A sociological examination of sports coaches' perceptions of their role in supporting participants' mental health and an evaluation of the Mental Health First Aid training course.

Luke Anthony Clayton

Submitted in accordance with the requirements for the degree of Master of Science by Research

York St John University

School of Science, Technology and Health

November 2020

The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

Acknowledgements

The completion of this research project would not have been possible without the vast amount of support and guidance from several significant others. I would firstly like to sincerely thank all of the participants who agreed to share their unique and highly appreciated opinions and experiences. I am very grateful for their engagement, willingness and time devoted to the research study. I would also like to thank all of the key partners involved in supporting the national #21by21 campaign which includes the national mental health charity Mind, Sport Wales and Sport for Development delivery organisations StreetGames and the Dame Kelly Holmes Trust.

I would like to acknowledge and thank my family and friends for their unconditional support and encouragement throughout the course of this research project. The challenges which faced many during 2020 as a result of the coronavirus pandemic also had implications for me and this research study. However, with the continuous support from my family, I am proud to have overcome these challenges. A special thanks goes to my girlfriend, Hannah, who has motivated me when things got tough and believed in me unconditionally. I would also like to thank my MSc research peers and the staff at York St John University who have supported and guided me throughout this academic year.

Finally, a particular thanks goes to my academic supervisor Dr Graeme Law. His continuous encouragement, time, knowledge and guidance have been extremely influential during this research study. I greatly appreciate the many academic tutorials, meetings, phone calls, video calls and strongly believe that the completion of this study would not have been possible without his ongoing leadership and reassurance.

Abstract

Mental health illnesses are becoming ever increasingly recognised as an important health concern within society, particularly amongst children and young people. Utilising the sport and physical activity environment to develop and improve mental health awareness and support is also gaining momentum. Community sports coaches have been identified as holding an important role in supporting their participants' mental health. However, existing research in the field has begun to highlight that community sports coaches lack the necessary training, knowledge and skills in order to effectively fulfil this role. Much of this research has focused upon quantitative research - using questionnaires to investigate coaches' perceptions of their role in supporting participants' mental health. This study, therefore, aimed to build upon the existing research by examining the sports coaches' perceptions through a qualitative lens whilst applying the theoretical orientation of Figurational Sociology. The aim of this study was to investigate the coach's role in supporting participants' mental health as well as their experiences of the Mental Health First Aid training courses. Semi-structured interviews were conducted with 16 community sports coaches from across the United Kingdom, analysed using Figurational Sociology concepts including figurations, habitus and power. Findings concluded that coaches recognised that their role in supporting participants' mental health was crucial and highlighted that the training regarding mental health awareness and support was fundamental in enabling them to effectively and confidently fulfil this role. Ultimately, this study has added to the existing evidence base regarding community sports coaches' role in supporting their participants' mental health, whilst examining the effectiveness of Mental Health First Aid training courses.

Table of Contents

Abbreviations

MHFA- Mental Health First Aid
YMHFA- Youth Mental Health First Aid
UK- United Kingdom
WHO- World Health Organisation

Chapter 1

Introduction

Mental illnesses are documented as one of the highest contributors to the global burden of disease (Costello, Egger and Angold 2005). The World Health Organisation (WHO) (2013) further conveys that mental health illnesses are the leading cause of health-related problems globally, for individuals aged between 10 and 24. Research conducted by Kelly et al. (2011) illustrates that 50% of individuals with a mental health condition experienced its onset at some point within their youth or adolescence. Nonetheless, it has been conveyed that adolescents are less likely to acknowledge or independently seek help and support for a mental illness when compared to the rest of society (Jorm 2012). The information from Lawrence et al. (2016) and Mojtabai, Olfson and Han (2016) coincides with this - identifying that children and young people have a tendency to avoid seeking professional help and that they have the lowest rate to receive mental health services within society. The WHO (2019a) suggests that mental health conditions (in other words, mental illnesses) can affect an individual's frame of mind through their thoughts, feelings and behaviours. Mental health conditions can take shape in a multitude of forms and severities and are accountable for a high percentage of the global disease burden (Breslin and Leavey 2019; WHO 2019a). Research suggests that anxiety and depression are the most prevalent mental health problems in society (Patel et al. 2010).

Sport and physical activity play an influential role in many individuals' lives within society and regular participation has been proven to provide health benefits physically, mentally and socially (Danish, Forneris and Wallace 2005; Fraser-Thomas, Cote and Deakin 2005). Furthermore, exercise has been proven to reduce anxiety and depression as well as improve self-efficacy, cognitive functioning and emotional regulation (Fox 2000; Callaghan 2004). The social support that also occurs within sport and physical activity is another significant factor in promoting and developing people's physical and mental wellbeing (Carless and Douglas 2008).

Raising public awareness of mental health awareness is becoming more widely supported and is gradually developing into a primary objective of several national mental health policies and guidelines, such as Australia, Ireland, the United Kingdom (UK) and other countries (Dewe and Kompier 2008; Australian Department of Health and Ageing 2009; Department of Children and Youth Affairs 2014). Recently, there has been an increased surge of attention in supporting the mental health and wellbeing of those involved

in physical or sporting activities such as the participants themselves and the coaches (Breslin and Leavey, 2019). However, theory, policy and practice within this area of research is still underdeveloped (Breslin and Leavey, 2019). Physical activity and sport environments are a community setting that recent research has started to investigate and consider as a fundamental area for improving the help and support for children and young people's mental health, particularly due to the large prevalence of young people involved in organised physical activity and sport (Tremblay et al. 2016). Sports coaches play a significant role in developing their participants holistically. It has been recognised within academic literature that the relationships developed between sports coaches and participants can be extremely influential due to the mutual trust and respect (Jowett 2005). As a result of regular interactions, coaches are in a distinct position to support and identify mental health issues amongst their participants (Mazzer and Rickwood 2009). In accordance with Henriksen et al. (2020), it is important to outline and define varying mental health illnesses and disorders particularly within sport and physical activity. Henriksen et al. (2020, p. 555) conclude that,

> We need to distinguish between clinical mental health disorders (diagnosed according to recognised criteria), subclinical mental ill health (not severe enough to meet diagnostic criteria), the human condition (periodic experiences of adversity and unpleasant thoughts and emotions as a consequence of living a full life), and the athlete condition (periodic experiences of unpleasant thoughts and emotions, such as performance anxiety, as a consequence of engaging in athletic pursuits).

Brown et al. (2017) importantly note that a potential concern links to the coaches' lack of training and qualifications within this area. Jorm (2012) highlights how coaches must develop their mental health literacy and acquire further skills in order to fully support their participants.

Mental health literacy is a strategy which promotes knowledge and understanding around mental health illnesses, more specifically considering how to recognise, support, refer, and provide early prevention (Jorm et al. 1997). Similarly to health literacy, mental health literacy was proposed as a means of developing personal and social empowerment, in order to tackle mental health inequalities and progress overall health and wellbeing (Gorczynski et al. 2019). Furthermore, mental health literacy aims to enhance knowledge and develop the ability to identify various mental health illnesses, understand risk factors and

causes, recognise available professional help and support, encourage positive attitudes around mental health and promote help seeking behaviours (Jorm 2012; Gorczynski et al. 2019).

According to research conducted by Furnham and Swami (2018), the development of mental health literacy amongst professionals, such as coaches, is imperative due to the low levels of mental health literacy within this area of society. The information from Swann et al. (2018) coincides with this, highlighting that children and young people perceive their coach's mental health literacy, knowledge and understanding to be major influences as to whether they would seek help and support from their coach. It has been acknowledged by Gorczynski et al. (2019) that there is a large requirement for evidence-based mental health literacy programmes to be used in order to effectively promote mental health and wellbeing within the sporting environment. Similarly, Duffy, Rooney and Matthews (2019) convey that there is a further necessity for additional investigation into coaches' mental health literacy and how this may subsequently influence their perceived role and engagement in promotion, prevention and early intervention behaviours.

Mental Health First Aid (MHFA) is an evidence-based public education programme designed to improve mental health within society by reducing mental health stigma; increasing mental health literacy and developing individual's confidence in providing help and support (Jorm 2000; Kitchener and Jorm 2002; Kitchener, Jorm and Kelly 2016; 2019). MHFA training was originally brought to England from Australia in 2007 and applied through the Department of Health (Kitchener, Jorm and Kelly 2019). Medical first aid training is widely accepted and prominent in many areas of society. However, traditionally it is not associated with mental health, exclusively focusing upon physical health (Jorm and Kitchener 2011). Consequently, the MHFA training was originally developed to educate people to detect, support and refer mental health illnesses amongst adults (Kitchener and Jorm 2004). The MHFA programme has now been adopted by a number of nations around the world and adapted through their own culture and healthcare systems (Kitchener, Jorm and Kelly 2016). The training has been developed further with a course focusing upon Youth Mental Health First Aid (YMHFA), revolving around young people with mental health issues (Kitchener, Jorm and Kelly 2019). The YMHFA training course is specifically designed for individuals who work or interact with adolescents frequently, such as teachers and coaches (Haggerty et al. 2019). Both Youth and Adult MHFA training programmes include engaging, reflective, thought-provoking activities around mental health stigma and mental health literacy. Once the training is completed, the individuals are referred to as mental health first aiders (Kitchener, Jorm and Kelly 2012; 2016; 2019). Both training

programmes were designed and premeditated through several evidence-based studies and professional panels (Van de Velde et al. 2007; Ross et al. 2012). The similarities between the two training courses and their methodologies are important to consider as this model increases the likelihood of the MHFA courses achieving a wider societal acceptance and implementation (Haggerty et al. 2019).

Despite the growing evidence base regarding mental health and sport, there is very little research investigating sports coaches' perceptions surrounding their role in supporting participants' mental health. This could be due to the fact that coaches have only recently begun to gain recognition as a source of support (Mazzer and Rickwood 2015). In addition, limited research has specifically explored the effectiveness of the MHFA training course in improving the coach's mental health literacy and ability to implement support within their role. Therefore, the following research questions will be examined within this research study:

- What are sports coaches' perceptions of their role in supporting participants' mental health?
- How does the MHFA training influence sports coaches' mental health literacy?

This research study will apply a sociological perspective employing the concepts of Figurational Sociology from the work of Norbert Elias (1897-1990) (Elias 1978). According to Elias (1978, p.17), sociologies principal goal is to, "enlarge our understanding of human and social processes and to acquire a growing fund of more reliable knowledge about them.". This narrative is a brief introduction to the wider concepts of Figurational Sociology which are included within this research project, for example habitus, power balances and figurations. These concepts will help to explain the relationships, both enabling and constraining, between the sports coaches and their participants regarding mental health support (Elias 1978).

The structure of this research project will be as follows: Chapter 2 will critically examine and review relevant existing academic literature, in order to identify a clear rationale. Chapter 3 will clearly describe and outline the theoretical framework of Figurational Sociology and how this will be applied to the current studies research findings. Chapter 4 explains the data collection method employed within this research project as well as identifying the design, data analysis and ethical considerations. Chapters 5, 6 and 7 present the results and findings from this study, discussing their relevance and meaning in accordance with the theoretical framework of Figurational Sociology and relevant academic literature. The final

chapter will succinctly conclude the key findings and provide suggestions for future research within the field of sport and mental health.

Chapter 2

Literature Review

The following chapter aims to examine and critique a breadth of relevant academic literature in order to further outline the rationale of this research study, as well as establish existing knowledge. There is extensive academic literature surrounding the MHFA training (Jorm et al. 2010; Kelly et al. 2011; Svensson et al. 2013a). However, the majority of this literature is not directly relevant to sport, physical activity or sports coaches. Academic literature examining the effectiveness of the MHFA training upon community sport coaches is limited, and the existing literature largely focuses upon groups such as Armed Forces personnel, teachers or the general public. The following literature review will include four subheadings: Mental Health and Wellbeing, The Association between Physical Activity, Sport and Mental Health, The Role of a Coach in Supporting Participants' Mental Health and The Effectiveness of MHFA Training. The first and second subheadings will provide a broad contextual understanding of mental health and wellbeing within the field of sport. The last two subheadings will draw the focus more narrowly onto studies relating to sports coaches' roles in supporting their participants' mental health and more specifically, the MHFA training course.

2.1. Mental Health and Wellbeing

Mental health has been defined as "a state of wellbeing in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." (WHO 2019a p. 104). However, Galderisi et al. (2015) argues that people with very good mental health still regularly experience feelings of distress, unhappiness and/or anger, and that this is part of an individual's day to day life. According to Gorczynski et al. (2019), the current research suggests that mental health is commonly viewed negatively with an illness-based lens within the media and academic literature, lacking clarity and clear definition. Mental health has been regularly conceptualised using positive emotions, indicated by feelings of joy, contentment, and an ascendancy of the environment (Waterman 1993; Diener et al. 1999; Lamers et al. 2011). In accordance with the research by Keyes (2006; 2014), mental health can be separated into three key components: emotional wellbeing (happiness, enjoyment), psychological wellbeing (liking one's own personality,

positive relationships with others) and social wellbeing (positively contributing to society, feeling part of a community). However, this perception of mental health once again can be critiqued for relaying positive functioning and emotions too heavily and is influenced by hedonic and eudaimonic traditions (Deci and Ryan 2008). The concept of mental health is heavily shaped by the culture which defines it and positive functioning excludes many groups within various cultures and societies including adolescents and discriminated minorities (Galderisi et al. 2015). Although, Vaillant (2012) suggests that essential aspects of mental health should be universal despite cultural differences. Galderisi et al. (2015 p. 3) have endeavoured to establish and propose an inclusive definition of mental health, whilst attempting to avert from constrictive and culturally constrained statements:

> Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium.

This proposed definition of mental health provides a more holistic overview of the complex interconnected components of mental health and wellbeing (Galderisi et al. 2015). Considering the association between body and mind as well as acknowledging an individual's ability to empathize with others and cope with negative life events helps to create an all-encompassing definition, applicable to wider societal groups. Galderisi et al. (2015) further assert that the notion of "dynamic state of internal equilibrium" reflects differing life events which require alterations to an individual's equilibrium such as adolescence, marriage, leaving home and retirement. This definition goes on to further recognise the importance of flexibility within one's mental health. Flexibility signifies the ability to overcome challenges and adapt behaviours based upon unpredicted obstacles (Galderisi et al. 2015). Lacking these qualities may result in distress and suffering for someone undergoing significant life changes.

The proposed definition of mental health by Galderisi et al. (2015) also aligns with the recovery movement perspective. The recovery movement perception refers to recovery being perceived as an achievable development by which individuals build upon certain aspects or functions (Slade et al. 2014). Whilst the WHO's (2019a) definition of mental health has been criticised for focusing solely on positive emotions and

lacking a holistic overview, it is important to acknowledge their extensive wider discussion surrounding the topic of mental health. A component of their mental health definition considers how people manage daily challenges in different ways and that feelings of sadness, anger, anxiety or fear are often experienced by people who have a positive mental wellbeing (WHO 2019a). This is shared within the definition by Galderisi et al. (2015), displaying mutual consensus and highlighting a significant element of mental health. The WHO (2019a) further adds that an individual's mental health can be understood to continuously fluctuate on a continuum depending upon day to day changes.

Numerous research studies have concluded that factors such as inactivity, poor diet, inadequate sleep and loneliness can negatively affect a person's mental health (Rohrer, Pierce and Blackburn 2005; Paluska and Schwenk 2012; Loewen et al. 2019; WHO 2019a). A cross-section telephone survey with 621 adults in Texas, USA was conducted by Rohrer, Pierce and Blackburn (2005) to determine the relationship between lifestyle factors and self-rated mental health. Following statistical analysis, the findings suggested that 12.8% of participants reported having poor mental health, all strongly associated with lifestyle variables; smoking and obesity. These findings indicate that lifestyle factors such as poor diet, lack of physical activity and daily smoking can negatively influence one's mental health and wellbeing. This concept is further highlighted within *The Lancet* Commission on global mental health review where Patel et al. (2018) explains that there are various factors which may increase the prospect of developing a mental health condition. These factors include; adverse events (particularly in childhood), a lack of social support, hereditary influences, environmental pollutants, substance abuse, poor nutrition, and additional lifestyle conditions (Patel et al. 2018).

Extensive research conducted within the Global Burden of Disease study estimated that in 2017, over 970 million people had a mental health condition (James et al. 2018). The significance of this statistic is intensified due to mental health conditions often also impacting the friends and families of the affected individual, as well as having wider societal implications (WHO 2019a). According to the WHO (2019a), there is a sizable gap between people who could benefit from mental health treatment and the people who are able to access evidence-based interventions and support. In other words, the inequalities which exist within society constrain the accessibility of mental health services and often result in individuals failing to receive adequate support. The study conducted by Kohn et al. (2004) examined the extent of the mental health treatment gap. The study design included reviewing community based psychiatric epidemiology studies to determine the percentage of individuals obtaining treatment for a variety of mental health conditions including schizophrenia, generalised anxiety disorder and alcohol abuse. The

results concluded that even in the countries with the most resources, two thirds of people with a mental health illness receive no support or treatment (Kohn et al. 2004), highlighting the global issue of inadequate mental health support.

In juxtaposition to the holistic concept of mental health, mental illness has been defined as a medical condition which can influence emotions, behaviour, vitality, or character, hindering an individual's capability to efficiently function in their daily life (Mental Health First Aid Australia 2017). The WHO (2019a) coincides with this statement, suggesting that mental health conditions (in other words, mental illnesses) can affect an individual's frame of mind through their thoughts, feelings and behaviours. Mental illness can take shape in a multitude of forms and severities and is accountable for a high percentage of the global disease burden (Breslin and Leavey 2019; WHO 2019a). Mental illness has developed into a substantial health concern, mainly due to the advancement of knowledge around the prevalence of mental health illnesses such as anxiety and depression (Australian Institute of Health and Welfare 2017; Murray et al. 2012). A study which aimed to highlight the extent of mental health illness globally was that of Murray et al. (2012). The researchers conducted a systematic reassessment of disease and injury-specific epidemiology, based upon the 1990 Global Burden of Disease Study (Murray et al. 2012). The researchers calculated disease burden globally, involving 21 regions across a twenty-year time frame, from 1990 to 2010. This longitudinal comparison allowed for the researchers to obtain meaningful conclusions, on a global scale. The methodology included calculating disability-adjusted life years as the sum of years of life lost as well as the years lived with disability; across 187 countries, including both sexes, 20 different age categories and incorporating 291 causes. The results concluded that mental illnesses accounted for 7.4% of disability-adjusted life years.

Stigmatisation of mental health can result in damaging stereotypes, prejudice and discrimination of people with mental health conditions within society (Corrigan and Blink 2005; Kaushik, Kostaki and Kyriakopoulos 2016; Sreevani 2016). Haggerty et al. (2019) explains this concept in more detail, suggesting that the stigma associated with mental health is a form of societal stigmatisation hostile to mental illness, which has a long-term damaging effect on a person's self-perception, confidence and likelihood of accessing mental health services and supportive interventions. The WHO (2019a) concludes that stigma associated with mental health is comprehensive in all areas of society. A non-experimental research study which investigated community thoughts regarding mental health supports this statement (Lavanya, 2019). After collecting questionnaire data with 100 participants, results found that 38% of participants displayed

negative attitudes towards mental health and a further 48% were neutral in response to questions regarding their attitude and feelings towards mental health (Lavanya, 2019). This is further reinforced by the findings from a systematic review of 42 studies conducted by Kaushik, Kostaki and Kyriakopoulos (2016). The researchers assessed self-stigma and public stigma, with a specific focus on children and adolescents who have mental health difficulties. The review concluded that stigmatisation is a universal and immobilising issue, causing severe distress to many within society (Kaushik, Kostaki and Kyriakopoulos 2016).

Consequently, stigmatisation across society often leads to individuals with mental health conditions feeling reluctant to seek professional help and support, in the fear of judgement and further discrimination (Gronholm et al. 2017; Lavanya 2019). Gronholm et al. (2017) sought to discover the relationship between stigma and pathways to seeking help for those suffering with psychotic disorders. Forty studies were reviewed over a 20-year period between 1996 and 2016, including findings from qualitative, quantitative and mixed-methods research, all of which investigated the association between stigma and pathways to care. The synthesis of data resulted in the formation of six themes which clearly highlight the complexity of how stigma can influence help seeking behaviours amongst psychotic patients and additional high risk groups; sense of difference, characterizing difference negatively, negative reactions (anticipated and experienced), strategies, lack of knowledge and understanding, and service-related factors (Gronholm et al. 2017). This systematic review highlights the complications relating to stigma within society and the interrelated relationship it has with the prevention of help seeking behaviours. The seriousness of this is highlighted by information from Lalitha (2009) who suggests that the likelihood of successful recovery from mental illnesses is strongly correlated with the accessibility and quality of mental health services, as well as their personal perceptions and understanding of mental health. Unfortunately, the stigma surrounding mental health can cause individuals to neither be aware of their own mental health or actively pursue professional help and support, particularly amongst children and young people (Gorczynski et al. 2019).

As mentioned earlier in the chapter, the likelihood of developing mental health conditions, amongst both children and adults are strongly correlated with lifestyle factors such as socio-economic status, social connectedness, family support as well as diet and activity levels (Rohrer et al. 2005; Royal Colleges of Paediatrics and Child Health 2017). However, it is apparent that the onset of mental health conditions largely commences within adolescence. Research has estimated that one in ten children and young people aged between 5-16 years old experience a clinically diagnosable mental health illness, 50% of all mental

health illnesses are first experienced by the age of 14, and 75% of mental illnesses were first present by the age of 18 (Department of Health 2015; Public Health England 2016; Royal Colleges of Paediatrics and Child Health 2017). Current data within the UK also indicates that six in ten children and young people who are in care have a mental health illness and up to 75% of children and young people with mental illnesses are not supported by the appropriate professional mental health services (Public Health England 2016).

