authors' own work; Tuite, 2022) (Table 3).

Six occupational therapists who facilitate the K2R programmes took part in the study. Due to the level of difficulty in the recruitment of footballers, more occupational therapists who facilitate the groups were recruited to explore in more detail how this type of activity could be used to facilitate recovery. It was found that the programme design for each site varied slightly which was often determined by access to resources, funding and what participants wanted the group to include. All OTFs chose to do their interview by phone (authors' own work; Tuite, 2022) (Table 4).

Instrument

Two pilot interviews of the HCP interview schedule were carried out. Two occupational therapists working in community mental health services within the study catchment area, one at senior level and one at staff grade level, were interviewed. These occupational therapists gave feedback on interview guides for the other participant groups as piloting these with the groups themselves was difficult due to limitations in access.

Data collection

Ethical approval for this study was sought and granted by the Faculty of Health Sciences in Trinity College Dublin and the Health Service Executive's Ethics Board. Participant groups were recruited through purposive sampling. Two occupational therapists at each study site acted as gatekeepers for the HCPs, footballers and coaches. The recruitment of OTFs was done

Table 1 Description of footballers

Name	Age (years)	Gender	History with football	Mental health and reason for group engagement	Community interests
F1	55	Male	Street footballer. Coached children's football but never received coaching. Stopped playing due to physical injury. Follows televised football	Wanted to engage in a community group. Experiences of group work in psychiatric hospital and community settings in the past	Member of two community organisations
F2	Not disclosed	Male	Big interest in football, particularly tactics. Enjoys learning new skills. Follows televised football	Desire to practice engaging socially with others	Involved in a community football group, plays twice weekly in same venue as group
F3	36	Male	Played some football but prefers GAA. Played GAA at a high level in the past	Managing a schizophrenia diagnosis and the side effects of medication	Attends the gym regularly and cinema occasionally

Note: GAA = Gaelic Athletic Association
Source: Authors' own work and Tuite (2022)

Table 2 Description of health-care professional

Name	Exposure to programme	Location
HP1	Has not observed sessions	North and North-East Leinster
HP2	Has observed sessions	North-East Leinster
HP3	Has not observed sessions	North Leinster
HP4	Facilitated the programme in the past at another site	North Leinster
HP5	Facilitated the programme in the past at one of the study sites	North Leinster
HP6	Has not observed sessions	North Leinster

Source: Authors' own work and Tuite (2022)

Table 3 Description of coaches

Name	Time coaching programme	Other experience/training	Urban/rural	Location
FAIC1	Four years	Not currently coaching	Urban and rural	East Leinster
FAIC2	Not disclosed	Experience working with people with mental health difficulties	Urban	East Leinster
FAIC4	Five years	Not currently coaching. Experience coaching adult and children's disability teams	Urban	East Leinster
FAIC5	Three years	Business degree in psychology and management. Experience coaching children's teams	Urban	East Leinster
FAIC6	Two years	Experience coaching children and accommodating people with disabilities and various needs	Urban	East Leinster
FAIC7	Five years	Coaches three groups in three different locations. No mental health training. Experience coaching children's disability teams	Urban and rural	East and North-East Leinster

Source: Authors' own work and Tuite (2022)

Table 4 Description of occupational therapist facilitators and programme design

Name	Length of facilitation	Group design	Location
OTF1	Three years	Eight-week blocks. Typically, four-week gap between blocks. Informal health discussions during sessions. Players re-engage in group	North-east Leinster
OTF2	Two years	Four blocks of eight weeks per year. Typically, a four-week break. Would continuously if funding was available. Players re-engaged in group for up to two years	West Connacht
OTF3	One year	Two or three six-week blocks a year at the start, now weekly with occasional breaks of one to two weeks. Players remain involved. Social element added to final week before break	South Connacht
OTF4	Two years	Six- or eight-week blocks, gaps vary from a few weeks to four months due to difficulty securing a coach. Would like less of a gap. Involved in the blitzes. Players re-engage	South Munster
OTF5	Facilitated once	Eight-week block. State groups need to be offered continuously. Players re-engaged from previous group with another facilitator	South Ulster

Source: Authors' own work and Tuite (2022)

through the Association of Occupational Therapists of Ireland acting as gatekeeper. In total, 21 participants consented to complete a once-off interview of duration 25–70 min. Arrangements were then made for the signed consent form to be provided to the researcher and verbal consent was sought at the start of each interview. Participants were made aware of their right to withdraw at the beginning of their interview and encouraged to contact the researcher should they have any questions before or after their interview. Interview transcripts were provided to participants and any edits requested were made before analysis was completed. Participants were informed again of their right to withdraw when their transcript was provided. No participants withdrew their data from the study.