Of specific concern is the prevalence of mental health conditions amongst young males. A review written by Milnes et al. (2011) conducted by the Australian Institute of Health and Welfare considered the health status of young people (12-24), as part of a series of national statistical reports. The results indicate that there are growing rates of mental disorders amongst young males (Milnes et al. 2011). The high occurrence of mental health illnesses amongst males specifically may be due to additional factors such as societal expectations and pressures, a reluctance to communicate their feelings and a fear of judgement. It is also argued that the barriers which young males face when trying to address mental health issues, concluding that males predominantly adopt negative attitudes towards seeking professional support (Gonzalez, Alergria and Prihoda 2005; Gulliver et al. 2012).

In relation to the UK, The House of Commons Health Committee (2014) stated that when compared to other groups within society, there is a deficiency of reliable data surrounding the prevalence and state of children and young people's mental health within England and the UK. The House of Commons Health Committee (2014, p.13) further states that:

> The shortfall of information in this area is not confined to data on the prevalence of mental health problems amongst children and young people, but extends into information about service provision as well, including levels of demand, access and expenditure.

This leads to difficulties in accurately estimating the scale of mental illness among children and young people within the UK, which in turn affects how suitable and sustainable policies, programmes and interventions can be developed in order to tackle mental illness (House of Commons Health Committee 2014). Similarly, the Royal Colleges of Paediatrics and Child Health (2017) have concluded that this lack of data surrounding the state of children and young people's mental health is in need of urgent action, due to the growing worldwide apprehension around mental health. Within the Royal Colleges of Paediatrics

and Child Health (2017) review, children and young people identified mental health as a major area of concern, predominantly due to the lack of support available to them and the lack of clarity relating to seeking help and support for their mental health. Rickwood et al. (2005) further suggest that the majority of adolescents do not have the skills, knowledge or experience to deal with the onset of mental health issues and therefore, often neglect the seriousness and opt for informal sources of help (Olsson and Kennedy 2010). Trojian (2016) suggests that associated stigma is a huge factor dissuading young people from obtaining appropriate support. Further academics suggest that young people are the most susceptible to negative outcomes of stigmatisation around mental health due to the societal pressures which adolescents face (Kelly et al. 2011; Jorm 2012; Sickel, Seacat and Narbors 2014).

This concept has been recognised within the United States of America with the launch of an international initiative, National Dialogue on Mental Health, aiming to reduce stigma and encourage help seeking behaviours (Canady 2013; Clay 2013). However, Haggerty et al. (2019) states that whilst these types of interventions encourage mental health awareness, further development and practical steps are required especially amongst key personnel who are likely to impact adolescent's mental health such as teachers and sports coaches. According to Patel et al. (2018), the strain on mental health services across the world is rapidly intensifying. However, the pattern of results outlined above demonstrate that young people hold firm reservations when it comes to seeking formal professional help. Therefore, there is an extensive need to consider alternative personnel and support systems which can offer primary interventions and mental health support for children and young people (Jorm 2012). There is increasing attention and expanding research focusing upon the potential of other settings within society, such as schools and sporting environments, to assist with the prevention and creation of early intervention programmes relating to mental health (Cane and Oland 2015; Public Health England 2015; Sharpe et al. 2016). The information highlighted within this first section of the literature review begins to explain and justify the need and rationale for the present research study. Gaining an understanding of the perceptions of community sports coaches in relation to their role in supporting participants' mental health, will help to identify how alternative personnel and support systems within the physical activity and sporting environment can aid in promoting positive mental health.

2.2. The Association between Physical Activity, Sport and Mental Health

The relationship between physical activity and mental health has received increased attention over the recent years (Vella et al. 2015). The benefits which can be obtained from participating in regular physical

activity and engaging with sport teams can make significant differences to one's mental health (Vella et al. 2015). Researchers suggest that the physiological effects of exercise on the brain as well as psychological feelings of belonging and social connectedness when participating in physical activity help to maintain positive mental wellbeing (Danish, Forneris and Wallace 2005). Alvarez et al. (2012) further adds that amongst children specifically, the environment of sport and physical activity can provide a wide range of benefits, including competency, autonomy and inclusivity.

Reavley and Jorm (2010) identify that there is an increasing recognition that other frameworks and societal settings, such as sport and physical activity environments, could provide mental health support through a holistic programme whereby individuals' lifestyles and personal circumstances can be considered. The rationale behind this notion is explained well by the social determinants of health concept (Marmot and Allen 2014; WHO 2014, 2019b). Social determinants is a term used to describe the social and environmental conditions in which people are born, grow, live, work, and age, which shape and drive health outcomes (Marmot and Allen 2014). Michael Marmot, the Chair of the Commission on Social Determinants of Health suggests that wider societal factors such as poverty, education and housing play a significant role in determining an individual's health outcomes (Marmot, 2020). Acknowledging how social determinants of health can impact vulnerable populations is important when considering mental health interventions to ensure inclusivity and appropriate programme design (Dorvil and Tousignant-Groulx 2019).

In order to avoid overprescribed clinical treatment, the concept of lifestyle medicine continues to grow in popularity (Martinsen and Raglin 2007; Sarris et al. 2014). Lifestyle medicine involves the use of environmental, behavioural, and psychological values to improve both physical and mental health (Sarris et al. 2014; Morton 2018). It has been proposed that there are huge advantages to prescribing lifestyle medicine as opposed to clinical medical treatments when addressing mental health conditions through prevention and treatment (Sarris et al. 2014). A systematic review of 30 high methodologic quality studies concluded that there is encouraging evidence that physical activity, in any form, can prevent the onset of depression (Mammen and Faulkner 2013). Additional studies from Singh et al. (2005) and Blumenthal, Babyak and Doraiswarmy (2007) show that physical activity and exercise can be compared to antidepressant medications with regards to effectiveness of relieving depression symptoms. To reach this conclusion, Blumenthal et al. (2007) conducted a prospective, randomised controlled trial with 202 participants who had been diagnosed with major depressive disorder. Participants were randomly

allocated to one of four control groups: supervised exercise in a group, home-based exercise, antidepressant medication or a placebo pill for a total of 16 weeks. Following the intervention, 41% of the participants no longer met the criteria for major depressive disorder and results were comparable between patients receiving antidepressant medication (47%) and those participating in the group exercise class (45%) (Blumenthal et al. 2007).

The association between physical activity and mental health improvement is gaining recognition by several international organisations and committees, including the United Nations who have suggested that sport and organised physical activity have the capacity to facilitate and promote health, both physical and mental, at a population level (Sport for Development and Peace International Working Group 2008; International Olympic Committee; Mountjoy 2011; WHO 2011). The use of sport and organised physical activity as a means for societal health promotion has a number of positive consequences such as established and recognised health improvement, both physically and mentally (Kokko, Green and Kannas 2013; Kokko 2014). Geidne, Quennerstedt and Eriksson (2013) reviewed 44 research publications to assess the suitability of youth sports clubs as a health-promoting setting. The researchers concluded that such sport clubs do have maximum opportunity to become health-promoting settings, as long as such practices are comprehensive and applicable to the specific age-group in question (Geidne et al. 2013).

Despite this growing evidence, according to Breslin et al. (2017a), mental health and wellbeing interventions within physical activity or sport settings are largely undeveloped and are often poorly theorised. One reason to explain this could be associated with the stigma which surrounds mental health (Lavanya, 2019). Within male sporting environments, the concept of stigma can be further exacerbated through cultural and masculinist perceptions that adhere to demonstrating strength and view help-seeking, particularly for mental health, as being weak and feeble (Gorczynski et al. 2019). Furthermore, women participating in traditionally ‘male’ sports are further marginalised, stereotyped and have unequal opportunities within sport (Castadelli et al. 2019). Further reasons as to why mental health interventions lack clarity within sport and physical activity settings may be due to the sports coach’s knowledge and confidence in supporting participants’ mental health (Mazzer and Rickwood 2015a). The following section will explore the role of a coach in supporting participants’ mental health, drawing upon existing literature and themes linking the concepts of mental health and physical activity.

2.3. The Role of a Coach in Supporting Participants' Mental Health

A significant component of the association between sport, physical activity and mental health lies within the supportive and engaging role of a sports coach (Mazzer and Rickwood 2015b; Brown et al. 2017; Liddle et al. 2019a). According to the Department for Health (2014, p.35), in order to achieve positive mental health across society, we need "to look beyond mental health services into wider public services; then beyond public services into our society as a whole". At present, the high prevalence of mental health stigma and low levels of mental health literacy within sporting environments and across wider society, are largely correlated with a lack of recognition and support for mental health illnesses (Jorm 2012). As a result of this inverse relationship, Haggerty et al. (2019) suggests that support for mental health conditions, including those amongst physical activity settings, will increase as individuals develop mental health literacy and subsequently, reduce levels of associated stigma. Due to these patterns of results, research confirms that there is an increasing requirement to design and utilise training programs which tackle the stigma associated with mental health, develop mental health literacy and increase the confidence of dealing with mental health conditions (Dew et al. 1991; Kelly et al. 2011; Jorm 2012; Haggerty et al. 2019). There is a substantial requirement for these improvements to occur amongst social support systems such as sport coaches, community workers and teachers who regularly interact with children and young people (Kessler et al. 2005).

Although children and young people are less likely to autonomously seek help for a mental health condition, research indicates that they are more likely to be persuaded into seeking help if a significant other advises to do so (Dew et al. 1991; Kohn et al. 2004; Jorm 2012). A study conducted by Duffy, Rooney and Matthews (2019) investigated 296 Gaelic games coaches' mental health literacy, perceptions of their role, and how these factors influenced their engagement in supportive behaviours for young people's mental health. The research study involved coaches completing an online survey, of which results indicated that developing a coach's knowledge and competence will help to increase their belief and confidence surrounding adopting helping behaviours within the sporting environment (Duffy, Rooney and Matthews 2019). The research study goes on to further define promotion, prevention and early intervention behaviours. Promotion type behaviours involve encouraging positive attitudes towards mental health and wellbeing, such as establishing holistic inclusivity and mental health literacy (Duffy, Rooney and Matthews 2019). Prevention behaviours aim to decrease specific risk factors towards mental health, such as stigmatisation and victimisation (Duffy, Rooney and Matthews 2019). And finally, early intervention behaviours encompass the previous two behaviours through initial detection and action

towards mental health illnesses, through support and referral to appropriate professional help (Haggerty and Mrazek 1994; Duffy, Rooney and Matthews 2019). This study provides the basis of how inspiring sports coaches to adopt such behaviours and equipping them with the necessary knowledge and skills, could make a considerable difference to the support participants receive for their mental health.

Research conducted by Ferguson et al. (2019) aimed to examine the understanding of mental health from the perspective of 20 Australian sports coaches. The research methodology included 5 focus groups based upon 5 different sports. Coaches identified that the promotion and support of their participants' mental health was as one of the many roles they possess. The participants stated that they often played the role of a; mentor, educator, confidant and motivator. There were slight conflicts of findings between the 20 Australian coaches with some stating that it was not within a sports coach's role to intervene with mental health problems, but they were however happy to take part within the referral processes. Given adequate training and support, the general consensus remained that coaches recognised their role in supporting participants' mental health. A similar consensus was determined within the research study by Liddle et al. (2019a), whereby the coaches perceived their role to be miscellaneous and to include the promotion of their participants' mental health and wellbeing. These results are consistent with previous academic research findings which also convey that coaches perceive their role as a gatekeeper for supporting and promoting their participants' mental health (Vella, Oades and Crowe 2011; Mazzer and Rickwood 2015b; Brown et al. 2017).

These studies begin to highlight how within physical activity and sporting environments, a coach is ideally positioned to be a supportive adult towards their participants (Liddle et al. 2019b). Participants, parents, and coaches themselves have all acknowledged within recent academic studies that community coaches have the potential to positively support participants who are experiencing mental health conditions due to the relationship and rapport in which they build (Mazzer and Rickwood 2015b; Brown et al. 2017; Swann et al. 2018; Ferguson et al. 2019). The study conducted by Duffy, Rooney and Matthews (2019), investigating Gaelic games coach's mental health literacy and role perceptions further concluded that coaches deemed themselves as a significant figure and gatekeeper in further developing mental health support for children and young people. Donovan et al. (2006) add that coaches hold a position of authority which involves a high degree of responsibility and duty of care towards the participants they work with in the setting of physical activity and sport. Furthermore, coaches formulate a level of trust and informal

relationships with their participants, building a rapport and accommodating a caring, supportive network (Duffy, Rooney and Matthews 2019).

According to Mazzer, Rickwood and Vanags (2012), a coaching environment, alongside a strong foundation of rapport, allows adolescents to become more relaxed and ready to discuss mental health problems and seek support. The concept of rapport between a coach and participant is displayed within qualitative research conducted by Brown et al. (2017). To investigate parental views regarding the role of a coach in supporting participants' mental health, Brown et al. (2017) interviewed 22 parents of adolescent males. Four overarching themes emerged including: communication, support, relationships and awareness, with the ultimate finding suggesting that parents felt a coach would be effective in promoting the state of positive mental health: reaching potential, coping with the stresses of daily life and working effectively (Vaillant, 2012). Some participants in the study commented that the effectiveness would depend on the coach's level of competence in the four themes identified (Brown et al. 2017).

Research from Swann et al. (2018) also investigated perceptions of the coach's role in supporting participants' mental health. In comparison to research by Brown et al. (2017) which considered parental views, Swann et al. (2018) focused upon the thoughts of 55 adolescent males through the use of focus groups. Following analysis, findings concluded that the majority of participants deemed sport to be an effective tool in supporting mental health and they specifically stated that coaches are a key supportive figure. Through encouraging open conversations, normalising mental health conditions and challenging mental health stigma, Duffy, Rooney and Matthews (2019) suggest that the role of a coach can effectively support participants' mental health. Promoting positive mental wellbeing through engaging activities as well as recognising signs and symptoms of mental illnesses and having the competence and confidence to signpost and support participants are all ways in which a sports coach can influence the mental health of participants (Duffy, Rooney and Matthews 2019).

Despite the great opportunity to positively influence participants mental health, coaches have also highlighted feeling incapable and uneducated in how to engage with these behaviours in practice (Pierce et al. 2010; Mazzer and Rickwood 2015b; Sebbens et al. 2016; Ferguson et al. 2019). According to Kitchener and Jorm (2008), influential individuals such as teachers and coaches recurrently lack the skills, knowledge and confidence relating to mental health literacy and support. Kitchener and Jorm (2008) further propose that adults in roles such as teaching and coaching, who are not directly associated with

the mental health workforce, lack the knowledge and confidence in discussing or referring adolescents to professional mental health support. When combining the research outlined so far, it is clear that appropriate and effective training courses are required to develop sports coaches' mental health literacy and confidence in supporting participants mental health (Mazzer, Rickwood and Vanags 2012; Brown et al. 2017; Duffy, Rooney, Matthews, 2019). One such training course is the MHFA programme designed to tackle the issues highlighted above such as limited mental health literacy, associated stigma and a lack of confidence amongst practitioners (Kitchener and Jorm 2002; Kitchener, Jorm and Kelly 2016; 2019). Following completion of such training courses, sports coaches could hold the potential to be a valuable, suitable and effective source of providing initial support to individuals regarding their mental health. The following section will critically review existing academic literature which has assessed the effectiveness of the MHFA training within varying societal groups.

2.4. The Effectiveness of MHFA Training

MHFA training is an evidence-based public education programme designed to improve mental health within society by reducing mental health stigma; increasing mental health literacy and developing individual's confidence in providing help and support (Jorm 2000; Kitchener and Jorm 2002; Kitchener, Jorm and Kelly 2016; 2019). The MHFA training programmes include engaging, reflective, thought-provoking activities around mental health stigma and mental health literacy. Once the training is completed, the individuals are referred to as mental health first aiders (Kitchener, Jorm and Kelly 2012; 2016; 2019). The MHFA training course has been investigated in a number of academic research articles, focusing upon a range of sectors and population groups. Due to the rising issues of mental health across society, it has been recognised that MHFA training is required amongst the general public as well as amongst specific roles and practitioners. A cluster randomised trial conducted by Jorm et al. (2004) aimed to measure outcomes relating to knowledge of mental illnesses and confidence and application of supporting people. 753 participants who were members of the public in Australia were randomly allocated to a training group of the MHFA course. The results showed that the training significantly increased the participants' knowledge and understanding regarding various mental health conditions, as well as improving their confidence in helping and supporting others. The study begins to highlight how the MHFA training can effectively improve an individual's knowledge and confidence surrounding mental health.

A similar study also investigating the general public's perceptions of the MHFA training in the workplace was conducted by Kitchener and Jorm (2004). A randomised control study was completed in Canberra,

Australia with 301 participants who were randomly allocated to either an immediate course or a 5-month waiting list. Following analysis of the pre-test and follow-up questionnaires, results displayed similar findings to Jorm et al. (2004) suggesting that numerous benefits were gained such as greater confidence and decreased stigma towards mental health. However, an additional finding not detected in the research conducted by Jorm et al. (2004) linked to the enhancement of the participants' own mental health. This could be due to the MHFA training involving many reflective practical and scenario-based activities which encourage participants to understand and engage with their own mental health and wellbeing. A concluding finding from Kitchener and Jorm's (2004) research study highlights how the MHFA training course is highly applicable to a wide range of groups and settings within society.

Another research study by Kelly et al. (2011) specifically focused upon the YMHFA training course for adult members of the Australian public. An uncontrolled trial was conducted with 246 adults to measure their "recognition of schizophrenia or depression; intention to offer and confidence in offering assistance; stigmatising attitudes; knowledge about adolescent mental health problems and also about the Mental Health First Aid action plan." (Kelly et al. 2011 p. 1). These outcomes were determined through a questionnaire both before attending the YMHFA course, one month after and six months after completion. The main findings showed improvement in all outcomes, with most results preserved and sustained at follow up. The above findings help to display the effectiveness of the MHFA training courses within multiple settings across Australia and help to develop the evidence as to why these courses should be employed on an international scale.

An additional sector of society which has also seen academic research reviewing the effectiveness of the MHFA training course is within rural communities and farmers. Sartore et al. (2008) assessed the success of the MHFA training within communities affected by drought in Australia. This was recognised as an important sample group as farming communities are largely subject to poor mental health and isolation (Page and Fragar 2002). Surveys were conducted with 99 participants before and after the completion of MHFA seminars. The surveys sought to discover knowledge and confidence in dealing with mental health, as well as attitudes and the perceived impact of the training. Participants' capability of identifying and supporting common mental health illnesses was found to increase, alongside their confidence, following the MHFA training. A similar study was conducted by Hossain et al. (2009) to improve the mental health literacy of Advisory and Extension Agents, who often work closely with rural farmers. A questionnaire was completed by the participants both before and six months after the MHFA training, also concluding that

the training successfully enhanced the participants ability to provide support and notice significant mental health symptoms (Hossain et al. 2009).

Another significant field in which MHFA training effectiveness has been assessed and investigated is within the education environment. Jorm et al. (2010) conducted a cluster randomised trial with teachers from 7 high schools across South Australia. The methodology was very similar to the Jorm et al. (2004) research study, whereby pre and post-training questionnaires were used to assess knowledge, confidence and stigma. However, Jorm et al. (2010) went on to further assess school policy and teacher's mental health. The results again demonstrated the effectiveness of the MHFA training via increased confidence and reduced perceptions of stigma. However, a significant development within this study relates to how the MHFA training did not increase the likelihood of the teachers directly supporting individuals with mental health problems. This finding could be due to a number of varying factors including the MHFA training insufficiently providing the teachers with the appropriate skills to practically support their students. Therefore, it can be concluded that the MHFA training increased the teacher's knowledge and confidence to a certain degree, but not enough to fully enforce behaviour change and implement new practice (Jorm et al. 2010).

A recent systematic review conducted by Sánchez et al. (2020) reviewed eight studies which all investigated the YMHFA training course for educators within school settings. Through the analysis of the eight relevant studies, conclusions were made suggesting that the YMHFA training improved the educator's youth mental health literacy. However, it is important to note that there were several limitations to the research studies which can be critiqued. These include a lack of long term follow ups, cultural considerations and limited control groups. These limitations undermine the full extent of the YMHFA training's success and effectiveness. Despite this, Sánchez et al. (2020) conclude that the strategies, skills and awareness obtained from the YMHFA training course develops and assists educators to effectively support adolescent's mental health. Sánchez et al. (2020) identify that future longitudinal research is required in order to determine the long-term effects of YMHFA training on educators.

A current study investigating a unique application of the MHFA training course has been conducted by Crone et al. (2020). The researchers investigated differences in knowledge, confidence and attitudes surrounding mental health following completion of a MHFA course, across the UK Armed Forces. This mixed methodology research study involved quantitative surveys both immediately after the training (*n* =

602) and 10 months from completion (*n* = 120), as well as qualitative telephone interviews (*n* = 13). Quantitative results indicated that participants' knowledge and confidence increased following the training, which was maintained at the 10-month review. The qualitative findings exposed that participants felt they could adopt an “ambassador” type role with regards to mental health and wellbeing within the UK Armed Forces. Similarly to the previously outlined studies, the fundamental finding from the study conducted by Crone et al. (2020) was that participants felt an increase in knowledge and confidence to support people who may be suffering with their mental health. The researchers suggest that an initiative such as the MHFA training course can significantly support personnel within the UK Armed Forces.

The findings highlighted within the research studies above indicate that the MHFA and YMHFA training courses have been successfully applied within a diverse range of sectors. A sector which lacks thorough investigation is the community sport and physical activity environment. One study which has considered MHFA training amongst sports coaches and club leaders was conducted by Pierce et al. (2010) in an Australian community football club. Through a mixed methodology approach, questionnaires and focus groups were employed to assess both club leaders (*n* = 36) and club players (*n* = 275) attitudes towards depression, as well as their understanding of treatment and recognition of mental health symptoms. The quantitative findings concluded that over 50% of club leaders who completed the MHFA training course displayed increased ability to identify mental illness. A further 66% reported enhanced confidence in responding to mental health challenges. Within the qualitative findings, coaches reported that the MHFA training had built upon a foundation of knowledge and skills which they already held, empowering them to support their participants' mental health. However, it is important to note that within this research study the club’s players did not recognise significant changes to club leaders’ behaviours or attitudes which in turn displayed concerns regarding the effectiveness of club leader’s behaviour change. Despite this, Pierce et al. (2010) concluded that the sport and physical activity setting remains a positive environment to improve mental health awareness. Pierce et al. (2010) strongly advise that due to the lack of research within the field of sport and physical activity, further rigorous studies must be conducted to draw firm conclusions.