Data analysis

Braun and Clarke's (2006) thematic analysis was used to analyse the data. The following is a summary of the steps taken:

- Familiarisation: Interviews were transcribed and corrected by the researcher. Corrections were done whilst re-listening to interview recordings to better become familiar with the data.
- Initial codes: Coding was initially inductive using a line-by-line method. Codes were then reduced using research questions.
- Search for themes: Once codes were reduced they were grouped to form themes.
- Review themes: Initial themes were brought to supervision with the research supervisor and the researcher's assumptions and thoughts when forming themes was questioned.
- Defining themes: Themes were reduced and the whole data set was then reviewed to ensure themes reflected participant perspectives.
- Producing the report: Themes were used to answer the research questions. Each participant received a letter of codes made in their interview and were asked to review and feedback to the researcher should they want changes made.

Potential sources of bias were explored during data analysis and a mitigation plan was created. This included the following:

- regular use of a reflective diary;
- maintenance of an audit trail;
- regular meetings with a research supervisor; and
- awareness of the researcher as a data collection tool. For example, the researcher took care not to respond with their opinion of what participants were discussing but rather to explore their perspectives further, particularly, if said perspective was one not heard in previous interviews.

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Findings

Findings from the wider study consisted of four themes which reflected the concerns of all stakeholders. These themes were (1) participation over performance, (2) learning through participation in football, (3) need for pathways and opportunities and (4) social inclusion, connection and flexibility. The first two themes addressed the format of the programme and how individuals felt about their participation in sessions. The second two themes addressed the issue of social inclusion and how programmes such as the K2R enable or fail to enable true integration into the wider community. As the focus of this article is to explore the issue of enabling social inclusion for those with mental health difficulties, only themes (3) and (4) will be discussed.

Theme 3: "Need for pathways and opportunities"

In order for people to feel connected to themselves and their communities, they need opportunities to explore occupations that are socially valued and to have ongoing engagement in those that reinforce their sense of identity (Townsend and Polatajko, 2007). This concept was reflected in the findings of this study. The footballer group expressed the value of taking part in a culturally valued sport within their community environments:

> There was things that (coach name) coached during the sessions [. . .] when I was watching, I could see what the (football team name) players were doing. So it actually made it more enjoyable [. . .] to see some of the skills that he had been showing us, to see them being done by professionals. (Footballer)

> I know that the clinic as well are doing a lot of work in terms of initiatives with the local community [. . .] that in itself is fantastic because that really breathes healthier interactions and understanding. (Footballer)

The need for this opportunity to be provided on an ongoing basis was made clear by the participants. It was found that although the K2R programme was designed to be a stepping stone to community-based groups, the eight-week design is not enough to combat exclusion and to establish a routine:

> It should be an ongoing feature [. . .] for the majority I'd say this was the highlight of theirweek [. . .] then that's their highlight gone [. . .] I have the evidence [. . .] they have been shunned in othercommunity groups. (OTF)

> More of it [. . .] throughout the year. More constant. (Footballer)

> People like routine and they like to know what they're doing for the week [. . .]. When that routine breaks potentially could set somebody back and they're not involved. (Coach)

All stakeholder groups gave suggestions on what additional pathways could be added to the programme to improve the sense of inclusion for players within both the K2R social circle and their wider communities. Suggestions included footballers having roles in local clubs:

> You'd try get them involved in [. . .] a local football club [. . .] they might have a role for somebody. (Coach)

Incorporating a social occupation after football sessions:

> Some sort of social aspect after [. . .] cup of tea, biscuit [. . .] it finishes, and everyone sort of goes their own way. (Coach)

And additional therapeutic inputs:

> They could do with some one-to-one therapy for a while first before they do it [. . .] a bit of an understanding of their situation [. . .] what getting better might look like for them. (HCP)

Theme 4: "Social inclusion, connection and flexibility"

When examining the difference between participation in an activity and participation in life, connection and inclusion are the key distinguishing factors (Townsend and Polatajko, 2007). Our ability to meaningfully connect with others and be included in social groups will largely impact the opportunities we have to engage in activities and what our experience will be whilst engaging (Townsend and Polatajko, 2007). Mental health service users are often excluded from social groups for a variety of reasons, one of which being that they can find it difficult to meet the groups' expectations (Repper and Perkins, 2003). The findings of this research reflect these concepts. Within this study, stakeholders discussed the connection and sense of inclusion within K2R sessions and the positive impact this had on the experience of the footballers:

> When you are there you don't feel like you're at [. . .] a mental health activity. I mean I think we just enjoy it [. . .] everybody's just a football player [. . .] you kind of lose a bit of the labels [. . .] people are brought together that way. (OTF)

> There's a natural empathy there [. . .] I've always seen that, my life experience of meeting people [. . .] with mental health difficulties, they tend to have a natural empathy [. . .] it came out on the football pitch. (Footballer)

Differing perspectives were given about the nature of connections made. Some HCPs maintained that friendships were built:

> One particular guy, because he made two friends [. . .] he sees them outside of here [. . .] his social circle grew. (HCP)

Others claimed that was not the purpose of the group:

> I don't think it's really about making friends. It's just about making connection of some sort [. . .] maybe bumping into that other person on the street [. . .] you have something in common to talk about rather than the clinic. (HP2)

The footballers maintained that the players did not form close connections amongst themselves:

> I don't think people were getting that close to be honest. The only person I got to know alittle bit is (client name), that's it. (Footballer)

All groups mentioned the environmental barriers that service users continue to experience when trying to engage in other activities in their communities and the need for additional support after K2R:

> I don't think it would transfer that easily to 'oh I want to join the club in town now' [. . .] someof them would have had quite negative experiences. (OTF)

And simple things such as having the right gear to be able to participate in the sport or being fit enough:

> [. . .] Basic ones would be having the right footwear having the clothing [. . .] all these are huge to the individual who doesn't have them. (Coach)

> I don't know if I'm fit for doing that. (Footballer)

Coaches facilitated social connections by being flexible in their session designs, willing to abandon session plans and using football to support social interactions:

> The plan may be ripped up after a couple of minutes [. . .] you have to be prepared to do anything. (Coach)

> Football as a tool to interact and get people talking. You get so much from sport [. . .] you learn how to communicate. (Coach)

Discussion

A gap was identified in existing studies with clinical populations investigating whether the engagement of service users in a football intervention, such as K2R, would be capable of having a positive impact specifically on their inclusion in community environments and if so, how does this come about. Findings showed that service users did feel included in the K2R group programme. However, this neither guarantees that footballers would go on to engage in their own communities nor did it guarantee they would be successful should they attempt to do so. Therefore, although footballers were engaging in a community-based environment, this study has found that it did not translate into becoming more socially included. This is an important finding as it contradicts conclusions from existing studies, such as by Brawn *et al.* (2015) and McElroy *et al.* (2008), that the positive connections and interactions made within football sessions are enough for players to then go on and re-integrate themselves into their local communities.

The footballers in this study perceived most community sports groups as being beyond their abilities and an environment they could not access. The occupational therapist facilitators and coaches also had the perception that players tend to be on the periphery of community sports groups and are more likely to be excluded. It was identified that because football is a competitive sport, players in community groups may not be as welcoming or supportive of players with a lower performance level. The social networks and environments individuals are included within or indeed excluded from have a significant impact on the success of their recovery journey (Townsend and Polatajko, 2007; MacKeith and Burns, 2008). This study has found the need for facilitators to expand their domain of concern beyond fostering positive interactions in the K2R group setting and to consider potentially addressing barriers in the wider social environment. This would then mirror best practice which centralises addressing the ways in which social exclusion and stigma operate within the client's environment (Bryant *et al.*, 2014; Garverich *et al.*, 2020).

K2R is tailored to the client's individual needs and removes a lot of the barriers and expectations present in community sport. Some HCPs and OTFs discussed what they perceive to be unrealistic expectations currently being placed on these types of interventions such as trying to connect people to their communities. They stated that more needs to be done to allow successful group engagement to transfer to successful community engagement and connection. The findings from this study support the need for interventions to be carried out within a community and at a societal level to enhance the inclusion of service users, thus supporting their personal and social recovery (Bryant *et al.*, 2014; Garverich *et al.*, 2020). Ramon (2007) states that there is a tendency to forget to consider how to remove social barriers such as stigma and disempowering interactions when designing such programmes. Within this study, participant groups were asked about the ways to address these issues and better connect service users to their communities through football.

Existing studies have identified the role communities and sports partnerships could have in supporting an individual's recovery journey (Hargreaves and Pringle, 2019; Benkwitz and Healy, 2019; Friedrich and Mason, 2018). Coaches suggested working with clubs and OTFs to form connections between K2R and sports partnerships building upon the concept of social inclusion from K2R to the community. One coach would like his players to have roles in local clubs which could provide more structured interactions and reduce the likelihood of football and social skill disparities being a barrier. Several studies (Curran *et al.*, 2017; Darongkamas *et al.*, 2011; Mason and Holt, 2012; Lamont *et al.*, 2017; Friedrich and Mason, 2018) have identified the need for these links to be made between community football and mental health service-based football. Transition should be seamless and allow people to engage longer term.

Within this study, facilitators recommend that more needs to be done before community settings are accepting of service users and so K2R should be provided as a continuous programme. OTFs identified that engagement in a group like K2R does not easily transfer to being able to do other activities, particularly after a short eight-week programme.

Occupational engagement is what connects individuals to their environments (Townsend and Polatajko, 2007). K2R was created as a tailored occupation that allowed this connection to occur for those with mental health difficulties who are often excluded from opportunities to engage in occupations in the community. The provision of K2R as a continuous programme would ensure service users always have access to occupational engagement and connection while at the same time exploring ways to overcome barriers to other opportunities within their communities. Occupational therapists are well placed to undertake this challenge of designing a programme that could develop pathways to inclusion (Townsend and Polatajko, 2007), which are also reflective of the principles of mental health recovery (Health Service Executive, 2017; Roe *et al.*, 2007; Davidson *et al.*, 2006).

Finally, facilitators recommended the incorporation of a social activity directly after the group, for example, going for tea and coffee, as it would enhance the chance for social connections to be made. Repper and Perkins (2003) state the importance of relationships, particularly with other service users, in tackling social exclusion for those with mental health difficulties. The footballers in this study identified that while they experienced positive social interactions over the course of the six-to-eight-week intervention block, friendships were not formed. It appears that the current design does not give footballers enough opportunities to develop connections and friendships. Programme designers need to build time for social relationship development within the programme and to actively choose occupations such as coffee time to promote it (Lamont *et al.*, 2017; Hargreaves and Pringle, 2019; Benkwitz and Healy, 2019; Friedrich and Mason, 2018; Magee *et al.*, 2015; Brawn *et al.*, 2015; McElroy *et al.*, 2008). Moloney and Rohde (2017) found that by incorporating a social activity, the footballers benefitted from it.

Study limitations

There were several limitations within this study which may have affected the findings. The number of footballers recruited did not meet the target sample number of six and there were no female footballers, this is thought to be the main limitation of this study. This occurred as the sample from which participants

were recruited from contained less than half the number of people than were expected by facilitators. This meant the researcher did not seek ethical approval from more sites and it was then not possible to obtain this in the remaining data collection time. There were two female players involved but they did not complete the programme. Furthermore, it was difficult for the researcher to build rapport with the footballers who were involved. Every effort was made to inform participants of the study and conduct data collection in a way that was most comfortable and convenient. Individuals may have been more comfortable answering a survey and therefore it is suggested that in future studies, a survey design be implemented to reach more individuals. Finally, qualitative research methods by their nature involve a level of bias and every effort was made to reduce bias within this study. For example, the researcher maintained a reflective diary to challenge any preconceived ideas around recovery, social inclusion and football.

Conclusion

Suggestions made in this article mirror recommendations made by other authors examining mental health recovery, such as Repper and Perkins (2003), who suggest that by creating links with the local community, facilitating contact between people with mental health difficulties and facilitating specialised groups in ordinary settings, it will most likely increase positive experiences which in turn will influence their recovery journey including their social connections.

Summary of findings and practice implications

- This study found that the programmes need to be flexible in their delivery to meet the social needs of individual participants. It is therefore recommended that the structure and duration of the programme be revisited to include a flexible approach that enhances social connections.
- This study found that footballers are often excluded from local sports settings which could play a role in combating social exclusion. It is therefore recommended that coaches act as a bridge between service-run sport and community sport clubs to support access and inclusion of mental health service users.
- This study found that social and community inclusion often do not occur after an individual takes part in the K2R programme. It is therefore recommended that social inclusion and community integration are made intentional outcomes of the group by offering social activities after sessions, encouraging friendships within the group and ensuring the K2R is a programme that is continuously offered for those not yet accepted by their communities.

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