To summarise, this literature review provides a clear rationale for the present research studies aims and focus which relate to understanding the perceptions of community sports coaches' role in mental health support as well as their experiences of the MHFA training course. The majority of previous studies, which have been evaluated within this chapter have taken a quantitative psychological stance, focusing upon

various sectors within society. As mentioned previously, there is limited research within the field of sport and physical activity. Therefore, there is a clear research gap for a qualitative study exploring MHFA training within the sport and physical activity environment, specifically gaining an insight into community sports coaches' thoughts and perceptions. The following chapter will draw upon Figurational Sociology and further explore concepts such as, power balances and habitus, in order to provide a theoretical perspective to the current research study.

Chapter 3

Theoretical Framework: Figurational Sociology

In accordance with Bloyce et al. (2008), Figurational Sociology has become a popular theoretical framework to be applied within the sociology of sport and physical activity. Furthermore, it has been noted by Waddington and Malcolm (2008, p.3) that the work of Eric Dunning alongside Elias's own writings on sport, "have helped to establish Figurational Sociology as a particularly influential theoretical framework within the sociological study of sport". However, Figurational Sociology has not yet been used to explore community sport coaches' perceptions of their role in supporting their participants' mental health. According to Malcolm (2008, p.261), "the maturity of Figurational Sociology is now such that we can move away from extended theoretical re-statements and assume that such information is readily available elsewhere" (see, for example, Mennell 1992; van Krieken 1998; Murphy, Sheard and Waddington 2000).

The following chapter will provide a brief overview of Figurational Sociology, and the way in which it will be utilised within this research study to explain the ways in which community sport coaches perceive their role in supporting their participants mental health. This chapter will present the ideologies and concepts that form the foundation of the theoretical framework, Figurational Sociology. More specifically, this will incorporate the Figurational Sociology concepts such as power, interdependencies, figurations and habitus, and intends to demonstrate how such concepts may provide further insight and perspective around the area of community sport coaches and mental health within sport and physical activity. Roderick, Smith and Potrac (2017) convey that, until quite recently, sociologists of sport have generally disregarded mental health and therefore overlooked how sociological insights could positively be applied to investigate sport, physical activity and mental health. Within this chapter the concepts are presented under separate headings and sections, however, it is important to highlight that this is simply for structural

and organisational purposes and that they are in fact considered to meaningfully overlap and interconnect with one another.

3.1. Introduction to Figurational Sociology

Figurational Sociology or as it is sometimes called, process sociology, derives predominantly from the work of the German sociologist Norbert Elias (1897-1990) (see Elias 1978, 1987, 1994, 2001a, 2001b). Figurational Sociology involves multiple notions which investigate the system of relationships between individuals and their environment (Elias 1978). Malcolm and Mansfield (2013) describe and summarise the fundamental principles of Figurational Sociology as long-term processes of change in which diverse, shifting and ever changing interdependent relations and balances of power exist within social life. According to Elias (1978, p.17), sociologies principal goal is to "enlarge our understanding of human and social processes and to acquire a growing fund of more reliable knowledge about them". Within the book "What is Sociology?", Elias (1978, p.14) stated that there is a "naive egocentric" understanding of society, and that it is this view that requires alteration. For instance, Elias (1978) implied that it was not beneficial to view "the individual" and "society" as separate or independent, but actually refers to the two concepts as "inseparable levels of the same human world" (Murphy, Sheard, and Waddington 2000, p.92). Elias strongly believed that focusing upon an individual as being independent of others (process-reduction) fails to acknowledge the many fluid relations and experiences people share within civilisation and therefore is not a holistic understanding of the term "society" (Elias 1978; Murphy, Sheard and Waddington 2000). Elias (1978) argued that individuals are "interdependent" with each other, conveying that people's lives develop as part of the "figurations" they form. This concept conveys the notion that Figurational Sociology aims to focus upon homines aperti (perceiving people as bonded together in "dynamic constellations" or "figurations") rather than homo clausus (viewing individuals as self-contained and separate from others) (Elias 1978; Murphy, Sheard and Waddington 2000). According to Roberts (2009, p.75), Figurational Sociology is a process that "starts with an individual or group, or form or behaviour, then maps into the surrounding, constantly changing, figuration of which it is a part". As this research project aims to explore the ever changing relations between community sport coaches, their participants and their environment, Elias' concepts of figurations, power, interdependencies and habitus were applied. As all relationships are relations of power, to understand community sport coaches' role in supporting their participants mental health, Elias' concepts of interdependence provide the opportunity to examine fluctuating power balances in a socio-cultural setting (Dunning and Hughes 2013).

3.2. Figurations and Interdependencies

This section focuses upon two key concepts of the figurational approach, which are figurations and human interdependencies. According to Murphy, Sheard and Waddington (2000) the key central concept of Figurational Sociology, naturally, is the notion of "figurations" itself. A figuration, as described by Elias (1978, p. 261), is "a structure of mutually orientated and dependent people". Elias (1978) applied the principal notion of the "figuration" to convey the complexity of social relationships within society. Jones, Tones and Foulkes (2020) described figurations as complex arrangements of interdependent relationships which are established between both individuals and groups within society. While any figuration is unique and has a particular order and structure, the individuals within that figuration align themselves in certain ways because of their interdependent relationships (Elias 1978). However, Elias (2009) implied that figurations are in a constant state of flux and change, for example, as individuals grow and develop, their social groups and interactions will alter in accordance with varying factors such as education, employment and hobbies. Consequently, there is a continuous need to examine the figurations within society as we cannot assume that once a figuration has been studied that it is then "understood" or "known" (Williams, Pill and Hewitt 2020). Elias (1978) conveyed that people are a strong part of their figurations, even though they lack individual control. Subsequently, this impacts social behaviour as individuals do not act independently but rather their opinions and actions are controlled by other people within their figurations (Green 2002). Therefore, in accordance with Dunning and Hughes (2013) human behaviour can be more amply understood when it is observed and investigated through the lens of interdependent relationships which individuals and groups have with one another within these figurations.

In accordance with Elias (1978), within figurations are interdependencies. Elias' (1978) applied the term interdependence to help explain the two-way links and connections between people centred around power balances. The notions of figurations and interdependencies are aligned closely with the concepts of the "unplanned processes" and "power balances", which will be discussed subsequently in this chapter. According to Dunning and Hughes (2013), people can be linked to one another through a variety of different forms of interdependencies such as emotionally, financially, through status or information. Elias (1978) believed that the mutual dependencies between people within the social world indicate that people are inseparably connected and exist as pluralities and in figurations. Elias' notion of interdependencies aspires to move away from observing people as detached or isolated from one another

and instead are inextricably linked together (Elias 1978). Elias' notion of figurations also proposes that interdependencies force restraints and restrictions on individual's behaviour (van Krieken 1998). In simple terms, an individual's actions have a ripple effect upon others due to people being inherently linked and connected through their interdependencies and figurations. In accordance with Dunning and Hughes (2013), when applying a figurational perspective, people are best understood or comprehended by observing and investigating the relationships they have with other people. For Elias (1987, p.79) one of the main goals of a sociologist is "to explore and to make people understand, the patterns they form together, the nature and the changing configuration of all that binds them to each other". Elias (2001a) added that in order to understand the combined social unit or the individual, the relationship between the two must first be examined and analysed. This is further supported by van Krieken (1998) and Dopson (2001) who summarise that social phenomena are most effectively examined through the interdependencies between people.

This research study will explore how community sports coaches are interlinked within their surrounding figurations and interdependencies, moving away from categorising them as singular or individual (Elias 1978). Community sports coaches' perceptions and experiences can only be truly understood when considering them as part of their interdependent relations within their social world. In the context of this research study, this relates to the coach's participants, other coaches, national governing bodies, the parents of participants and additional significant others within their figurations. Throughout this research, understanding the networks which surround sports coaches will help to highlight the association and ability for the community sports coaches to influence their participants mental health, whether this be advantageous or restricting.

3.3. Habitus

The following section will focus upon a further concept within Figurational Sociology, the concept of habitus. According to Dunning (2002, p.214), Elias believed habitus represented peoples' deeply ingrained second nature or their "embodied social learning". van Krieken (1998, p.55) implied that figurations are "characterised by socially and historically specific forms of habitus, or personality structure". A person's habitus develops within the diverse range of figurations and social interdependencies of which they are a part (Elias 1978). Elias (1994, p.137) implied that habitus is associated with an "automatic self-restraint, a habit that, within certain limits, also functions when a person is alone". Elias further suggested that a person's habitus can change and develop within their figurations, however it is important to highlight that

this is a slow process and can only be attained by building upon already existing dispositions (Dunning 2002). Additionally, habitus can be understood as,

> The durable and generalized disposition that suffuses a person's action throughout an entire domain of life or, in the extreme instance, throughout all of life − in which case the term comes to mean the whole manner, turn, cast, or mold of the personality (van Krieken 1998, p.47).

In accordance with Fletcher (2013), the development of an individual's habitus stems from within their figurations and the process of socialisation as individuals learn the norms, values and behaviours assigned to these social groups. For Elias, habitus compromised of an individual's temperament where actions and behaviours were a result of internal understandings or second nature principles (Paulle, van Heerikhuizen and Emirbayer 2012). According to Fletcher (2013) and van Krieken (1998), habitus is socially constructed due to people acquiring these dispositions through their everyday experiences and relationships with other people. Elias believed that a person's habitus develops continuously over a lifetime due to the ever-increasing and changing social interactions within increasingly dynamic figurations (van Krieken 1998). However, Elias considered this long-term process to be particularly influenced within the life stages of childhood and youth where a deep-rooted personality structure can first be established (Green 2003). Therefore, the community sport coaches' early experiences may be useful in understanding their deep-rooted dispositions around coaching and supporting their participants' mental health. However, a person's habitus does continually develop over the lifecourse and is considered as an ongoing process which is influenced and adapted over time via changing interdependencies (Elias 1988, 1994; van Krieken 1998; Alfrey and Gard 2019).

3.4. Unplanned Processes and Power Balances

This segment centres around two further concepts of Figurational Sociology, the unplanned processes and dynamic power balances within social figurations. In accordance with Maguire (2011), the longstanding developments residing from human figurations are for the most part unplanned and unanticipated. Elias (1987, p.99) argued that the unintentional results from within figurations are "blind social processes" and should be perceived as normal characteristics of daily human social relationships. van Krieken (1998) further conveys that the blind social processes are not intended by any individual, group or network. Due to the intricacy and dynamic nature of human figurations, especially long-term relations, outcomes frequently occur that no individual within the figuration chose or designed (Elias 2001a). Therefore, this

research study will aim to investigate both the intended and unintended outcomes of the community sport coaches' figurations. Community sport coaches are interdependent with other coaches, teachers, their participants, national governing bodies, and many others in and amongst their figuration. This will in turn lead to various intended and unintended outcomes which then affect the sports coaches themselves. For example, the governing bodies who develop campaigns and initiatives around sport and physical activity, which affect the community sport coaches lives, are not in direct control of the coaches or their participants but the results of the unintended outcomes of the intended acts affect all parties involved.

Elias (1978) utilized the term "power balance" to explain how he understood power as being fluid or in a constant position of change rather than a fixed permanent state. Power is a dynamic aspect of relationships within Figurational Sociology, which overlaps and interconnects with the previously discussed concepts and is closely linked to unplanned processes (Elias 1978). The systems and networks of social relationships that are formed within society are perceived by figurational sociologists as both fluid and multifaceted (van Krieken 1998). For example, the individuals and groups involved will differ and alternate, alongside the change in nature and strength of the bonds holding them together (van Krieken 1998). Elias (1978) implied that certain individuals will have larger quantities of the resources that are needed by others. It is this central dimension of figurations or dynamic interdependencies which Elias believed led to the power connections that occur within social groups. According to van Krieken (1998), one of the main examples of the fluidity previously spoken about within figurations and interdependencies is the constantly altering dynamic power balances within social life. van Krieken (1998) further conveys that social power is not something that one individual or group possesses, and others do not, but rather it exists relatively. Therefore, whilst power is a fundamental characteristic of human relationships, it is never absolute. In addition, Elias (2001a, p.52) concludes that if,

> The social power of people or groups in the same social area is exceptionally unequal, if socially weak and low ranking groups without significant opportunities to improve their position are coupled to others with monopoly control of far greater opportunities of social power, the members of the weak group have exceptionally little scope for individual decision.

The fluctuating balance of power within a figuration can be both enabling and constraining within the social world of human relations (van Krieken 1998; Malcolm 2018). Figurational sociologists perceive the

various relationships between people by contemplating the dynamic and multifaceted divisions of power within a figuration (Maguire 2005). For example, it can be assumed that within the figurations of community sport coaches, various layers of power balances exist. The power balance between a coach and their participants, as well as the power a national governing body holds, is continuously in flux due to numerous factors and higher or lower power ratios (the amount in which power is shared between different groups in the hierarchy) can be possessed at different times. The power within these social relations must be understood as being both enabling and constraining. Within this research study, Figurational Sociology will be utilised in an endeavour to emphasise the sheer complexity of the power relationships within the community sport coaches figurations.

Elias (1978) implied that power involves varying balances, stating that no one person or group ever has absolute power or is powerless, but it is more or less unevenly distributed throughout the figuration. The concept of game models was used by Elias (1978) to help explain and highlight the ever changing dimensions of power in human relations comprising of various numbers of people (Maguire 2005). Elias (1978) suggested that the game is more complex with a greater number of players and that as these chains of interdependency lengthen the ability for an individual, or group of individuals, to control the figuration lessens, and unintended outcomes transpire. Where chains of interdependency are extended within greater and multifaceted figurations, the power differences amongst individuals and groups are decreased (Green 2000). Within the book “What is Sociology?”, Elias (1978) demonstrated varying game situations to illustrate the power relations within such games, with more simple games between two people and more complex games involving several players. It is important to highlight however that even within the simplest of games, no one player can wield complete control. Although Elias (1978) does suggest that whilst the control is not complete, the direction of the game can be largely determined. In accordance with Law and Bloyce (2019), game models as a concept has been utilised and applied in a limited number of cases. Therefore, within this research study Elias’ concept of game models will be applied to investigate the fluctuating dimensions of power between a sports coach and their participants.

Within this chapter, a number of concepts stemming from the theoretical framework of Figurational Sociology have been explored including figurations and interdependencies, the unplanned processes and power balances, as well as the concept of habitus. The fundamental notion of Elias’ work is that people exist within their relationships with others, therefore in order to study and fully understand social behaviour, the context of figurations should be applied (Jones, Tones and Foulkes 2020). The outcomes

of human relations are often unplanned and unintended due to the complex networks and interdependencies where power balances are often changing and developing over time (Elias 1978; Dunning and Hughes 2013). It has been conveyed that a figurational viewpoint may help provide a more sufficient investigation and examination of the community sports coaches and their role in supporting participants' mental health. This should provide a framework in order to consider, investigate and more adequately understand how the sports coach's actions are enabled and/or constrained through their interdependence with others.

Chapter 4

Research Methodology

The aim of this chapter is to explain and examine the methodological approach to this research study as well as discuss the rationale of the chosen methods. The chapter includes subsections in order to efficiently discuss the philosophical orientation and design; the participants; data collection; reflections of using interviews; ethical considerations and data analysis.

Research methodologies are an integral part of the research process as they shape the foundations of all research projects, establishing the rationale, style and design (Corbetta 2003; Trochim and Donnelly 2007; Kumar 2014; 2019). Qualitative and quantitative are the two leading approaches when conducting research (Tariq and Woodman 2013; Neuman 2014; Bryman 2017; Veal 2018; Kumar 2019). Qualitative research observes and investigates perceptions, thoughts and experiences to develop comprehensive findings (Cronin, McCarthy and Collins 2014; Gratton and Jones 2015). Qualitative research aligns with the interpretivist paradigm, the focal point of the interpretivist paradigm concentrates upon investigating and exploring the social world through determining individuals' thoughts, perceptions and feelings around a specific topic in order to acquire meaningful comprehensive data (Kumar 2014; 2019; Gratton and Jones 2015; Creswell and Poth 2016). Qualitative approaches have a tendency to produce non-numerical data, through the use of methods such as semi-structured interviews and focus groups (Tariq and Woodman 2013). Conversely, the quantitative approach is founded by the philosophy of rationalism, this follows a rigid and structured set of procedures and focuses upon quantifiable statistics and factual data (Kumar 2014; 2019). The quantitative approach provides an objective, statistical and deductive style which is effective in research studies aiming to quantify data and draw generalisable conclusions (Bryman 2017). The quantitative approach is underpinned by the ontological stance of positivism which follows a rational, objective and deductive approach to research which is directed via hypotheses (Davies and Hughes 2014;

Brown 2015). Quantitative research, for example a clinical trial or observational study, tends to generate numerical data (Tariq and Woodman 2013).

4.1. Philosophical Orientation and Design

Ontology is a branch of philosophy concerned with the nature of reality (Bryman, 2008). Epistemology is a branch of philosophy concerned with the nature of knowledge (Bryman, 2008). Due to the topic area and identified social issue, this research study adopted an ontological stance which was underpinned by interpretivist philosophical assumptions (Kumar 2014; 2019). The interpretivist paradigm is regularly used within qualitative research which allows for the collection of in-depth, meaningful data to examine the participants views, thoughts and perceptions surrounding a social phenomenon (Gratton and Jones 2004; Sandelowski 2004; Kumar 2014; 2019; Lewis 2015; Thanh and Thanh 2015). This research study adopted a qualitative approach focusing upon analysing emerging themes and patterns from the participants' views and opinions surrounding the topic area (Spencer and Ritchie 2002; Huberman and Miles 2002; Hennink, Hutter and Bailey 2011; Maxwell 2012). The qualitative research design adopted is also compatible with Figurational Sociology (Baur and Ernst, 2011). The qualitative research design focuses upon depictions of perceptions, insights and experiences allowing for a flexible and adaptable approach towards the study (Kumar 2014). Despite the many positives of the qualitative approach it can be critiqued. Gratton and Jones (2004) and Kumar (2019) have identified that the interpretation of data within qualitative research studies can be viewed as extremely subjective and it cannot be quantified as within the quantitative approach, therefore questions of reliability have been raised. Further criticisms of qualitative research are associated with a lack of validity and reliability, researcher bias and potentially and limited sample sizes (Trochim and Donnelly 2007; Kumar 2014; 2019). However, it has been argued that by collecting rich, in-depth data through thoughts, feelings, ideas and beliefs, a deeper interpretation of data collected can occur (Gratton and Jones 2004; Silverman 2013; Kumar 2014; Sparkes and Smith 2014; Jones 2015).

In parallel with other qualitative research investigating within the field of mental health and community sport (Coyle, Gorczynski and Gibson 2017; Hurley et al. 2017; Ferguson et al. 2019), this research study embraces the interpretation of reality being subjective and socially constructed (Smith and Caddick 2012). Consequently, knowledge is socially constructed and subject to various interpretations and mediated by values and principles (Ferguson et al. 2019). Like Coyle, Gorczynski and Gibson (2017) and Ferguson et al. (2019), this research study sought to investigate and explore the subjective perspectives and

interpretations of mental health awareness within the social context of community sport coaches and their participants. As acknowledged within preceding research with relatable intentions, the implementation of a qualitative research design was advantageous as it developed rich and detailed responses from the participants (Coyle, Gorczynski and Gibson 2017; Ferguson et al. 2019). More specifically, this research study strived to explore how community sport coaches distinguish their role within the support of their young participants' mental health and their preferences towards mental health awareness training courses. Within research, it is exceedingly important for the empirical data to be sufficiently informed and supported by an appropriate theoretical framework. The capacity of a research study to successfully highlight the area or topic being investigated is predominantly dependent upon a delicate balance between the theoretical approach(es) being applied and empirical rigour (Bloyce and Murphy 2008). Bloyce and Murphy (2008, p.120) further state that:

> When one's theory is insufficiently constrained by the available evidence, it runs the risk of becoming idle, albeit perhaps, interesting speculation. When empirical research is insufficiently informed by theory, it runs the counter-danger of becoming an exercise in fact gathering, albeit perhaps interesting fact gathering.

Therefore, a research project should incorporate a varied blend of both theoretical orientation and empirical rigour and this research study will endeavour to achieve and attain this throughout. According to Elias (1987, p.20), from a figurational perspective the process of conducting research should incorporate "two-way traffic", by both examining current prevailing explanations and producing first-hand original ideas directly from the raw data. Bryman (2016) suggests that when this is achieved, a progressive step forward can be made, moving away from simple descriptive accounts towards developed explanations of experiences.

4.2. Participants

The research study included 16 participants for the individual semi-structured interviews, the participants consisted of five female and eleven male and ranged from 18-65+ years of age. The 16 participants were all community sport coaches who had undergone mental health awareness training, these participants stemmed from networking connections with the partners of the #21by21 campaign and coached a wide range of sporting or physical activities such as football, yoga and tennis (see Appendix A for a full list). The community sport coaches were located across the UK, ranging from the North East of England and the

South of Wales. The sample size was determined to allow for sufficient relevant, meaningful data to be collected whilst remaining realistic and achievable. At this stage of the research process, the thoughts and opinions of the participants concerning their perceptions of mental health awareness training were undetermined, therefore considerably heightening the reliability of the research study (Bryman 2016).

The sampling methods which were adopted within this research study were a collaboration of criterion-based sampling and snowball sampling (Emmel 2013; Ritchie et al. 2013). The criterion-based sampling approach was grounded by the criteria of participants having undergone a mental health awareness course stemming from the #21by21 campaign (Sparkes and Smith 2014). Further to this the community sport coaches must have utilized the training for a minimum of two months. This was important as it gave the participants time to fully digest and apply their learning before being questioned about their thoughts surrounding the course. Without having this two month period, comprehensive data collection from the participants that was contextually reliable and representable would not have been guaranteed: the participants had a truthful understanding of the research focus when interviewed (Bryman 2012). Snowball sampling occurred as several participants assisted in networking and recommending other potential participants who met the requirements of the criterion-based sampling approach (Ritchie et al. 2013).

4.3. Data Collection

Following the obtainment of ethical approval, participants were contacted via email with all the relevant information and recruited to participate within the research study. Due to the nature of the research topic, sensitive issues regarding individuals' attitudes and feelings were treated with care and consideration throughout the collection of data (Dickson-Swift et al. 2007). The collection of data was organised to take place within a suitable environment in order to not influence or affect the participants' responses (Flick 2009). Within this study the data collection was completed through individual semi-structured interviews as they allowed for participants to provide rich, detailed responses (Flyan 2005; Kumar 2019). The first five interviews were conducted face-to-face with participants in a neutral environment. However, due to the unprecedented coronavirus pandemic and social restrictions, the remaining eleven interviews were conducted on virtual platforms, such as Zoom and Microsoft Teams.

Semi-structured interviews were considered as the most viable and suitable method of data collection in order to encourage discussions between the participants and the researcher around the topic area of

mental health within sport (Ferguson et al. 2019). This approach was selected as it can provide rich, detailed, comprehensive data by enabling the participants to communicate, reflect, and converse openly a varied range of ideas and opinions (Harwood, Drew and Knight 2010; Sparkes and Smith 2014; Gratton and Jones 2015; Creswell and Poth 2016). Semi-structured interviews can also create a safe and secure space for the participants to articulate their views regarding the sensitive topic of mental health (Carless and Sparkes 2008).

Flyan (2005) asserts that within qualitative research, semi-structured interviews are viewed as an unequivocal means of attaining an individual's experiences, concepts and opinions around a specific matter. Due to open-ended questions used within the semi-structured interviews, there was an opportunity to be flexible and room to modify in order to further investigate underlying responses from the community sport coaches (Bryman 2016). As well as semi-structured interviews allowing the participants to provide their thoughts and conceptions in rich detail, the researcher was also able to adapt for clarification and meaning throughout the interviews (Holloway and Todres 2003; Turner 2010; Gratton and Jones 2014; Galletta 2013; Braun, Clarke and Weate 2016; Silverman 2017). The various probes which were used aligned with the probing techniques outlined by Kvale (2008). The research incorporated within the literature review informed and guided the design of the semi-structured interview, it was evident that the framework and scaffolding of the semi-structured interview supported the participants during their responses (Kumar 2014).

While there are many advantages of implementing semi-structured interviews as a data collection method, it should be acknowledged that this method can be critiqued (Hofisi, Hofisi and Mago 2014). Semi-structured interviews can often be time consuming and depend upon the interviewer's ability to conduct effective interviews (Hofisi, Hofisi and Mago 2014). According to Hofisi, Hofisi and Mago (2014), because of the high levels of flexibility within semi-structured interviews they may lack reliability. More specifically, the subjectivity and potential for the interviewer to be bias through their interactions and adaptations of questions has been a criticism for the use of semi-structured interviews. Despite these criticisms semi-structured interviews were decided upon, as if used accurately, ethically and appropriately semi-structured interviews allowed for an open, free-flowing, reliable discussion to take place whereby the researcher could interact with the participants depending upon their responses (Silverman 2013). The semi-structured interviews also allowed for an interview guide (see Appendix B), allowing the potential follow up questions and prompts to be pre-determined and used as a research tool to ensure the

responses were covering the desired topic areas (Kumar 2005; Pedersen et al. 2016). Towards the end of the interviews, the researcher checked that the participants did not want to add any further points and were thanked for their participation whilst being made aware of the debrief sheet (see Appendix C) which contained details of charities such as "Mind" which could offer support and advice if necessary. It is important to highlight however that none of the participants alluded to any such issue or concern before or after the interviews.

4.4. Reflections of using interviews

Directly after each interview, the researcher undertook a reflection of what had been said and noted down key points for later consideration. In accordance with Bryman (2016), this reflective action by the researcher assists in eradicating any potential bias within the interviews. Although the researcher was not a community sports coach, the MHFA two-day training course had been completed prior to commencing the research study. The reflective log was a method to alleviate bias potentially brought into the interviews by the researcher when comparing training courses and also provided an increased dependability and confirmability (Tracy 2013; Sparkes and Smith 2018).

Prior to the official data collection, a pilot interview was delivered in order to ensure the researcher was proficient and experienced in delivering their interview guide in a manner which avoided bias and addresses the research aims and objectives (Roderick 2003; Armour and Griffiths 2012; Ennis and Chen 2012). On reflection the data collection process was affected and altered due to the coronavirus pandemic. After reflecting upon conducting semi-structured interviews both virtually and face-to-face, it can be concluded that there are various positives and negatives to these styles of data collection. Firstly, the face-to-face interviews allowed for a stronger rapport and relationship to be built between the researcher and the participants, which was more difficult to achieve virtually. Despite the restrictive conditions of the global pandemic, the virtual interviews were still a success for several reasons. Firstly, the virtual interviews did allow for a strong rapport to be built between researcher and participant as virtual communication had become embedded into daily life: the skills required to effectively communicate virtually had been enhanced due to the national lockdown. Pursuing virtual interviews led to the attainment of a larger sample size as the participants were more readily available and willing to take part in the interviews.

The concept which Elias (1978) called "involvement and detachment" forms an essential part of conducting successful interviews. Upon reflection of the 16 conducted interviews it can be concluded that

the researcher successfully maintained a clear distinction between “involvement and detachment”. In accordance with Elias, sociological researchers can naturally become actively involved within their research as their research methods adopt a clear engagement and involvement with the figuration in question (van Krieken 1998). However, Elias argued that for the research to be ethical and gain non-biased data, researchers must adhere to a certain extent of detachment in order to observe the figuration independently (Elias 1978; Roderick 2003). Furthermore, Elias maintained that in order to achieve a high standard of rigorous research, the researcher should apply both concepts of involvement and detachment (Elias 1978). However, it is important to state that all researchers have a degree of emotional attachment and are unable to totally distance themselves from the world in which they are a part (Perry et al. 2006). Elias (1987) further acknowledges that achieving a greater degree of detachment from the research can, however, be difficult as the researchers themselves are part of society. To conclude, it is important to provide clarity that the methodology and theoretical framework underpinning this research thesis are coherently entwined with one prompting the other, the importance of both involvement and detachment were consistently applied through consistent professionalism (Roderick 2003).

4.5. Ethical Considerations

In accordance with the conduction of research, ethical considerations are extremely important as they allow for any potential issues or concerns to be raised, analysed and addressed appropriately before practical research takes place (David and Resnik 2015). All research at York St John University is conducted according to the principles identified within the universities research ethics policy. The application for ethical approval was reviewed by the School of Science, Technology, and Health Research Ethics Committee. According to Burn and Grove (1999), ethical policies are of extreme importance and must be adhered to in order to safeguard not only the participants of the study but also the researcher themselves. After receiving points of feedback, a favourable ethical opinion was obtained in January 2020 providing the research study formal ethical approval to proceed (see Appendix D). In accordance with the British Sociological Association (2007), within the participant information sheets (see Appendix E) it was clearly pronounced that the participants had the ability to withdraw from the research process at any time. Furthermore, the participant information sheet provided a clear and concise report of the relevant information, objectives and purposes of the research study in order to fully inform and notify all of the participants (Andrews, Mason and Silk 2006; Ritchie et al. 2013). Through the process of ethical considerations, confidentiality and anonymity were acknowledged as a potential ethical concern or issues due to the researcher being able to determine and pinpoint the participants identity (Oltmann 2016;

Creswell and Poth 2017). However, upon reflection the issue was analysed and addressed appropriately, pseudonyms were applied in order to safeguard the participants identities and provide anonymity (Sparkes and Smith 2014). This alteration involved editing the interview transcripts guaranteeing the extraction of identities, personal data and specific demographic information from the data. Ensuring that all of the participants' personal details and responsive data were kept fully confidential was highly regarded to avoid any unwanted exposure within the research process (Walford 2005; Kaiser 2012).

4.6. Data Analysis

Thematic analysis was the adopted method to analyse the collected data in order to correlate patterns and themes that emerge from the transcripts (Guest, MacQueen and Namey 2011). Thematic analysis is a flexible systematic technique allowing for the organisation and display of rich detailed data into sub-categories and themes (Miles and Huberman 1994; Flick 1998; 2009; Thorne 2000; Braun and Clarke 2006; Sparkes and Smith 2013; 2014; Kumar 2014). The decision to implement thematic analysis within this research study as the method of analysis was notably influenced by its increased use and prevalence within recent qualitative academic research and literature (Bryman 2016). According to Joffe and Yardley (2004), thematic analysis is an approach that positively correlates with a qualitative dataset. Due to the research revolving around a qualitative methodology and consisting of rich, comprehensive, personal data, thematic analysis directly correlated as the most suitable data analysis method (Miles, Huberman and Saldana 2013). Furthermore, according to Braun, Clarke and Weate (2016) thematic analysis is positively associated with the research study as it is linked to efficiently analyzing semi-structured interviews. Despite the numerous advantages to the use of thematic analysis there are drawbacks and critiques to this method of analysis. It is acknowledged by Braun and Clarke (2006) and Guest, MacQueen and Namey (2011) that thematic analysis can lead to concerns around reliability linking to interpretation and subjectivity. However, this remained the most appropriate and applicable means of data analysis.

To assist with the data analysis and more specifically, the six-stages of thematic analysis, the programme Nvivo 12 was utilized (Braun and Clarke 2006). Nvivo 12 assists researchers with the management and analysis of qualitative data, specifically large quantities of interview transcripts (Bryman 2016). In align with stage one of thematic analysis, the researcher immersed themselves within the data by repeatedly listening and coding the raw data in accordance with reoccurring words, phrases and initial patterns (Parker 1996; Roderick 2006a; 2006b; Platts 2012). Following this, the standard qualitative procedure of transcription was completed using pseudonyms to protect participants, and the data was stored securely.

The next two stages of thematic analysis involved coding and grouping data which shared similarities (Braun and Clarke 2006). The theoretical perspective of Figurational Sociology and Elias' key concepts, such as habitus and power, were applied by the researcher through actively thinking about their impact upon the data in order to successfully organise the data into codes. Coding with NVivo 12 made the data analysis process simpler as the researcher could effectively allocate raw data into the already established codes (Bryman 2016; Jackson and Bazeley 2019). Altogether, there were 71 codes created which included increased knowledge around mental health, negative stigma around mental health in society and sport and areas for improvement of the training course. Following the creation of these, further analysis narrowed down the codes into overarching themes whilst consistently applying key concepts of Elias' Figurational Sociology (Braun and Clarke 2006).

Stage four of thematic analysis allowed the researcher to organise the 71 codes into concise themes which aided with prioritisation of findings and maintained the research studies aims and focus. Following this, stage five and six could be performed which involved the creation of 6 sub-headings which would feed into the penultimate development of three-chapter headings (or general dimensions) within the results and discussion section of this research project (Sparkes and Smith 2018; Jackson and Bazeley 2019). This was aided by the research project supervisor's guidance and feedback to maintain credibility. The final three-chapter headings were the role of a coach in supporting participants' mental health, coaches' knowledge of mental and their confidence of application and perceptions of the mental health first aid training. In conclusion, through the use of NVivo 12 the large amounts of data collected from the interviews were more easily manageable and patterns could be identified in a quicker, sharper process (Jackson and Bazeley 2019). The following chapters will discuss the identified themes in more detail.

Chapter 5

The Role of a Coach in Supporting Participants Mental Health

The subsequent three chapters will present detailed discussions regarding the main findings from this research study. The results and discussion are significantly interconnected and therefore, they will be presented in combination of one another together with relevant academic literature and key concepts of the theoretical framework, Figurational Sociology. The 16 participants were all fully qualified community sport coaches who were both employed and worked voluntarily. They coached a wide range of sporting or physical activities and all completed MHFA training to a minimum of 'Mental Health First Aider' and some went on to complete MHFA instructor training. The results obtained from the sixteen semi-

structured interviews, surrounding sports coaches' perceptions of their role in supporting participants mental health, have been methodically presented in relation to the studies research questions and evidence acknowledged within the literature review. Three general dimensions have been developed through the process of thematic analysis in order to clearly present the obtained research findings. Through ongoing analysis of the raw data and initial codes general dimensions were generated. Respectively, the general dimensions interconnect and contain several sub-themes. Firstly, this chapter will examine the various experiences of all interviewed coaches on their role in supporting participants' mental health and will be divided into subsections due to obtaining the coaches' perceptions both before and after the MHFA training. Chapter 6 will discuss the coaches' knowledge of mental health and their confidence of application. Chapter 7 will then explore the coaches' perceptions of the MHFA training itself, including areas for future development and improvement. This chapter will begin with an examination of the coaches' perceived role in supporting their participants' mental health.

5.1. Perceptions of a Coaches' Role Before the MHFA Training

When asked questions regarding how they perceived the role of a coach linking to or being involved in supporting their participants mental health before they underwent the MHFA training, the coaches provided mixed responses. The majority of participants' first responses centred around how they supported their participants by creating safe and fun environments within their sessions as well as presenting themselves as a positive role model. It is well supported within literature that in addition to the principal role of coaching being training and developing participants potential and instructing in certain skills, various other roles such as confidantes, role models and mentors are continuously developing (Ferguson et al., 2018; Jowett & Cockerill, 2003; Mazzer & Rickwood, 2015a). Many of the coaches interviewed explained how they strived towards being a caring and supportive character for their participants through their sport and physical activity sessions. As Alex and Hannah explained:

> *"So the role of the coach, so what I would always try and do was trying to just make sure that for that one hour, or an hour and a half, that people came to my session, it would just be so that they could enjoy, take part, have a good time, and that socially, everyone was involved as well […] the aim is just to make that experience the best as possible because I love being involved in sport and trying to share that with somebody else so you are trying to always role model positive behaviours and how you act and carry yourself." (Interview 03: Alex)*

> *"Erm I think so purely because as a coach, you're their role model, and they're someone you know, to look up to." (Interview 09: Hannah)*

These results are in line with the findings from Lebrun et al. (2020) who interviewed 11 coaches from England regarding the coaches' experiences of athletes having faced mental health issues within their sporting environment. The coaches within the Lebrun et al. (2020) study highlighted how they perceived their role to directly relate to being caring and supportive within their sessions and generally maintaining a positive role model identity for their participants. Coaches perceiving their role in supporting their participants through a more general stance within their sessions rather than directly supporting participants' mental health also aligns with Mazzer and Rickwood's (2015) study, which found that coaches identified their role as providing a positive, safe and friendly environment whereby they can encourage participants.

When questioned further regarding the role of a coach and more specifically around supporting participants' mental health, the coaches reported that their role was very limited. Typically, the coaches described how supporting their participants' mental health was deemed outside of their remit and the responsibility of other roles such as; teachers, doctors and other mental health professionals. These findings are in line with research conducted by Mazzer and Rickwood (2015a) and Ferguson et al. (2019), who found that the coaches within those studies did not perceive supporting participants' mental health as part of their role. The participants within this study highlighted how before they went on the MHFA training they did not view supporting participants mental health as a role of a coach but rather another's responsibility:

> *"It's one of those things where you think it's down to the professionals and your role your role isn't in it your role is where you don't really have one, it's kind the thought that someone else will pick that up." (Interview 01: Josh)*

> *"I didn't really think about it to be fair […] I didn't really think it was my sort of position to deal with it. And I thought it was kind of, you know, the teachers or someone else will deal with that who knew kind of what it was about." (Interview 09: Hannah)*

Many coaches described a significant difference in the generational views around mental health and the role of a coach in supporting participants, stating that older coaches will possess a varied attitude of

mental health and their perceived role. Participants stated that the perceived role of a coach will come from previous experiences of their own coaches and previous training:

> *"I do think it is like a generational thing. So, like some older coaches will just will be like very army, drill sergeant and direct well that's only because that is how it was for them so they are doing what they know and remember and mental health will not have been a part of that." (Interview 05: Patrick)*

> *"And I think depending on the sort of coach you are, maybe also the age of the coach because I think, obviously the older generation see mental health much differently." (Interview 11: Claire)*

These perceived role limits regarding supporting participants mental health could be understood as firmly established dispositions or second nature, due to previous perceptions of a coaches' role and societal views surrounding mental health. It could be argued that this aligns with the concept of habitus, Elias considered habitus to represent a person's engrained second nature or their "embodied social learning" (Dunning 2002, p.214). According to Elias (1978), an individual's habitus is dependent upon the wide range of figurations and social interdependencies of which they are a part, in this case that of a coach. The development of a person's habitus stems from within their figurations and is directly linked to socialisation, whereby people learn the norms, values and behaviours associated within these social groups (Fletcher 2013). Furthermore, van Krieken (1998, p.55) stated that figurations are "characterised by socially and historically specific forms of habitus, or personality structure". Within this research study for example, the figuration of sports coaches' will be characterised by both socially developed and historical forms of habitus therefore influencing the coaches' views, perceptions and dispositions. Elias believed this long-term process to be particularly influenced within a person's childhood and youth where deep-rooted personality structures can first be established (Green 2003). Cushion and Jones (2014) further state that absorbed values and norms during educational years can internalise behaviours and practices that lead to a specific identity. Therefore, the coaches' experiences during their childhood could account for their firmly established dispositions around the role of a coach in supporting participants mental health.

In comparison, the majority of the participants reported that they believed supporting their participants' mental health was quickly developing into a key area or role of a modern-day coach. Many of the

participant's described how they perceived mental health in previous years or generations to be disregarded or overlooked but highlighted how mental health is becoming more prevalent in everyday society and within the field of sport and physical activity. The Royal Colleges of Paediatrics and Child Health (2017) have concluded that there is a growing worldwide apprehension around mental health. Mental illness has developed into a substantial health concern, mainly due to the advancement of knowledge around the prevalence of mental health illnesses such as anxiety and depression as well as an increase in mental health reporting (Australian Institute of Health and Welfare 2017; Murray et al. 2012). The participants identified how the role of the coach is evolving and furthermore that the expectations around their role have changed over time. The data obtained aligns with the research stating that mental health awareness is developing and becoming more widely supported within society (Dewe and Kompier 2008; Australian Department of Health and Ageing 2009; Department of Children and Youth Affairs 2014). Mazzer and Rickwood (2015) identified that the role of a coach has evolved drastically over time and the continuously developing responsibilities and duties within a coach's role is now providing an increased opportunity to be a source of support for their participants' mental health. Within Mazzer and Rickwood's (2015) research study the 13 sports coaches from Canberra, Australia also highlighted that the role of a coach was changing and adapting specifically around coaches being involved in supporting their participants mental health. When the coaches' views and opinions of their role in supporting participants' mental health were explored, it was highlighted that the coaches believe that mental health awareness and support has been developing in recent years. This was explained well by John:

> *"It's getting more well known in the world of sport, but yeah, a couple of years ago, they had nothing […] I think that's the evolving role of the coach, I think many years ago, it was purely about turn up, I'm gonna make you better, go home, then the role was developed into this holistic approach to developing people into better people. So, I think now that has sort of become more of a part of the role." (Interview 10: John)*

This was elaborated further by Scott:

> *"I think more so yeah in the past few years, just because of the prevalence of mental health in everyday life, in the media, in coaching, you know, it's come out in elite sport as well. So I think that naturally you kind of feel that you are responsible for that as well, rather than just trying to put on a good enough session." (Interview 12: Scott)*

The data would suggest that perceptions regarding the coaches' role and mental health are developing in wider society and therefore influencing their own views and perceptions, which could also be linked to the concept of habitus. The responses demonstrate how the coaches' habitus is changing overtime and evolving in accordance with wider societal views around their role and mental health. From a young age, coaches are socialised through their lived experiences to perceive mental health and their role in supporting participants mental health as a social norm within the coaching environment. The obtained data demonstrates how this is becoming more apparent in recent years with the majority of younger aged participants highlighting these points. Elias argued that a person's habitus is developing continuously over a lifetime due to the ongoing social interactions within a wider range of dynamic figurations (van Krieken 1998). It is important to highlight that Elias believed this to be a long-term process; however, a person's habitus does continually develop over the lifecourse and is viewed as a never-ending process.

Another common theme which participants conversed linked to their position of leadership alongside the relationships in which they develop with their participants. According to Donovan et al. (2006), coaches hold a key position of authority involving high levels of responsibility and a duty of care towards the participants they work with. When asked if the coaches believed that they have a key opportunity to positively impact their participants mental health, a large percentage commented that they are in a substantial position due to a strong rapport or significant relationship with their participants. Coaches typically described that they have regular reoccurring contact with their participants often over an extensive period of time within their sessions. This allows them to develop strong relationships with many of their participants. In addition, coaches acknowledged that in such a position they can often act as an external and trusted individual whereas a teacher, parent or guardian may not. The ability to establish these relationships with their participants and build such a rapport was expressed as a key factor regarding a coaches' opportunity to positively support their participants' mental health. As explained by the following coaches in these examples:

> *"You're not an authority figure, as such, so you're not a teacher, you're not a parent. So you've kind of got that respect for that young person, or old person quite quickly. So we need to make sure that we grasp that opportunity and use it well, especially around mental health. Because we might be able to tell something or they might act differently in front of us than they do to others,*

which is a tell-tale sign of kind of where they're at mentally or things they're really happy about, things they're really anxious about." (Interview 08: Max)

"when you're in that environment and community setting, you will build strong relationships and you will end up being far more than a coach to them kids and perhaps in other settings." (Interview 11: Claire)

The findings within this research study coincide with a number of previous studies, demonstrating that coaches hold a key position whereby they could positively support their participant's mental health (Jowett 2005; Brown et al. 2017; Liddle et al. 2019b). In accordance with Jowett (2005), a positive coach-participant relationship is trusting and is characterised by mutual respect and appreciation. Liddle et al. (2019b) further explains how within the physical activity and sporting environment coaches are ideally positioned to be a key external supportive adult towards their participants. More recent studies have highlighted that coaches perceive their role as a means of positively supporting participants' mental health due to the relationship and rapport in which they build (Mazzer and Rickwood 2015b; Brown et al. 2017; Swann et al. 2018 and Ferguson et al. 2019). Moreover, Mazzer and Rickwood (2009) also highlighted that due to the frequent contact between a coach and their participants, coaches are in a key role to notice any significant changes in their participants mental health. This may lead to the coach acting as a gatekeeper for further support from mental health professionals. Duffy, Rooney and Matthews (2019) suggest that there is increasing acknowledgment and recognition in regard to the role of a coach as a gatekeeper and initial source of help and support for their participants. However, participants in the present study identified a number of barriers which prevent and restrict the coach's ability to fulfil this potential role of support and guidance. The following section will examine the barriers perceived by the coaches in more detail.

5.2. The Perceived Barriers for Coaches in Supporting Participants Mental Health

Within the interviews, all coaches were questioned about previous training around mental health awareness before they underwent the MHFA training. Of the 16 participants, none had had any previous training regarding mental health awareness and support. This directly links to the first and most prominent barrier that the coaches highlighted within the interviews. Coaches within this study described how they were able to notice basic mental health behaviour changes such as feelings of sadness or acting out of character. However, due to their lack of training, the coaches expressed that they were unable to

distinguish or identify specific signs and symptoms of clinical conditions such as depression, psychosis or bipolar. This was explained well by Hannah: *"I think in some aspects, like you know if somebody is anxious but in things like you know, psychosis, depression, no way. Definitely not." (Interview 09: Hannah).* The coaches further perceived how they had the ability to recognise possible problems or areas for concern due to the duty of care a coach holds for their participants. However, they explicitly mentioned that they lacked the knowledge or skills to effectively identify mental health illnesses to the extent that they felt incapable of intervening or supporting. This was highlighted well by the following statements:

> *"I think I would recognise if someone was different if they'd been acting out of character, or they weren't maybe themselves, but I wouldn't have been able to be like it might be this or, or identify certain signs or symptoms around it." (Interview 03: Alex)*

> *"Erm there would be like things here and there, but not I would say on the whole, as a coach you notice slight things or if somebody had come to me or the individual had said over time little things that just didn't seem to quite match up. That was when it was kind of made it aware to me. But not a full understanding or knowledge no." (Interview 04: Anna)*

> *"So often, I'd be like, okay, I understand or I've noticed this, but maybe I won't say anything, because I don't really know how to speak." (Interview 06: Emma)*

A further barrier identified by the coaches linked to how their actions may cause further negative impacts on their participants. Many coaches described how they were reluctant to intervene in a fear of making things worse or saying the wrong thing which could in turn, worsen the participants mental wellbeing. The majority of coaches stated that they felt a need to improve their knowledge and understanding of mental health because without any training, they were worried or unsure about what to say, how to interact or support their participants. Coaches within the current study also expressed concerns regarding self-protection, specifically relating to their status and reputation. Further comments were made regarding the repercussions of supporting participants beyond their perceived role which could be detrimental to their long-term professional development as a coach. The overarching fear of communicating with participants in an inappropriate and untrained manner is articulated well in the quotes below:

> *"Like, you know, you're always fearful when you have a lack of knowledge in something, a real fear that you don't want to do something that is wrong and then makes it worse so there was a real okay I will not talk about it, not address it, or not challenge anything around mental health and then I won't have any kind of negative impact or interaction with that individual or person." (Interview 01: Josh)*

> *"I think erm, you're kind of worried that you might say something that's going to push them over a certain direction and might just like negatively affect them and that might be like their last opportunity to speak to somebody about it before they go down a certain rabbit hole. You kind of feel too much pressure around it I'd say without the training." (Interview 15: Richard)*

This emerging theme is dissimilar to the findings found within research conducted by Jowett and Cockerill (2003), Gulliver et al. (2012) and Ferguson et al. (2018) whereby coaches conveyed a confident role in supporting their participants and did not suggest that they could have a negative impact. The findings within the present study do however echo that of Lebrun et al. (2020). Similarly to the present study, this paper investigated coaches' experiences and their perceived role in supporting mental health issues. They found that their participants also reported a reluctance to support or intervene in the fear of negative consequences due to a lack of understanding. In addition to this, Ferguson et al. (2019) discovered similar findings. The coaches within their study were unsure of what support was required or how to facilitate this. Furthermore, the coaches identified that they were not adequately trained regarding mental health and expressed apprehensions about worsening the situation. The findings within these studies and the present study are unsurprising as according to Mazzer and Rickwood (2009; 2015), current training and education courses for coaches do not sufficiently provide the skills and knowledge to address the issues surrounding mental health.

Within the interviews, all coaches were questioned regarding the stigma surrounding mental health in society and within the field of sport and physical activity. The coaches were questioned concerning their perceptions of stigma around mental health and if this dissuaded them from supporting their participants. It was identified within the semi-structured interviews that a number of coaches considered the negative stigma around mental health as a perceived barrier to supporting their participants mental health. Due to the negative attitudes and stigma associated with mental health the coaches did not approach supporting their participants. This was explained well by Emma:

> *"Researcher: Did the stigma around mental health previously dissuade you from supporting your participants mental health?*
>
> *Emma: I suppose in a way yeah. Because I wouldn't want to say to someone, I feel like you might have depression because of the negative connotation that holds today. (Interview 06: Emma)*

The focus around stigma being a perceived barrier was elaborated on further by Nick:

> *"Yes, a little bit. I think because we view mental health quite negatively in general and all this stuff and yeah, I wouldn't want to get involved because I viewed it so negatively, if that makes sense" (Interview 14: Nick)*

These findings are in alignment with the study conducted by Ferguson et al. (2019). The coaches within their study described how they did not approach the subject of mental health directly due to negative attitudes and the stigma associated with it. In addition, existing literature by Lebrun et al. (2020) discovered that coaches perceived that their participants would also be influenced by the negative stigma associated with mental health. They described how participants would fear disclosing information around mental health issues to their coaches due to the perception of mental health illnesses often being considered as a sign of weakness. In the present study coaches also described how participants would not disclose mental health concerns or illnesses with them due to the competitive nature of sport and physical activity:

> *"it's like kind of like that thing of that if you're a player and you disclose with a coach that you're that you're feeling like this, you probably worry that I am then going to think that you aren't up for it. And that I am then going to say actually, I'm not going to play you so, you know, I think it's about not wanting to show a weakness." (Interview 02: Sarah)*

These findings demonstrate further perceived barriers by the coaches relating to the negative stigma surrounding mental health dissuading both coaches and their participants. Furthermore, these views indicate how greater education regarding mental health is required for both participants and the coaches. Livingston et al. (2013) conveyed that evidence-based approaches to reducing stigma should be incorporated within areas of society such as sport and physical activity clubs as this is often where stigma is structurally embedded. In accordance with Gulliver et al. (2012), young participants or athletes have

relatively poor knowledge regarding mental health awareness and support and are often reluctant to seek help. Jorm and Wright (2008) further identify that within the competitive sporting and physical activity environments the social stigma associated with mental health can be intensified. Due to these embedded perceptions, participants are often reluctant to reveal signs of vulnerability or weakness to coaches and other members of the sports team (Mazzer and Rickwood 2009; Schaal et al. 2011; Gulliver et al. 2012). It could be argued that this aligns with the concept of habitus, Elias considered habitus to represent a person's engrained second nature or their "embodied social learning" (Dunning 2002, p.214). According to Elias (1978), an individual's habitus is dependent upon the wide range of figurations and social interdependencies of which they are a part, in this case that of a coach. The development of a person's habitus stems from within their figurations and is directly linked to socialisation, whereby people learn the norms, values and behaviours associated within these social groups (Fletcher 2013).

5.3. Perceptions of a Coaches' Role After the MHFA Training

Coaches play an important role in the lives of a diverse range of participants. They support their participants in achieving the natural rewards of physical activity and sport and the coach's role ranges further than competition and performance (Bloom et al. 1998; Fraser-Thomas, Cote and Deakin 2005). According to Williams et al. (2003), the majority of sport coaches try to act in a manner that encourages success and development of their participants. Furthermore, Bell (1997) and Danish, Forneris and Wallace (2005) identify that coaches are able to utilise sport and physical activity as an environment to develop positive life skills and principles such as leadership, confidence, self-motivation and problem solving. As stated earlier, the role of a coach is widening and the responsibility for coaches to support their participants' mental health is continuously growing (Mazzer and Rickwood 2015). Therefore, it is vitally important for coaches to have the necessary knowledge and skills to support their participants mental health (Mason et al. 2015). According to Kitchener and Jorm (2008), the necessary knowledge and skills required are well incorporated within the MHFA training. The MHFA training programme has recently been applied within the sport and physical activity environment (Bapat, Jorm and Lawrence 2009; Pierce et al. 2010). However, there has been very little research investigating the role of a coach in supporting their participants mental health or more specifically investigating the effectiveness of the MHFA training for sports coaches (Piece et al. 2010; Mazzer and Rickwood 2015; Ferguson et al. 2019).

Within the present study, the coaches were questioned regarding how they perceived the role of a coach in supporting their participants' mental health after they had completed the MHFA training. The coaches

provided consistent results with all 16 of the coaches stating that after they had completed the MHFA training, they perceived that supporting participants' mental health was a major characteristic or responsibility of their role. This was explained well by Emma: *"I definitely think after the training that as a coach, that you have a really important role to play in making sure that the people that you're coaching have good mental health." (Interview 06: Emma).* These findings demonstrate how the sports coaches' perceptions around their role in supporting mental health were either confirmed or altered via completion of the MHFA training, depending upon their prior views. The coaches' perceptions before the training were mixed with participants stating that mental health support was not part of their role or responsibility as a coach and others describing how it was key. However, after the MHFA training, all of the coaches interviewed identified that mental health support was a key element of their role. The following statements highlight a number of coaches who now firmly believe that supporting their participants mental health is a key role of a coach:

> *"Yes, coaches do. I think they always have but after the training. It's just I think that by doing the course, one has become more aware of how one can influence and how it is part of the role the job." (Interview 07: Billy)*

> *"Yeah, I think it's solidified my thoughts on the area, as I suggested before, I thought I had a good opportunity to really impact on them and make a change and to develop them. I think that from doing the course and post the course, it really did help me think yeah, that actually this is a really good opportunity. I'm in a privileged position. So before I thought it was, whereas now after the course it has sort of justified it, it strengthened my argument around it." (Interview 10: John)*

In comparison, prior to the training, a number of coaches did not identify mental health support to be within their role. However, after undergoing the training their views and perceptions changed. The coaches who previously perceived mental health support to be within the role of another professional such as a teacher or mental health practitioner changed their views to now believe sports coaches are affiliated with mental health support. This alteration to coaches' perceptions is demonstrated in the quotes below:

"So yeah after the training I think it's certainly part of the role now, I think one of the most important factors behind everything, which makes it even more shocking that when you look back and go "Wow, it wasn't something I thought about before at all"." (Interview 08: Max)

"Yeah, I think so. I think that I didn't see it as a responsibility beforehand to check in on a participants or the children's mental health as much as I should, but I think after the training knowing that it is my responsibility now has definitely changed that." (Interview 12: Scott)

"Yeah, I don't think a lot of coaches think it is because it's not a requirement as a coach to have the training. Whereas, safeguarding, they think that's a requirement of their role, first aid, that's a requirement that you have to do. But a lot of coaches don't think that about mental health but now that I've done it [the MHFA training], I definitely think it is." (Interview 15: Richard)

The data would suggest that perceptions regarding the coaches' role in supporting participants' mental health have changed or developed after completing the MHFA training. This could be argued to correlate to Elias' concept of habitus. Through the MHFA training, for some participants, norms and practices were reinforced and for others, new norms and practices were formed due to the formation of this new fluid interdependency (Elias 1978; Dunning and Hughes 2013). Although it is important to state that a habitus is built slowly over a long period of time, the coaches appear to demonstrate Elias' notions regarding the social construction of a habitus within this figuration (Dunning 2002). As many coaches stated that they believed the role of a coach to involve supporting participants' mental health before the training, the training is building upon existing dispositions or second nature for these individuals. The results are a slow, processual moulding and changing of their existing habitus (Paulle and Heenkuizen 2012). However, it can also be argued that the habitus of the participants who previously did not perceive mental health support to be within their role as a coach is now changing. The development of an individual's habitus stems from within their figurations and is closely linked with the process of socialisation, due to people learning the norms, values and behaviours associated with their social groups (Fletcher 2013). According to Fletcher (2013) and van Krieken (1998), habitus is socially constructed due to people acquiring these dispositions through their everyday experiences and relationships with other people. Elias believed that a person's habitus develops continuously over a lifetime due to the ever-increasing and changing social interactions within increasingly dynamic figurations (van Krieken 1998). Due to the literature explained above, it can be argued that the MHFA training can develop coaches' habitus gradually over time as they become more

informed and aware of their role. However, it would be interesting to conduct future research in order to identify whether the changes to coaches' habits and practice were sustained or whether they reverted back, as this would help identify and conclude whether the coach's habitus can be changed over a sustained period of time.

In accordance with Ferguson et al. (2018) and Mazzer and Rickwood (2015a), it is vitally important that in order to be effective in this role, coaches must acquire sufficient knowledge around mental health awareness and support. Furthermore, Lauber et al. (2003) highlight that relevant knowledge regarding mental health can assist coaches in recognising, preventing and supporting possible mental health illnesses, further highlighting its importance for coaches. The findings within this study correspond and build upon existing literature by Pierce et al. (2010) who investigated the impact of the MHFA training on 36 Australian football coaches through both a questionnaire and focus group interviews. Pierce et al. (2010) found that the MHFA training increased the coaches' knowledge and capacity to recognise mental illness as well as an increased confidence to respond to mental health issues or concerns. The coaches within Pierce's study further reported that the training built upon their existing skills, fulfilled their perceived responsibilities and further empowered them within this role. The empowerment of coaches was also echoed within the present study with participants commenting that due to increased awareness, skills and knowledge, coaches felt more capable and empowered to effectively support participants mental health, after completing the MHFA training:

> *"Yeah, yeah, I think so, I think, like you do hold a lot of power as a coach so normalising conversations around mental health and just creating that environment where people feel comfortable and confident. I think as a coach, you definitely have the power to be able to do that." (Interview 06: Emma)*

The participants described that after the training they viewed their role as a position of power or authority which could positively influence their participants' understanding around mental health as well as encourage participants to seek help and support if required. The coaches further discussed how they could use this power to create a positive environment within their sporting or physical activity sessions in order to further influence perceptions and understanding regarding mental health awareness. These perceptions were explained well by the participants Emma, Max and Scott:

> *"I think using coaches is a good idea. Because again, like we spoke about earlier, if you're using teachers, parents, people in positions of power, they're used to maybe taking orders from those people or being told what to do. Whereas if you're getting it from a coach who is a position of power but more advising you to do this, it might be a more natural way of getting that to work, potentially." (Interview 08: Max)*

> *"I think not just through putting on sessions, enjoyable sessions and engaging sessions. I think actually, because you are that role model and you are in a position of power and that position of trust, I think it's a great opportunity for you to be kind of going the extra mile and speaking to them about their mental health and allowing them to open up to you, which they may not feel that they're able to do with other people." (Interview 12: Scott)*

These results regarding notions of empowerment could arguably correlate to another concept of Figurational Sociology, the concept of power. Elias (1978) believed power to be a dynamic component of social relationships within Figurational Sociology. Elias (1978) implied that within figurations, certain people will have greater proportions of the resources that are needed by others. It is this central dimension of figurations or dynamic interdependencies which Elias believed led to the power interactions which exist amongst social groups. The social interactions that occur within figurations are thought to influence behaviour and result in the formation of individual habitus. For Elias, habitus refers to the deeply ingrained "second nature" that is established in people as an aspect of social interdependencies. This conception is different from the understanding of habitus through the work of Bourdieu (Dunning, 2002). It is important to mention and include Pierre Boudieu's habitus. The first step within Bourdieu's (1984) theory is the mixing of one's habitus and capital. One's habitus is a set of embodied dispositions and tendencies that determines how an individual behaves (Smith and Green 2015). Bourdieu (1984) argues that, as an economical capital can be invested and profited from, so can a social and/or cultural capital. Bourdieu (1984) states that class is not only linked to employment inequalities, but also the collaboration of economic, social and cultural capital. While there are clear similarities between the two, Bourdieu's use of the term characteristically includes greater reference to bodily habitus, while Elias emphasises a conception that is centred on personality structure and habitual behaviour (Dunning, 2002; Van Krieken, 1998). For Elias (1994), habitus relates to an "automatic self-restraint, a habit that, within certain limits, also functions when a person is alone" (p.137). Within the present study, this can be viewed as the relationship between coaches and their participants. Furthermore, the resources required for coaches in

order to effectively support mental health are knowledge and skills which the coaches can acquire from the MHFA training. van Krieken (1998) conveys that social power exists relatively, shared amongst individuals and groups. Elias (1978) implies that power involves varying balances, stating that no one person or group ever has absolute power or is powerless, but it is more or less unevenly distributed throughout the figuration.

Elias (1978) utilized the term “power balance” to explain how he understood power as being fluid or in a constant position of change rather than a fixed permanent state. Elias (1978, p.116) perceived power as “an attribute of relationships”, that is to say power is a fundamental feature of all human relationships. van Krieken (1998) argues that power is a feature of all social relations and that figurations are constantly structured around the distribution of power. The fluctuating balance of power within a figuration can be both enabling and constraining within the social world of human relations (van Krieken 1998; Malcolm 2018). The concept of game models was used by Elias (1978) to help explain and highlight the ever changing dimensions of power in human relations comprising various numbers of people (Maguire 2005). The data stemming from this research study enables Elias’ concept of game models to be applied to the fluctuating dimensions of power between the sports coach and their participants. Within this scenario or game, the coach is comparatively strong compared to the participant and therefore the coach has a much greater control of the game and therefore a greater influence upon their participants. Elias (1978) argued that although the power is not wholly on one side, the direction of the “game” can be largely determined and controlled, which in this case is by the coach.

Chapter 6

Coaches’ Knowledge of Mental Health and their Confidence of Application

This chapter examines the coaches’ knowledge and awareness of mental health. The first section of the chapter focuses upon the coach's awareness of mental health prior to completing the MHFA training. Themes are identified which demonstrate how the coach’s knowledge and awareness of mental health positively increases, highlighting the effectiveness of the training programme. Further to this, the coaches’ confidence in supporting participants' mental health is explored in more detail, again reflecting on both before and after they had completed the training. On a whole, this chapter demonstrates the journey which the coaches have undertaken in completing the MHFA training course.

6.1. Coaches' Awareness of Mental Health and the Stigma Attached

Prior to completing the MHFA training, participants stated that their knowledge and awareness of mental health as a broad term or concept was somewhat limited. When probed to elaborate further, most of the participants described how due to a lack of personal experience, mental health was a term often overlooked or disregarded. When questioned regarding their perceptions of mental health, some coaches specifically mentioned mental health conditions such as depression and anxiety. These findings are unsurprising as research suggests that anxiety and depression are the most prevalent mental health problems in society (Patel et al. 2010) and therefore are more likely to be considered. The coaches involved in the present study expressed during the interviews that before the MHFA training they had very little knowledge or awareness regarding mental health and described how they were unaware of specific signs or symptoms that may suggest an individual is struggling. Coaches within the research study conducted by Ferguson et al. (2019) highlighted similar aspects regarding a lack of awareness, knowledge and training surrounding mental health. Furthermore, the findings within the present study also align with Mazzer and Rickwood's (2015) study which found that all of the coaches interviewed reported a deficit of mental health knowledge and awareness. The participants within the present study highlighted how before they went on the MHFA training they lacked knowledge and awareness of mental health and previously disregarded the topic:

> *"I'll be completely honest it was something that personally I had never like kind of erm thought I had never suffered from myself or really come across well kind of what I thought I hadn't come across because I didn't really have a great awareness it was kind of something that I kind of pushed over." (Interview 01: Josh)*

> *"I had no idea before, I just kind of thought of extreme things like suicide and things like that I didn't think of it really, I had a lack of knowledge around the whole topic of mental health really. I wouldn't know any signs or symptoms or anything really." (Interview 02: Sarah)*

> *"I think before the training, I associated mental health with illness and not as like a general concept. So I always consider mental health to be depression or anxiety or a common illness that I've heard of, but I wouldn't really consider mental health to be something that everyone would have had." (Interview 06: Emma)*

It was also identified within this study that some coaches viewed the subject of mental health as a negative topic due to adverse attitudes and associated stigma. When questioned regarding knowledge and awareness of mental health before they had completed the training, coaches described how they associated mental health with negative connotations and perceived a reluctance to discuss mental health or even use the phrase “mental health”. These perceptions were explained well by participants Max and Scott:

> *“I think before that, it was just a bit, a bit of a broad term in all honesty. We do a little bit of CPD here around lots of different issues, but it's not something we've really covered. So before I went on the course it was kind of my own interpretation of probably, issues. And actually, maybe it had quite a negative connotation. The phrase mental health.” (Interview 08: Max)*

> *“I think that it is all about just understanding people's mindsets and head spaces. I'd seen mental health as quite just a negative term, negative perception of it if people ever mentioned it.” (Interview 12: Scott)*

The findings within the present research study coincide with literature from Gorczynski et al. (2019) who suggests that mental health is commonly discussed and viewed negatively with an illness-based lens within the media and academic literature. Due to this implicit discussion and largely negative perspective, a lack of understanding and stigma surrounds mental health (Gorczynski et al. 2019). It could be argued that the coaches have adopted this illness-based lens and associated negativity regarding mental health due to its current status within society and their lack of knowledge and awareness. This is supported by the WHO (2019a) who concludes that hostile stigma towards mental health is comprehensive in all areas of society, including the sport and physical activity sector. It has been well documented within academic literature that there is a widespread stigmatization of mental health problems, a lack of knowledge regarding identifying such problems and protective factors or treatment options within society (Baumann 2007; Kelly et al. 2007; Wasserman and Wasserman 2009; Ahmedani 2011; Rickwood and Thomas 2012; Wasserman et al. 2012; Hatzenbuehler 2013; Henderson et al. 2013). According to Hinshaw and Cicchetti (2000), individuals with mental health problems are often perceived as incompetent and dangerous, and the general public often exhibit an unwillingness to socialize with them. The stigma surrounding mental health is an important area of concern as according to Trojian (2016), negative stigma could influence

participants and prevent them from seeking help and obtaining support, particularly amongst children and young people. Castadelli-Maia et al. (2019 p.15) concludes that:

> Stigma, low mental health literacy, negative past experiences with mental health treatment-seeking, busy schedules, and hypermasculinity are important barriers to mental health treatment-seeking.

Bauman (2016) suggests that the stigma attached to mental health specifically within sport and physical activity is driven by historical social bias, a similar bias found within sport organizations, people within sport organizations, and individuals responding to these external sources. These all fuel the stigma about athletes or participants who have been championed to be “mentally tough” within sport and physical activity. In accordance with Hadlaczky et al. (2014), a lack of knowledge regarding mental health could lead to a valuable source of support, such as a coach, to misinterpret or completely fail to notice symptoms of a mental illness.

Furthermore, the coaches believed that they had a lack of awareness and knowledge around the skills needed to support participants' mental health before they went on the MHFA training. In other words, the participants stated how they did not know or were unsure of what to do or say regarding how to support a participant who may be suffering from mental health problems. Coaches within the present study described how if a participant confided in them regarding their mental health and wellbeing, they were unsure of what specific language to use other than adopting a basic friendly and supportive approach. Coaches further described how they would often try to support participants but recognised that this was in a generic way, not specified for mental health. As previously mentioned, it is vitally important that coaches gain the appropriate and satisfactory knowledge and training surrounding mental health awareness and support in order to be effective in this role (Ferguson et al. 2018; Mazzer and Rickwood 2015a). It is crucially important for coaches to gain the ability and skills required to effectively recognise early signs or symptoms of mental health illnesses, understand the skills around supporting individuals who may be suffering and to know where to gain further information or professional support (Lauber et al. 2003). Due to the appropriate knowledge and skills concerning mental health greatly assisting in recognising, supporting and preventing further mental health illnesses (Lauber et al. 2003). In the present study, when asked if the coaches had any knowledge of how to promote positive mental health or if they had any skills in supporting their participants mental health, all of the coaches stated that

they lacked the necessary knowledge or skills. Coaches Josh, Alex and Emma summarised this well in the examples below:

> *"Absolutely nothing, none at all, none [Shaking head]. I just didn't think, it was probably something I wasn't really comfortable discussing, you know interacting with people about, or really talking about at all. It was real for real weak area of knowledge. I could give you a brief outline of what depression was, what anxiety was, I knew what suicide was you know, I had no, zero knowledge on how to approach or have these conversations with people to just to check like kind of check in, or just say is everything okay, I just had nothing no knowledge or skills around mental health" (Interview 01: Josh)*

> *"Erm probably not a great deal. If someone came to me and said, I'm anxious or I'm depressed, I probably wouldn't have known what to what to really do apart from a generic answer or response to them." (Interview 03: Alex)*

> *"No, I wouldn't say that I'd know really. I feel like I had limited knowledge and skills to support someone. And I wouldn't say that I felt comfortable merely instigating these conversations. And there was a time where I feel like maybe I should have. I had really limited knowledge as to like professional services that people could access." (Interview 06: Emma)*

In accordance with the findings of Ferguson et al. (2019) and Mazzer and Rickwood (2015a), coaches are well positioned to support their participants' mental health if concerns arise and additionally encourage help-seeking behaviours. Conversely, from the data obtained it is clear that before the MHFA training the coaches were uncomfortable talking or interacting with their participants regarding mental health due to a lack of knowledge or supportive skills in this area. Previous literature has stated that coaches reported confidence in the role of supporting participants mental health due to their established, familiar and trusted relationships with their participants (Jowett and Cockerill 2003; Mazzer and Rickwood 2009, 2015a; Gulliver et al. 2012; Ferguson et al. 2019). However, within the present study contradicting findings can be observed, as the coaches were not confident in supporting their participants mental health as they highlighted a lack of knowledge or skills in how to practically employ this support. These findings do however align with the research study conducted by Lebrun et al. (2020), whose coaches reported that they were reluctant to provide mental health support to their participants due to a lack of knowledge, awareness or understanding regarding the skills required to perform such actions.

Although it has been noted by Roberts et al. (2016) that coaches may not be the most suitable or qualified personnel to deal with mental health issues, a number of studies have argued that they hold a key role in aiding early detection and adopting supportive behaviours regarding their participants mental health (Gulliver et al. 2012; Mazzer and Rickwood 2015a; Ferguson et al. 2019). A major factor around coaches holding a potentially key role is due to the regular contact over sustained periods of time that they have with their participants, providing them with an advantageous position to notice changes in behaviour which may link to the signs or symptoms of mental health issues (Hill et al. 2015; Mazzer and Rickwood 2015a; Sebbens et al. 2016). However, as identified within the present research study and a number of previous studies (Kitchener and Jorm 2008; Pierce et al. 2010; Sebbens et al. 2016; Furnham and Swami 2018; Lebrun et al. 2020), the coaches are not always aware of what to do or how to practically implement support and have described a lack of knowledge or training regarding mental health awareness. Which leads onto the MHFA training which the coaches within the present study have completed. According to Sebbens et al. (2016), mental health literacy training, such as the MHFA training course, has been shown to increase knowledge of the signs and symptoms and even increase the coach's confidence to support their participants. The following section will focus upon the coach's responses regarding mental health awareness after completion of the MHFA training course.

The MHFA training course is an educational programme developed in order to advance mental health awareness in the general public by increasing knowledge, developing positive outlooks and encouraging helping behaviours (Kitchener and Jorm 2002). Originally the programme was developed in Australia (Kitchener and Jorm 2002), although it has now been adopted in over 20 other countries and consistently reviewed within academic literature (e.g. Kitchener and Jorm 2004; Massey et al. 2010). A meta-analysis research study was conducted by Hadlaczky et al. (2017) investigating the effectiveness of the MHFA programme based upon previously reported results from 15 articles (e.g. Kitchener and Jorm 2002, 2004; Jorm et al. 2004; Sartore et al. 2008; Hossain et al. 2009; Minas et al. 2009; Jorm et al. 2010; Lam et al. 2010; Massey et al. 2010; Pierce et al. 2010; Kelly et al. 2011; O'Reilly et al. 2011; Morawska et al. 2013; Svensson et al. 2013a, 2013b). The 15 research studies investigated the effectiveness of the MHFA training on a wide range of samples including high school teachers, multicultural communities, pharmacy students, farmers and the general public. Hadlaczky et al. (2017) concluded that the results of the meta-analysis demonstrated how the MHFA training effectively boosted individuals' knowledge of mental health, lessened their negative perceptions, and increased supportive behaviours towards others. Furthermore, Hadlaczky et al. (2017) recommended the MHFA educational programme for public health action.

However, research focusing more specifically on the application of the MHFA training to increase sports coaches' mental health knowledge and skills is limited (Pierce et al. 2010). The current study aimed to develop and build upon the limited research focusing upon the MHFA training course as an educational programme for sports coaches.

When the sports coaches were questioned regarding their perceptions of mental health after the completion of the MHFA training, all 16 participants described a general increase in mental health awareness and knowledge. The coaches described many areas of awareness and knowledge which they believed were positively enhanced or increased via the MHFA training. Similar findings can be observed from the research study conducted by Pierce et al. (2010), who investigated the effectiveness of the MHFA training in Australia for rural football coaches through pre-post questionnaires and focus groups. The coaches in the Pierce et al. (2010) research study demonstrated an increase in their capacity to recognise mental health illnesses and stated that the MHFA training positively benefited their role, building upon their existing knowledge and awareness of mental health. The participants in the present study further described how the training provided them with a more holistic understanding of mental health as well as reducing the negative connotations which the coaches held around mental health before the training. A more holistic overview of mental health and wellbeing considers the association between body and mind as well as acknowledging an individual's ability to empathize with others and cope with negative life events which helps to create an all-encompassing understanding of mental health applicable to wider societal groups (Galderisi et al. 2015). The data from the semi-structured interviews displays how the coaches positively advanced their mental health awareness due to the training. This was explained well by participants Alex and Max:

> *"Erm so the training was very eye opening, I mean, it explained the different types of mental health and it broke them down. Erm so we all have mental health, whether it's positive or negative, it's important that it's a topic that's covered in sport and spoken about. Erm obviously, it helped explain around physical and mental health as well. So, I guess the course gave us more awareness about what mental health was and what mental health wasn't as well." (Interview 03: Alex)*

> *"So it now means something more, a whole more holistic phrase. It's not just a negative connotation, it means lots of different things. It means different not only behaviours, but it can mean good mental health. Whereas before, it wasn't something that I probably even considered could be a positive, which is crazy." (Interview 08: Max)*

The results of the present study coincide with the research findings of Sebbens et al. (2016) who similarly investigated the effectiveness of a mental health workshop for elite sport staff and coaches. Sebbens et al. (2016) also found that the mental health training was effective in improving the participants' knowledge and awareness of mental health and empowered the coaches to positively utilise the relationships with their athletes to support, intervene and encourage help-seeking behaviours. Furthermore, the coaches in the present study explained how they felt more educated and knowledgeable in supporting participants' mental health after completing the MHFA training. The majority of coaches highlighted how by increasing their knowledge and awareness, they felt more comfortable to talk and discuss the subject of mental health with their participants and other people with whom they work with:

> *"Yeah. So, I think just having the knowledge and education just gives that confidence to talk about it as a subject and also like, approach it across all the different groups that we work with and not be afraid to kind of discuss it with people as well. I think I have a better awareness and also how to like talk to people a bit more openly about it. And sort of support them around mental health, I think." (Interview 03: Alex)*

The coaches in the present study also highlighted an increased knowledge and awareness regarding sources of help and support which they can signpost their participants towards. Before the MHFA training, this was described by the coaches as an area which they lacked knowledge in and often overlooked. However, from the data it can be observed that the MHFA training has provided the coaches with a more advanced understanding and awareness of mental health through increasing their mental health literacy, developing positive attitudes and encouraging supporting behaviours. The data obtained within this study correlates with the research findings of Kelly et al. (2011), who investigated the effects of the MHFA training on adults who work with or care for adolescents. Within the research study, Kelly et al. (2011) concluded that the MHFA training was associated with increased mental health knowledge and a greater likelihood of providing helping behaviours or supporting external professional help. Within the present study, these findings are also observed in the coach's responses to questions regarding their knowledge and awareness after completing the MHFA training. The coaches increased knowledge and awareness regarding other sources of help and support were explained well by Emma and John:

> *"Since doing the training, I feel like a lot more confident and knowing that I'm referring people into services that actually can support them, whether that's like professional services or charities, that kind of thing. Yeah but prior to the training, I didn't." (Interview 06: Emma)*

> *"I am definitely in a better position in terms of awareness and also awareness of where to send people. So for example, I'll be much more happy to send and direct people to certain resources if I'm not knowledgeable and to be happy to admit to people that I'm not like an expert in the area." (Interview 10: John)*

Another theme which the coaches described within the semi-structured interviews links to their awareness and understanding of the negative stigma surrounding mental health in society. After the MHFA training the coaches highlighted how they were more aware of the stigma and also how they believed they were more likely to actively challenge negative language used to reduce the stigma within their social groups. These findings are in alignment with a research study conducted by Bapat, Jorm and Lawrence (2009) which evaluated a training programme which was based upon the MHFA training, designed to improve the mental health literacy of junior sport club coaches and leaders. This was evaluated using pre and post-questionnaires. In accordance with Bapat, Jorm and Lawrence (2009), the training course led to significant improvements in knowledge regarding mental health and also increased the participants' positive attitudes towards mental health. Furthermore, the study conducted by Kelly et al. (2011) also found that the MHFA training increased the participants mental health knowledge as well forming greater disagreement with stigmatising attitudes towards mental health. The present study builds upon these findings and demonstrates a major benefit of the MHFA training course revolving around significant improvement in the coach's knowledge about mental health but also reducing their negative perceptions and increasing more positive attitudes towards mental health, therefore reducing stigma. These findings were explained well by coaches Josh, Anna and Claire:

> *"Yeah, it made me realise that it shouldn't be such a taboo because so many people are actually struggling with it, erm and that a lot of people do keep it bottle up, because there is that taboo or stigma about it. And that they really shouldn't because the likelihood that if people accept mental health more, they're more likely to go get help, which is more likely to decrease the issues around it. So, if that taboo or stigma is decrease, then it's going to benefit everybody really." (Interview 04: Anna)*

> *"So I suppose, understanding what stigma is more. So the first point of call is understanding some of the stuff that impacts on people being stigmatised, so like language. There are a few people in my club that still see mental health issues as that thing that you don't talk about. You know, I'd*

question the stigma that they have attached to mental health. So yeah, there's definitely a real stigma to address massively still and I feel more aware of that." (Interview 11: Claire)

The results of the present study clearly highlight how prior to the MHFA training, the coach's knowledge and awareness of mental health was deficient. However, the completion of the MHFA training demonstrates a clear positive correlation with the coach's knowledge and awareness. Increasing coaches' knowledge and understanding of mental health should help them to support their participants by obtaining the "ability to gain access to, understand, and use information in ways which promote and maintain good mental health" (Lauber et al. 2003, p. 248). According to Swann et al. (2018), this could also lead towards encouraging the coaches' participants to open up and discuss their emotions, due to the fact that the participants' perception of their coaches' mental health literacy influences their inclination to talk and ask for help. The following section will outline and discuss the relationship between the MHFA training and the coach's confidence in applying their knowledge and skills obtained from the training.

6.2. Coaches' Perceived Confidence and Competence

Within the interviews, coaches were asked if they felt confident in supporting their participants' mental health before they completed the MHFA training. The majority of coaches highlighted a lack of confidence however, an opposing theme did emerge. Several coaches described a degree of confidence in supporting their participants' mental health prior to completing the training. The coaches who reported that they were confident in supporting their participants' mental health suggested that although they did not have relevant training or a specific qualification, they would always try to support their participants to the best of their ability. It was described by one participant that due to their age and years of experience in coaching, they felt confident and comfortable before the MHFA training:

"I did feel quite confident because I'm maybe a more mature individual than some of the participants that were actually on the course. […] you could actually sort of see that difference between the life skills that I've already gained and had behind me were different to those younger students. So I could actually hand on heart, say, yes I'm quite comfortable and confident that I was doing it in the appropriate manner." (Interview 16: Ben)

Furthermore, other coaches similarly expressed that due to their own experiences and trusted relationships with their participants, they were already confident to a certain extent. These findings correlate with previous research studies which also found that coaches, on a general level, reported confidence in supporting their participants mental health (Jowett and Cockerill 2003; Gulliver et al. 2012; Mazzer and Rickwood 2015a; Ferguson et al. 2019). Within the present study, a number of coaches did describe notions of confidence prior to the MHFA training, however it is important to highlight that this was only a partial confidence with participants commenting that further training was required in order to become wholly confident. When asked if they felt confident in providing initial help and support to their participants, the following coaches expressed notions of confidence before the MHFA training:

> *"Yeah. I would say I'm confident in doing it, but I wouldn't have like a qualification sort of thing or saying I professionally know how to like deal with it. But I would have like my own way which without sounding big headed, I would know how like to promote positive mental health within children and young people, sort of thing I think like how to speak to them and stuff." (Interview 05: Patrick)*

> *"Yeah, I would have been confident in helping people, well trying to help people." (Interview 07: Billy)*

In addition, many coaches further detailed how the confidence they had before the MHFA training revolved around supporting their participants by signposting them to other sources of help and support. The responses demonstrate how the coaches believed that they were lacking training or awareness surrounding mental health support but still considered themselves as able to help through means of signposting and referral to other sources. These findings coincide with the previous results which suggested that coaches understood mental health support to be the responsibility of others and therefore, referred their participants to individuals such as teachers, doctors and other mental health professionals. Mazzer and Rickwood (2015a) and Ferguson et al. (2019) found similar findings with coaches perceiving mental health support to be the role of other professionals. The data within the present research study demonstrates how the coaches were confident and willing to signpost their participants to other sources of help but lacked confidence in their own ability to support participants' mental health. These perceptions were explained well by the participants Alex, Mac and Scott:

> *"Erm I would say semi confident, again, as you're sort of talking to somebody, I guess if someone disclosed something to me, I wouldn't have known, I wouldn't have been confident, but I would have*

probably just been like lets go to your GP or like a counsellor as a standard answer. I wouldn't have known how to like, properly support them in the best way possible." (Interview 03: Alex)

"Yeah, I think that without a full understanding or full confidence, signposting is something that I'm quite keen on doing erm, I'm not going to solve everyone's problems all the time, in fact most of time. So, knowing who you can signpost to, whether that's just a colleague, I think that yeah, that's something that I would be comfortable doing." (Interview 08: Max)

"Yeah, I think I would be confident signposting if I've noticed the participant was maybe down on a regular basis. I think that would be a case of having conversations with maybe their teachers in they're in school or maybe their parents if it's outside of school. But again, that'd be me passing on to someone and kind of giving responsibility to someone else straight away rather than me actually supporting them because I lacked confidence." (Interview 12: Scott)

However, the vast majority of coaches did not express notions of confidence and described how before the MHFA training, they lacked confidence and competence in supporting their participants' mental health. The participants previously highlighted how they required further knowledge and awareness of mental health and in turn, the coaches were clearly deficient in confidence, describing how they would not feel competent at all. The findings of the present study correspond with previous literature as several research studies found similar results. For example, Kitchener and Jorm (2008) concluded that external sources of mental health support, such as coaches, repeatedly lack the confidence or competence to support their participants' mental health. Further research studies have highlighted how coaches felt uneducated in mental health support and therefore inevitably lacked confidence and felt incapable of practically supporting their participants mental health (Pierce et al. 2010; Mazzer and Rickwood 2015b; Sebbens et al. 2016; Ferguson et al. 2019). Within the present study, a large number of coaches lacked confidence in providing initial help and support to their participants, coach Josh said:

"Absolutely not I would have had no confidence in how to have that conversation or support my participants mental health before the training" (Interview 01: Josh)

Participants Claire and Scott further elaborated on how they lacked confidence and competence in supporting their participants mental health before they completed the MHFA training:

"If someone came to me, that felt that they might have a mental illness, or they were at that point. I'm not sure I would have felt confident or able at all. I really don't think I would, I think I would have lacked any confidence. You know, I think I just wasn't confident in supporting anything around mental health." (Interview 11: Claire)

"Probably not, no, I would say before for the training, no. I think I'd be aware of the different mental health issues that people can have and some of the symptoms that you might be able to see in someone. But actually, dealing with them and supporting them as much they needed, I probably wouldn't feel comfortable or confident in doing that really." (Interview 12: Scott)

In accordance with Mazzer and Rickwood (2015), the MHFA training programme delivered to sport leaders and coaches can target particular barriers or issues surrounding mental health awareness and support. Mazzer and Rickwood (2015) further suggest that coaches will gain increased confidence in the appropriate language to use and how to support a participant who may be experiencing a mental health illness. Pierce et al. (2010) further conveys that MHFA training has been shown to effectively improve coaches' confidence and capability to support their participants' mental health concerns. Within the research study conducted by Pierce et al. (2010), coaches' confidence in helping somebody with a mental health problem increased significantly after completion of the MHFA training course. Furthermore, the meta-analysis conducted by Hadlaczky et al. (2014) concluded that the MHFA training is successful in increasing individuals' confidence in supportive behaviours towards people who may be suffering from mental health problems. The present research study displays identical findings as all of the coaches described how they had a general increase in confidence with regards to supporting their participants' mental health after completion of the MHFA training. Throughout the semi-structured interviews, it was clearly highlighted that the training provided an increased knowledge and awareness as well as an upsurge of confidence which was evidently lacking before. A main theme that emerged from the data in this study, in relation to confidence relates to the simple aspect of coaches feeling more confident in approaching and talking to their participants in order to initiate supportive behaviour. There was a consensus among all the coaches interviewed regarding an increased confidence to support their participants mental health, however this was explained well by the following coaches:

"Yeah. So, I think just having the knowledge and education just gives that confidence to talk about it as a subject and also like, approach it across all the different groups that we work with and not be afraid to kind of discuss it with people as well." (Interview 03: Alex)

> *"Yeah just that confidence, so now if someone says something to me, I would kind of like probe a bit more and I like poke them try to get more out of them but not to the point where they don't feel comfortable telling me. Erm just so it makes myself more aware of the situation and allows them to know that they can trust me, that I would be there if they ever needed anything." (Interview 04: Anna)*

> *"Yeah, I think, as I suggested before, I think I was pretty good at being able to spot little bits of what's going on, maybe some differences in someone's demeanour. But I definitely feel more confident in doing that post the training now. Yeah. So yes, much more confident in supporting my participants mental health." (Interview 10: John)*

This evidence corresponds with previous literature as Bapat, Jorm and Lawrence (2009) suggest that the MHFA training course has several benefits, a major benefit being an increased confidence in helping someone who may be suffering from a mental health issue. A similar theme was recognised within the research study conducted by Kelly et al. (2011) who found that the MHFA training was associated with a number of benefits. A key benefit was linked to how an increase in confidence helped coaches to play an active role in supporting a young person with a mental health issue. In the present study, there were a great number of participants who further expressed how the MHFA training provided them with a confidence to raise awareness of mental health through discussions with their participants and colleagues. The coaches expressed how they felt more comfortable and confident in creating a positive environment within their sessions, to raise awareness of mental health and encourage their participants to normalise discussion of mental health. These findings are supported by previous research studies who concluded similar results relating to how the MHFA training course increases confidence. For example, the results from Sebbens et al. (2016) demonstrated that mental health awareness training is effective in improving an individual's confidence to support someone who may be struggling with a mental health problem and raise positive awareness. Furthermore, in accordance with Bandura (1993) and Vuori et al. (2012), an increased confidence and competence in a particular area has been correlated with an increased likelihood of engagement in a particular behaviour. When applying this concept to the present study, the increase in knowledge and confidence obtained from the MHFA course has led to coaches becoming more actively involved in supporting their participants' mental health. The coaches increased confidence to talk,

discuss and raise awareness of mental health after the training was elaborated well by the following participants:

> *"Yeah, I'd definitely say I am more confident. I think just having the initial confidence to just do it. Um, yeah, I feel more comfortable. I feel more confident after undergoing the training that I'm kind of facilitating the right kind of conversations and if I am linking people in with services, I know that it's the right ones and that I am positively raising awareness in my sessions." (Interview 06: Emma)*

> *"It's just I feel a lot more confident, feel a lot more comfortable having had this training in doing what I'm doing and its supported and promoted mental health awareness." (Interview 16: Ben)*

In addition, participants also expressed how their increased confidence, stemming from the MHFA training, led to them counteracting and challenging negative stigma. The coaches described how they had an increased confidence to actively challenge negative stigma within their social groups, for example with their colleagues or participants:

> *"I think the kind of qualification and training now kind of kind of give you a better understanding around, potentially why that stigma takes place and the confidence to kind of challenge that stigma. I think that comes with trying to break down that stigma and challenge it and know that you know, explaining to participants that this is a totally normal thing to feel and there are lines of support to help you through." (Interview 01: Josh)*

As well as increasing general awareness of mental health, the coaches stated how they believed challenging and eradicating negative stigma was extremely important. The MHFA training can be observed as providing the coaches with the confidence to discuss mental health but also raise awareness and educate others in order to inform individuals and attempt to reduce negative stigma. These findings correlate with the results of the meta-analysis conducted by Hadlaczky et al. (2014). Hadlaczky et al. (2014) concluded that the MHFA training increases individual's confidence in counteracting stigma and also improves their knowledge, attitudes and behaviour. The change in behaviour is a key factor as it demonstrates a practical change which allows them to become more active in supporting mental health and challenging negative stigma. These findings can also be observed within the present study, the

following participants explained how the MHFA training provided them with an increased confidence to challenge stigma:

> *"I just think the course made me think actually like, this is life, and this is just normal. And if we stop making it abnormal, then it becomes more normal and it's more okay. I think things still come out your mouth and you think, like, sometimes we might say in the office like you shouldn't say things like that after we all did the course. I now feel confident to challenge it in the same way that like, I heard somebody say something that I thought was like, racist or sexist or inappropriate, like I would challenge it. (Interview 02: Sarah)*

> *"Erm, I think the course taught me and gave me confidence to challenge people that might have a negative conception of mental health and actually have a conversation with them around why they have that perception. Try and make them aware that everyone has mental health." (Interview 06: Emma)*

It is clear to see from the data obtained and analysed that the MHFA training has provided the coaches with increased knowledge, awareness and confidence in supporting their participants' mental health. The coaches have explained their thoughts and perceptions both before and after completion of the training. It can be concluded that participants felt more positive and confident surrounding the topic of mental health and their role in supporting participants after completion of the training. The present study builds upon and reinforces the findings of Pierce et al. (2010) who concluded that the MHFA training increased coaches' knowledge of mental health awareness as well as developing their confidence in responding to and supporting mental health issues. Previous research has demonstrated that by increasing an individual's knowledge and confidence within the area of mental health, more supportive behaviours will ultimately follow (Kitchener and Jorm 2006; Hadlaczky et al. 2014). In accordance with Sebbens et al. (2016), targeting individuals' knowledge and confidence are key strategies to increase the prospect of supportive behaviours. The following chapter will discuss the coach's perceptions of the MHFA training course, analysing several components relating to the delivery and content as well as highlighting areas for future development.

Chapter 7

Perceptions of the Mental Health First Aid Training

In accordance with Mason, Hart, Rossetto and Jorm (2015), it is essential that coaches hold the necessary knowledge and skills to successfully support their participants' mental health. It is also vital that coaches have a good knowledge of mental health services as well as high levels of mental health literacy (Jorm 2012). As stated by Kitchener and Jorm (2008) and presented within this research studies findings, the MHFA training course incorporates a number of these skills. As stated previously, when the MHFA training has been provided to coaches, their ability to recognise mental health problems and their confidence to respond with supportive behaviours increased (Pierce et al. 2010). Both the youth and standard MHFA training courses have been developed and updated with ongoing improvements (Kelly et al. 2011). New guidelines using the Delphi method, a technique for reaching consensus within and between groups of experts, were applied to the MHFA training courses and described as Edition 2 in 2010. Ongoing feedback from the MHFA instructors and participants, which could be recorded on the MHFA website, were also used to improve and develop the courses (Kelly et al. 2011). However, there have been limited studies which explore the participants' thoughts and perceptions of the MHFA training. Furthermore, there has been little research investigating specifically how sports coaches perceived the MHFA training. A study conducted by Breslin, Shannon, Haughey and Leavey (2016), examined the delivery of mental health literacy training within the sport and physical activity setting and conveyed how there was an uncertainty and ambiguity regarding who should deliver such training, the content included within the training and who should be trained. Therefore, within the semi-structured interviews we sought information from the coaches regarding their thoughts and opinions of the training as well as their preferences for training in relation to mental health. This chapter will focus upon the coach’s responses to questions relating to the significance of the training as well as questions around areas for development or improvement of the training course.

7.1. Significance of Mental Health First Aid Training

The coaches were questioned in regard to the MHFA training, particularly regarding their own perceptions of the training and if they thought the training was important for coaches. The consensus was that the training is an essential element of sports coaches' continued professional development. All of the coaches highlighted how the MHFA training provided them with a holistic and broader understanding of mental health and the importance of facilitating a positive mental health environment. The coaches further

described how all sport and physical activity coaches both at grassroots and professional levels should undergo the MHFA training course. All of the coaches stated how the training was a positive step towards becoming a modern-day coach who can fully appreciate and comprehend the extent and severity of mental health issues within society. Furthermore, the coaches within the present study explained how the training equipped them with relevant skills and attributes to be able to successfully support participants and tackle societal stigma. The following quotes articulate some of the main positive comments and thoughts surrounding the MHFA training:

> *"Yeah, I think every coach should go on Mental Health First Aid training. I just think it's a really useful course for your coaching life and in your everyday life as well. It should be up there as one of ones that you have to cover to be able to coach and be fully qualified. I honestly think that everyone should attend this training, I think it's really important." (Interview 06: Emma)*

> *"I think it is central within coaching because I think as I suggested, if you want to really get to know your participant and help them develop holistically, then you need to be as equipped and as armed as possible. The MHFA training is just another set of tools, which is really beneficial." (Interview 10: John)*

> *"I think it is really valuable. The MHFA training two-day course, I think like every full-time permanent coach, absolutely should do it. And I know it is a big ask but the training is so current and just really good." (Interview 11: Claire)*

The coaches went on to further highlight positive notions of the MHFA course by expressing how it should be an integral part of their training and development as a coach. Due to the growing importance of mental health awareness within society and the sporting sector, incorporating the MHFA course into the current initial compulsory training for coaches would help to increase the number of coaches obtaining the qualification. The coaches stated within the semi-structured interviews how the MHFA training course should be of the same importance as other well established continued professional development courses for coaches, such as the first aid and safeguarding qualifications. Similar findings can be observed within the research study conducted by Ferguson et al. (2019). Ferguson et al. (2019) concluded that mental health training which is specifically designed for coaches could be effective, particularly if the training could be merged into current coaching training and initiatives. This can be further supported by the research of Vargas-Tonsing (2007) who suggested that coaches are more inclined to partake in training

courses if they are a compulsory component of their role. For example, a number of the coaches expressed how the MHFA should be incorporated into their governing bodies policies and requirements before they can gain qualified coaching status. The quotes below highlight a number of coaches who elaborated this concept well:

> *"So, I think as coaches or within the sport and fitness environment, mental health should be something that's actively promoted, or organisation should be looking for that. Just like you do for first aid or safeguarding or have a DBS check I think mental health should be on that level as well." (Interview 03: Alex)*

> *"For coaches I would say it's definitely becoming much more of a prevalent issue. And I know that my mental health first aid training will be used or applied much more than my physical first aid. And I think Mental Health First Aid could have a much bigger impact than the physical first aid which you're required to have as a coach, so you should be required to have both of them I believe coaches should be required to have both." (Interview 04: Anna)*

> *"I do think as coaches like you do, you do need you should have at least have like a level one and you have to go in and re-sit it every year like you have with like your first aid. Like you cannot coach, unless you've got first aid. So now Mental Health Training should be included on that. Same with like a DBS, it's just as important. I think everyone should have at least a full day course on it (MHFA)." (Interview 05: Patrick)*

Almost all of the participants directly discussed the MHFA training in parallel with the medical first aid training, comparing them as similar and highlighting how they should be interlinked and as important as one another. Internationally, "first aid" is commonly practiced, appreciated and understood within society (Cleary, Horsfall and Escott 2015). The MHFA training is built to directly build upon the familiar concepts of medical first aid, in other words MHFA was modelled on traditional physical first aid (Jorm and Kitchener 2011). The similarities between medical first aid and MHFA were woven within the course in order to increase the likelihood that MHFA training would achieve the same widespread acceptance and implementation within society (Haggerty et al. 2019). Within this study, it was highlighted by the coaches that the MHFA training should be regarded with the same status as physical first aid training. By using the

first aid model, MHFA links to the present social concept of early assistance and is understood within wider society (Jorm and Kitchener 2011).

7.2. Areas for Development and Improvement

During the interviews, the coaches were asked to provide possible feedback on areas for development or improvement of the MHFA training course. The coaches believed the training was significant and very positive however they did provide a number of factors which could be improved upon. Firstly, the coaches described how the course provided them with a brief introduction to mental health awareness and support yet, they felt that further training was required. Coaches expressed how a further training course or follow up session would provide them with more detail on certain mental health issues as well as additional supportive strategies which could be adopted within their practice. The concept of requiring further guidance after the training is similarly discussed within the research by Ferguson et al. (2019), whose participants also highlighted that an additional online resource tool kit would be beneficial to refer to after completion of the MHFA training. Within the present study, coaches also expressed how the MHFA course cannot include all aspects and topics relating to mental health due to the sheer complexity and depth. However, they were keen for further training as they understood that mental health awareness and support is an ever-growing and developing topic, and therefore their knowledge must be kept up to date. Coaches Anna, Patrick and Emma explained how further training after the initial MHFA training course was an area for improvement:

> *"I feel like I, there is still a lot more that I could be aware of whether that's by going on the longer 2 day course or I don't know, but I feel like there is still a lot more and there's so much about mental health that you could like, learn and know what to do in supporting people that I think I need more." (Interview 04: Anna)*

> *"Erm yes and no so I do think I have the skills, but I still think there's like obviously a lot more to learn and to do things in the right way and like a better manner then what I would do now for instance. Maybe that's where I need more training and again if I'm going to do something, I need to make sure I'm doing it as best as I can." (Interview 05: Patrick)*

> *"I feel like I would like to do some more training to better understanding specific mental health illnesses and how to support someone. I'd like to do that just to be able to dig a little bit deeper*

because it's just scratches the surface. I mean, like, there's two days to go through like nine different illnesses. So, I think some follow up training that's a bit more detail will be useful." (Interview 06: Emma)

Like physical first aid and safeguarding courses for coaches, participants within the present study commented how the MHFA training course should also follow a renewal process. The details regarding time frames of this suggested renewal were discussed with a number of participants but not all. A few participants suggested it could be annually due to the current and continuously changing knowledge of mental health awareness and support. The coaches identified that new ideas and practices regularly emerge within the field of mental health and therefore one session does not suffice. The coaches described how the MHFA training should be similar to other continued professional development courses in requiring a renewal after a duration of time. In accordance with Ferguson et al. (2019), sports coaches have previously questioned whether a one-off session would have a great enough impact. Ferguson et al. (2019) also found that coaches believed a follow-up session would be beneficial and a need to regularly renew and reinforce the training would be required. When the participants in the present study were questioned around areas of development for the MHFA training course a number of the coaches suggested a requirement to renew:

"Yeah, I think people should go on a top up almost maybe like a refresher course, to renew the training. Erm so, after actually delivering a lot of courses we'll ask for feedback and lots of people will say "I'd like this training to be more regular" Because a lot of people will say "Am I done now? I don't need to go on again?" People put on their feedback that they wish that there were more opportunities to kind of attend these courses more frequently." (Interview 06: Emma)

"You know, new ideas come out. I've still got badges of stuff, but the courses have changed. And we need to maintain continuity, because new ideas come out, new practices come out, new thoughts come out from senior professional people. You know, if it changes, it needs a follow up or renewal. There has to be some sort of a recertification. Maybe there will be better ways of doing things, maybe there's a new way of doing things and maybe there are improvements." (Interview 07: Billy)

"Yeah, definitely. Hundred percent. Just, if you have to redo your first aid, why shouldn't you have to do redo your mental health first aid" (Interview 09: Hannah)

In addition, the participants also described how the MHFA training could be improved by making it specific for sports coaches. A key theme to emerge from the data revolved around tailoring the course to meet the needs of the participants. The coaches described how they believed tailoring the course towards their specific needs would further enhance the training. Increasing the use of sport specific examples would be more beneficial for the participants as the coaches highlighted how this would allow them to tailor their knowledge to their practice in a more effective and appropriate way. The coaches also highlighted how they were more engaged and interactive with one another and the instructor if the questions or scenarios were tailored to their specific sport or field. Similar results were found by Ferguson et al. (2019) whose coaches suggested that training should revolve around practical experience which is specific to certain scenarios that could occur within a sporting or physical activity session. Ferguson et al. (2019) also discovered that the coaches would prefer to be in a homogenous group setting in order to discuss similar experiences or possible scenarios. This type of approach would be coherent with the notion of a community of practice, which enables continuing coach development (Bertram and Gilbert 2011). Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Bertram and Gilbert 2011). For example, the community sport coaches could engage in a process of collective learning in the shared domain of mental health and sport.

In accordance with Haggerty et al. (2019), the MHFA training courses are adaptable to a diverse range of individuals who are encouraged to participate. Previously, the MHFA program was written to be applicable to a broad range of people (Kitchener, Jorm and Kelly 2010). However, it was soon decided that the course should and could be tailored for specific cultures, ages and disability groups (Jorm and Kitchener 2011). For example, currently there are versions of the MHFA training course developed specifically for Aboriginal and Torres Strait Islander peoples in Australia and Vietnamese Australians, delivered by MHFA instructors from these relevant cultural groups (Kitchener, Jorm and Kanowski 2008; Hart et al. 2010). Furthermore, Jorm and Kitchener (2011) suggest that the MHFA instructors can ensure the course is relevant to the selected audience by adapting activities and using specific examples within the course. Therefore, the courses could be adapted to adopt a more sport and physical activity stance, delivered by MHFA instructors with a background in sport and tailored for their specific needs and requirements. Coaches Emma, Max and John explained the notion of tailoring the MHFA course more specifically towards a sporting background in order to further enhance the effectiveness of the training:

"Yeah, I think if you're going to deliver it to coaches, you should make it more sport specific. The course as a whole is really generic. I mean, like, understanding what depression looks like in Joe Bloggs is fine, but what it might look like in an athlete or a participant, that kind of thing is very different. So, I think coaches having that level of knowledge in a sporting context will be far more valuable. It's really interesting doing it from a sport specific context, it facilitates far more engagement than doing it as a generic training course." (Interview 06: Emma)

"I think in general, I thought it was a pretty good course. I think it helped that the group we had was quite a small group. It turned out that we were all kind of similar minded, we've all got similar goals and similar aims in working with people in the community. So, I think it's important that it was done with people from similar sectors." (Interview 08: Max)

"So maybe if I was gonna do like a recommendation of how you could link it to the population that you're working with a bit more. But maybe it could cover some specific sporty examples. So maybe some of the sections need a bit of a sporty lens because working with the participants who would be on the course, it's just trying to make sure it hits home with them as well." (Interview 10: John)

A variety of participants were questioned within this research study who had attended an online, half day and two-day MHFA training course. The majority of the participants who had completed either the online or half day training course highlighted alternative experiences when compared to the two-day MHFA training. The online and half day course was criticised by the coaches as not providing sufficient knowledge, detail or practical experiences. Whilst the coaches expressed positive elements of their training, they went on to explicitly highlight how they thought these shorter and online training sessions were not sufficient. The half day and online training courses were lacking in detailed content, real life examples and open conversation due to the restrictions of time and the fact it was on a virtual platform. According to Vargas-Tonsing (2007), online training content was preferred amongst volunteer youth coaches, although they also state that further research is needed to determine if this is a viable form of effective education training. Yang and Cornelius (2004) have suggested that although online training has benefits due to its flexibility, online education can cause delayed feedback, feelings of isolation amongst participants, and a lack of self-motivation. Participants within the present study also described self-motivation and concentration issues when the training was virtual on an online platform reading slides. Research by Nash and Sproule (2012) concluded that coach improvement is more likely to occur if coaches

are able to see the long-term benefits of the learning process, which is unlikely to occur online. The coaches within the present study clearly highlighted that the online and half day courses were insufficient and recommended that the MHFA two-day training course should be focused upon. When questioned around areas for improvement and development, the majority of coaches stated that they felt the two-day practical MHFA training course would have been more beneficial than the half day or online versions of the training:

> *"Yeah, so like the half day course was good, but I feel like it maybe didn't cover enough, and the 2-day course would be more beneficial. I probably would feel more comfortable if I went on more training or the 2-day course so I could get more practicality out of it. I felt like this training didn't have a big enough impact for me to be like guys come and speak to me." (Interview 04: Anna)*

> *"So yeah, I thought it was not long enough, the half day course. I think the like a two-day course would be better. I just think with stuff like this because it's so like prevalent now. If something needs to be longer than just like, make it longer, just don't rush it. Because the half day is good for the amount of time that you're in there. But then obviously, I'm like, well, I didn't feel like I've learned enough. So, the half day is too short." (Interview 05: Patrick)*

> *"I thought the online training was good, good information, I actually felt like I was learning a few different terminologies. And the statistics were good and informative. But I think what would have been good would be to have some practical training if possible. Rather than just sitting on your computer and kind of whizzing through the training, I think practical sessions are much more sort of hands on so no one can really hide. I think that people will get a lot more out of it. A practical aspect of it I think will have a larger impact on the learners understanding of the sessions. So, I think the practical impact will help having conversations with people because that obviously automatically delves deeper. I think having a practical aspect to training and having that level of conversation could be really good." (Interview 12: Scott)*

The coaches were further questioned regarding the delivery and format of the training. All of the coaches interviewed within the semi-structured interviews described how they believed the training should be practical, face to face and delivered by an instructor. The coaches stated that due to the practical nature of learning how to support a participant through conversation and listening skills, the training needed to be practical and not delivered online. Within the study conducted by Ferguson et al. (2019) which

investigated youth sports coaches' perceptions of their role in adolescent mental health, it was found that the sports coaches believed face-to-face workshops which were practically delivered would be the most beneficial and engaging. The results of the present study build upon and reinforce these findings from Ferguson et al. (2019) by demonstrating that coaches who have completed MHFA training, both face-to-face and online, all suggested that the training course should be delivered face-to-face and that this would result in the greatest impact. The coaches within the present study clearly highlighted that the MHFA training courses would be best delivered face-to-face, allowing for key practical experience of scenarios and conversations due to the element of discussion being a major aspect of the course. The following quotes demonstrate the consensus relating to the practical delivery of the course:

> *"100% face to face, I think because online lends itself to you just click through as much as you can. And then you like, fill in the quiz. And like, for me, the whole point of it all is that it's people and it's dealing with people and it's having a conversation. If you're not able to talk about it on a course or listen to it, how are you going to do that with your players or participants. It's about communication and openness and, connecting with people. That's the heart of everything." (Interview 02: Sarah)*

> *"I feel like a face to face session really brings it home, how important it is. And I feel like with mental health, a lot of it is about talking. So, having that person to deliver the session to talk to, helps a lot. Because a lot of it if online you could like, not read properly, or it doesn't get you thinking as much were as if somebody is in front of you, like probing you and making you think about mental health in a different way, which you wouldn't have got in an online version." (Interview 04: Anna)*

It has been suggested that many community coaches within youth sport are volunteers and therefore are often restricted by time constraints, limiting their commitment to further coach education (Ferguson et al. 2019). In accordance with Sebbens et al. (2016), this is similar for elite coaches in professional sport who make huge commitments to training, travel and competing, making it more difficult to engage with time-pressuring training courses such as MHFA training. It is very important that this is considered when developing the MHFA training course for future coach education (Vargas-Tonsing 2007). It is therefore essential to contemplate whether the future development of mental health training programmes could benefit from being concise and flexible in their delivery method, in order to meet the target audience's

needs and requirements. Ferguson et al. (2019) suggested that a combination of both face-to-face and online training methods may suit individual coaches' needs. However, it is clear to see from the present study that coaches strongly believe that the MHFA training should be delivered face-to-face in order to have the most beneficial impact upon their knowledge, understanding and confidence to support their participants' mental health. To conclude this chapter, the MHFA training was appreciated and regarded as highly important by all the sports coaches. Due to the prevalence of mental health issues within society, coaches recognised that this type of training should become an integral component of their continued professional development. However, criticisms and areas for improvement of the training were identified by the coaches. These largely revolved around the format of delivery with a face-to-face, two-day course which is regularly renewed, being the preferred option.

Chapter 8

Conclusion

This research study has made a unique contribution to the understanding of community sports coaches' perceptions of their role in supporting participants' mental health and the effectiveness of the MHFA training course. By examining the impact of the MHFA training course upon community sports coaches, their real-life experiences have been presented. A number of key, concluding findings can be made based upon the data gathered and analysed from the present research study. Firstly, prior to completing the MHFA training the majority of coaches perceived their role as diverse and varied. However, supporting participants' mental health was considered as outside of their remit and not a coach's direct responsibility but that of mental health professionals. The coaches articulated several barriers which prevented them from fully engaging with supportive behaviours. These included: a lack of training with regards to mental health awareness and support, insufficient knowledge, a fear of negatively impacting their participants, and the associated stigma. However, following the MHFA training all coaches recognised the promotion and support of their participants mental health as a significant component of their role. These findings were in alignment with the Figurational Sociology concepts of power balances and habitus (Elias 1978). Due to an increase in knowledge from the MHFA training, it can be suggested that coaches hold more power within their figuration to effectively support and influence participants' mental health. With regards to habitus, results demonstrate that following the MHFA training, coach's habitus slowly alters with their supportive behaviours becoming second nature. However, it is important for future research to

evaluate the longer-term impact of this evolving and changing habitus amongst sports coaches as Elias (1978) proposes that this is a slow process which occurs over their lifetime.

An additional finding relates to a lack of knowledge prior to the MHFA training amongst the coaches with regards to mental health awareness and support. Coaches expressed that their knowledge of mental health was limited and described how they were ignorant of the complexity and depth of mental health within society. However, following the MHFA training, the coach's knowledge of mental health increased, allowing coaches to take a more active role in supporting participants' mental health. Furthermore, the same pattern of development was identified in relation to coaches' confidence in supporting their participants' mental health. Prior to the MHFA training, the majority of coaches described that they lacked confidence in adopting supportive behaviours regarding mental health, however, they did feel confident in signposting their participants to additional sources of help. Following the training, the coach's confidence increased, and coaches explained that they now felt they could challenge stigma, create a sporting environment which encouraged and normalised mental health awareness and support, as well as signpost their participants more efficiently. These research findings coincide with and reinforce the existing literature surrounding the effectiveness of the MHFA training course.

The final notable findings relate to the significance of the MHFA training and potential areas for development. Coaches agreed that the MHFA training is an essential component of sports coaches' continued professional development. Coaches further articulated that the MHFA course should become an integral part of their initial training as a coach, supported and commissioned by a variety of national governing bodies. Comparisons were made between the MHFA training and the physical first aid training, highlighting the equal importance of both. Alongside the positive feedback, coaches highlighted areas for improvement and future development including the importance of a follow up session, renewing the course regularly, practical delivery and developing a sport specific course.

The next section of this chapter discusses the limitations of the research and recommendations for future research, based on the main findings of this study.

8.1. Limitations, future recommendations and implications for research

Findings from the present study have been very encouraging, demonstrating community sports coaches' willingness to support their participants' mental health and the effectiveness of the MHFA training programme. However, within this chapter it is important to highlight and acknowledge some of the

limitations of this research study. Firstly, previous research has stated that coaches can be inaccurate when assessing their participants mental health and often view their own supportive behaviours as more encouraging and supportive than their actual behaviour presents (Salminen, Luikkonen and Telema 1992). The current study utilised self-reporting semi-structured interviews and therefore the responses of the coaches may be overestimated in regard to the extent to which the coaches' actual behaviour changed and is supportive of their participants mental health. To provide a more precise illustration of the coaches' behaviour, upcoming studies should include responses from the coach's actual participants in order to understand their perceptions of their coach's role and behaviour in supporting their participants' mental health.

It could also be argued that within this research study a larger sample size would have provided more depth and understanding of the power balances at play between a coach and their participants. However, this was unachievable due to the coronavirus pandemic which struck in March 2020. The pandemic led to a national lockdown whereby the government instructed individuals to stay at home. This has direct implications upon the data collection method, moving semi-structured interviews to virtual platforms. A sample of 16 participants can be regarded as a significant achievement when considering the implications of a global pandemic. Upon reflection, it should also be acknowledged that within certain interviews, the flow of the conversation would have been improved through the use of probing. On a limited number of occasions this was impacted by the Wi-Fi signal strength, causing a delay to a small number of online interviews. Therefore, follow up questions and probing were not always utilised to maximum effect as the researcher aimed to ensure all key questions were covered and was conscious of the poor signal. However, for the vast majority of the online interviews the Wi-Fi signal remained strong and the interviews ran smoothly and clearly.

Although this study contributes to further understanding the role of community sports coaches supporting their participants' mental health, there are several potential possibilities for future research. For example, future studies may consider ascertaining an equal divide of both female and male community sport coaches in order to understand the opinions of both, as gender differences may lead to variations in the results obtained. Within the present study 69% of the sample were male, leaving only 31% of participants female. This can be considered as a limitation of the present study, as the majority of community sport coaches interviewed were male. Further research is also needed and should continue to explore the range of activities that coaches use to support their participants' mental health. This could further inform future

MHFA training courses and other such initiatives. Another important area of study for future research would be the community sports coach's habitus. As discussed previously, habitus is socially constructed due to people acquiring dispositions through their everyday experiences and relationships with other people (van Krieken 1998; Fletcher 2013). Elias (1978) believed that a person's habitus develops continuously over a lifetime due to the ever-increasing and changing social interactions within increasingly dynamic figurations (van Krieken 1998). However, Elias believed this to be a long-term process. Therefore, it would be interesting to revisit the participants who displayed signs of change within their habitus to further investigate and conclude if their habitus has in fact changed or reverted back to their previous norms and habits over time.

References

Aakre, J.M., Lucksted, A. and Browning-McNee, L.A. (2016) Evaluation of Youth Mental Health First Aid USA: A program to assist young people in psychological distress. *Psychological services*, 13 (2), p. 121.

Ahmedani, B.K. (2011) Mental health stigma: Society, individuals, and the profession. *Journal of social work values and ethics*, 8 (2), pp. 4-1.

Ahn, S. and Fedewa, A.L. (2011) A meta-analysis of the relationship between children's physical activity and mental health. *Journal of pediatric psychology*, 36 (4), pp. 385-397.

Alfrey, L. and Gard, M. (2019) Figuring out the prevalence of fitness testing in physical education: a figurational analysis. *European Physical Education Review,* 25 (1), pp. 187-202.

Alvarez, M.S., Balaguer, I., Castillo, I. and Duda, J.L. (2012) The coach-created motivational climate, young athletes' well-being, and intentions to continue participation. *Journal of clinical sport psychology*, 6 (2), pp. 166-179.

Anderson, R.J. and Pierce, D. (2012) Assumptions associated with mental health literacy training–Insights from initiatives in rural Australia. *Advances in Mental Health*, 10 (3), pp. 258-267.

Andrews, D.L., Mason, D.S. and Silk, M.L. (2006) *Qualitative methods in sport studies.* Oxford, Berg.

Anthony, B. (2016) *Unified Theory of Behaviour [Webinar].*

Ashdown-Franks, G., Sabiston, C.M., Solomon-Krakus, S. and O'Loughlin, J.L. (2017) Sport participation in high school and anxiety symptoms in young adulthood. *Mental Health and Physical Activity*, 12, pp. 19-24.

Australian Department of Health and Ageing (2009) *Fourth national mental health plan: An agenda for collaborative government action in mental health 2009–2014.* Canberra, ACT: Commonwealth of Australia.

Australian Government Department of Health (2015) *Australian Government Response to Contributing Lives, Thriving Communities–Review of Mental Health Programmes and Services.* Commonwealth of Australia, Canberra.

Australian Institute of Health and Welfare (2017) *Mental health services – In brief 2017.* Canberra, Australian Institute of Health and Welfare.

Bale, J., Grové, C. and Costello, S. (2018) A narrative literature review of child-focused mental health literacy attributes and scales. *Mental Health & Prevention*, 12, pp. 26-35.

Bandura, A. (1993) Perceived self-efficacy in cognitive development and functioning. *Educational psychologist*, 28 (2), pp. 117-148.

Bapat, S., Jorm, A. and Lawrence, K. (2009) Evaluation of a mental health literacy training program for junior sporting clubs. *Australasian psychiatry*, 17 (6), pp. 475-479.

Barry, M.M., Clarke, A.M., Jenkins, R. and Patel, V. (2013) A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries. *BMC public health*, 13 (1), p. 835.

Baumann, A.E. (2007) Stigmatization, social distance and exclusion because of mental illness: The individual with mental illness as a 'stranger.' *International Review of Psychiatry,* 19, pp. 131-135.

Bauman, N.J. (2016) The stigma of mental health in athletes: are mental toughness and mental health seen as contradictory in elite sport? p. 135-136.

Baur, C., Martinez, L.M., Tchangalova, N. and Rubin, D. (2017) *A Review and Report of Community-based Health Literacy Interventions.* Washington, D.C., National Academies of Sciences, Engineering, and Medicine.

Baur, N. and Ernst, S. (2011) Towards a process-oriented methodology: modern social science research methods and Norbert Elias's figurational sociology. *The sociological review*, 59, pp. 117-139.

Bean, C., McFadden, T., Fortier, M. and Forneris, T. (2019) Understanding the relationships between programme quality, psychological needs satisfaction, and mental well-being in competitive youth sport. *International Journal of Sport and Exercise Psychology*, pp. 1-19.

Bell, C.C. (1997) Promotion of mental health through coaching competitive sports. *Journal of the National Medical Association*, 89 (8), p. 517.

Bertram, R. and Gilbert, W. (2011) Learning communities as continuing professional development for sport coaches. *Journal of Coaching Education*, 4 (2), pp. 40-61.

Biddle, S.J. and Asare, M. (2011) Physical activity and mental health in children and adolescents: a review of reviews. *British journal of sports medicine*, 45 (11), pp. 886-895.

Biddle, S.J., Ciaccioni, S., Thomas, G. and Vergeer, I. (2019) Physical activity and mental health in children and adolescents: An updated review of reviews and an analysis of causality. *Psychology of Sport and Exercise*, 42, pp. 146-155.

Bloom, G.A., Durand-Bush, N., Schinke, R.J. and Salmela, J.H. (1998) The importance of mentoring in the development of coaches and athletes. *International journal of sport psychology*, 29, pp. 267-281.

Bloyce, D. and Murphy, P. (2008) Baseball in England: A case of prolonged cultural resistance. *Journal of Historical Sociology*, 21 (1), pp. 120-142.

Bloyce, D., Smith, A., Mead, R. and Morris, J. (2008) 'Playing the game (plan)': A figurational analysis of organizational change in sports development in England. *European sport management quarterly*, 8 (4), pp. 359-378.

Blumenthal, J.A., Babyak, M.A., Doraiswamy, P.M., Watkins, L., Hoffman, B.M., Barbour, K.A., Herman, S., Craighead, W.E., Brosse, A.L., Waugh, R. and Hinderliter, A. (2007) Exercise and pharmacotherapy in the treatment of major depressive disorder. *Psychosomatic medicine*, 69 (7), p. 587.

Borrill, J. (2010) *Mental health first aid training: initial evaluation by private sector participants.* London, MHFA England.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative research in psychology*, 3 (2), pp. 77-101.

Braun, V., Clarke, V. and Weate, P. (2016) Using thematic analysis in sport and exercise research. In: Smith, B and Sparkes, A, C. ed. *Routledge handbook of qualitative research in sport and exercise*. Abingdon, Routledge, pp. 191-205.

Breslin, G., Haughey, T., O'Brien, W., Caulfield, L., Robertson, A. and Lawlor, M. (2018) Increasing athlete knowledge of mental health and intentions to seek help: The State of Mind Ireland (SOMI) Pilot Program. *Journal of Clinical Sport Psychology*, 12 (1), pp. 39-56.

Breslin, G., Haughey, T.J., Donnelly, P., Kearney, C. and Prentice, G. (2017a) Promoting mental health awareness in sport clubs. *Journal of Public Mental Health*, 16 (2), pp. 55-62.

Breslin, G., Shannon, S., Haughey, T. and Leavey, G. (2016) A review of mental health and wellbeing awareness Programmes in sport. *Sport Northern Ireland.*

Breslin, G., Shannon, S., Haughey, T., Donnelly, P. and Leavey, G. (2017b) A systematic review of interventions to increase awareness of mental health and well-being in athletes, coaches and officials. *Systematic reviews*, 6 (1), p. 177.

Breslin, G., Shannon, S., Haughey, T., Sarju, N., Neill, D., Leavey, G. and Lawlor, M. (2019a) Athlete and Nonathlete Intentions to Self-Manage Mental Health: Applying the Integrated Behavior Change Model to the State of Mind Program. *Journal of Applied Sport Psychology*, pp. 1-15.

Breslin, G., Smith, A., Donohue, B., Donnelly, P., Shannon, S., Haughey, T.J., Vella, S.A., Swann, C., Cotterill, S., Macintyre, T. and Rogers, T. (2019b) International consensus statement on the psychosocial and policy-related approaches to mental health awareness programmes in sport. *BMJ open sport & exercise medicine*, 5 (1), p. e000585.

British Sociological Association (2007) *Cultural Sociology: A Journal of the British Sociological Association*. London, Sage.

Brown, J. D. (2015) Characteristics of sound quantitative research. *Shiken*, 19 (2), pp. 24-28.

Brown, M., Deane, F.P., Vella, S.A. and Liddle, S.K. (2017) Parents views of the role of sports coaches as mental health gatekeepers for adolescent males. *International Journal of Mental Health Promotion*, 19 (5), pp. 239-251.

Bryman, A. (2007) Barriers to integrating quantitative and qualitative research. *Journal of mixed methods research*, 1 (1), pp. 8-22.

Bryman, A. (2012) *Social Research Methods*. 4th ed. Oxford, Oxford University Press.

Bryman, A. (2016) *Social Research Methods.* 5th ed. Oxford, Oxford University Press.

Bryman, A. (2017) Quantitative and qualitative research: further reflections on their integration. In: Brannen, J. ed. *Mixing methods: Qualitative and quantitative research*. London, Routledge, pp. 57-78.

Burns, N. and Grove, S.K. (1999) *Understanding Nursing Research.* Philadelphia, W.B. Saunders Company.

Callaghan, P. (2004) Exercise: a neglected intervention in mental health care? *Journal of psychiatric and mental health nursing*, 11 (4), pp. 476-483.

Canady, V. A. (2013) MH community applauds White House launch of national dialogue. *Mental Health Weekly,* 23 (23), pp. 1-8.

Cane, F.E. and Oland, L. (2015) Evaluating the outcomes and implementation of a TaMHS (Targeting Mental Health in Schools) project in four West Midlands (UK) schools using activity theory. *Educational Psychology in Practice*, 31 (1), pp. 1-20.

Carless, D. and Douglas, K. (2008) Social support for and through exercise and sport in a sample of men with serious mental illness. *Issues in mental health nursing*, 29 (11), pp. 1179-1199.

Carless, D. and Sparkes, A.C. (2008) The physical activity experiences of men with serious mental illness: Three short stories. *Psychology of sport and exercise*, 9 (2), pp. 191-210.

Castaer, M., Anguera, T. and Camerino, O. (2012) *Mixed Methods Research in the Movement Sciences*. London, Routledge.

Castaldelli-Maia, J.M., e Gallinaro, J.G.D.M., Falcão, R.S., Gouttebarge, V., Hitchcock, M.E., Hainline, B., Reardon, C.L. and Stull, T. (2019) Mental health symptoms and disorders in elite athletes: a systematic review on cultural influencers and barriers to athletes seeking treatment. *British Journal of Sports Medicine*, 53 (11), pp. 707-721.

Cavioni, V., Agliati, A. and Grazzani, I. (2019) Exploring school mental health, student-teacher relationship, and school climate among adolescents: results of a survey study in Italy. *19th European Conference of Developmental Psychology*, pp. 660-660.

Clay, R. A. (2013) Mental health first aid. *American Psychological Association*, 44 (32).

Cleary, M., Horsfall, J. and Escott, P. (2015) Compassion and mental health nursing. *Issues in mental health nursing*, 36 (7), pp. 563-565.

Cohen, L., Manion, L. and Morrison, K. (2007) *Research methods in education*. 6th ed. London, Routledge.

Corbetta, P. (2003) *Social research: theory, methods and techniques*. London, Sage.

Corrigan, P. and Bink, A.B. (2005) On the stigma of mental illness. *American Psychological Association,* pp. 11-44.

Costello, E.J., Egger, H. and Angold, A. (2005) 10-year research update review: the epidemiology of child and adolescent psychiatric disorders: I. Methods and public health burden. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44 (10), pp. 972-986.

Coyle, M., Gorczynski, P. and Gibson, K. (2017) "You have to be mental to jump off a board any way": Elite divers' conceptualizations and perceptions of mental health. *Psychology of Sport and Exercise*, 29, pp. 10-18.

Creswell, J. (2018) *Research Design: Qualitative, Quantitative and Mixed Methods Approaches.* 5th ed. Los Angeles, Sage.

Creswell, J.W. and Poth, C.N. (2016) *Qualitative inquiry and research design: Choosing among five approaches*. London, Sage.

Creswell, J.W. and Poth, C.N. (2018) *Qualitative injury & research design: choosing among five approaches.* London, Sage.

Cronin, J. M., McCarthy, M. B. and Collins, A. M. (2014) Covert distinction: how hipsters practice food-based resistance strategies in the production of identity. *Consumption Markets & Culture*, 17 (1), pp. 2-28.

Cushion, C.J. and Jones, R.L. (2014) A Bourdieusian analysis of cultural reproduction: Socialisation and the 'hidden curriculum' in professional football. *Sport, education and society*, *19* (3), pp. 276-298.

Czosnek, L., Lederman, O., Cormie, P., Zopf, E., Stubbs, B. and Rosenbaum, S. (2019) Health benefits, safety and cost of physical activity interventions for mental health conditions: A meta-review to inform translation efforts. *Mental Health and Physical Activity*, 16, pp. 140-151.

Dahlberg, K.M., Waern, M. and Runeson, B. (2008) Mental health literacy and attitudes in a Swedish community sample–Investigating the role of personal experience of mental health care. *BMC Public Health*, 8 (1), p.8.

Dale, L.P., Vanderloo, L., Moore, S. and Faulkner, G. (2019) Physical activity and depression, anxiety, and self-esteem in children and youth: An umbrella systematic review. *Mental Health and Physical Activity*, 16, pp. 66-79.

Danish, S.J., Forneris, T. and Wallace, I. (2005) Sport-based life skills programming in the schools. *Journal of Applied School Psychology*, 21 (2), pp. 41-62.

Das, J.K., Salam, R.A., Lassi, Z.S., Khan, M.N., Mahmood, W., Patel, V. and Bhutta, Z.A. (2016) Interventions for adolescent mental health: an overview of systematic reviews. *Journal of Adolescent Health*, 59 (4), pp. 49-60.

David, B. and Resnik, D. (2015) *What is Ethics in Research and Why is it Important? National Institute of Environmental Health Sciences* [Internet]. Available from https://www.niehs.nih.gov/research/resources/bioethics/whatis/index.cfm?links=false [Accessed 26th February 2019].

Davies, M. B. and Hughes, N. (2014) *Doing a successful research project: Using qualitative or quantitative methods*. 2nd ed. London, Macmillan International Higher Education.

Dean, B.A. (2018) The Interpretivist and The Learner. *International Journal of Doctoral Studies.* 13, pp. 1-8.

Deci, E.L. and Ryan, R.M. (2008) Hedonia, eudaimonia, and well-being: An introduction. *Journal of happiness studies*, 9 (1), pp. 1-11.

Denzin, N.K. and Lincoln, Y.S. (1994) *Handbook of Qualitative Research.* Thousand Oaks, CA, Sage.

Department of Children and Youth Affairs (2014) *Better outcomes, brighter futures: The national policy framework for children and young people 2014–2020.* Dublin, The Stationary Office.

Department of Health (2014) Closing the Gap: Priorities for Essential Change in Mental Health. Department of Health. London: Department of Health. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf [Accessed 21st November 2019].

Department of Health (2015) *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.* London, Routledge.

Dew, M.A., Bromet, E.J., Schulberg, H.C., Parkinson, D.K. and Curtis, E.C. (1991) Factors affecting service utilization for depression in a white collar population. *Social Psychiatry and Psychiatric Epidemiology*, 26 (5), pp. 230-237.

Dewe, P. and Kompier, M. (2008) *Foresight Mental Capital and Wellbeing Project. Wellbeing and work: Future challenges, Final Project Report*. London, The Government Office for Science.

Dey, M., Marti, L. and Jorm, A.F. (2019) The Swiss Youth Mental Health Literacy and Stigma Survey: Study methodology, survey questions/vignettes, and lessons learned. *The European Journal of Psychiatry*, 33 (2), pp. 72-82.

Dickson-Swift, V., James, E.L., Kippen, S. and Liamputtong, P. (2007) Doing sensitive research: what challenges do qualitative researchers face? *Qualitative research*, 7 (3), pp. 327-353.

Diener, E., Suh, E.M., Lucas, R.E. and Smith, H.L. (1999) Subjective well-being: Three decades of progress. *Psychological bulletin*, 125 (2), p. 276.

Donovan, R.J., Henley, N., Jalleh, G., Silburn, S., Zubrick, S. and Williams, A. (2006) The impact on mental health in others of those in a position of authority: a perspective of parents, teachers, trainers and supervisors. *Australian e-Journal for the Advancement of Mental Health*, 5 (1), pp. 60-66.

Dopson, S. (2001) Applying an Elisian approach to organizational analysis. *Organization*, 8 (3), pp. 515-535.

Doré, I., O'loughlin, J.L., Schnitzer, M.E., Datta, G.D. and Fournier, L. (2018) The longitudinal association between the context of physical activity and mental health in early adulthood. *Mental Health and Physical Activity*, 14, pp. 121-130.

Dorvil, H. and Tousignant-Groulx, J. (2019) Models of Housing in the Quebec Setting for Individuals with Mental Illness. *Frontiers in Psychiatry*, 10, p.850.

Downe-Wamboldt, B. (1992) Content analysis: method, applications, and issues. *Health care for women international*, 13 (3), pp. 313-321.

Duffy, J., Rooney, B. and Matthews, J. (2019) Coaches' Mental Health Literacy and Role Perceptions for Supporting Young People's Mental Health. *Journal of Applied Sport Psychology*, pp. 1-15.

Dunning, E. (2002) Figurational contributions to the sociological study of sport. In: Maguire, J. and Young, K. eds. *Theory, Sport and Society.* Oxford, Elsevier Science, pp. 211-38.

Dunning, E. and Hughes, J. (2013) *Norbert Elias and Modern Sociology: Knowledge, Interdependence, Power, Process*. London, Bloomsbury.

Elias, N. (1978) *What is Sociology?* London, Hutchinson & Co ltd.

Elias, N. (1987) *Involvement and detachment.* Oxford, Blackwell ltd.

Elias, N. (1988) Violence and civilization: the state monopoly of physical violence and its infringement. In: Keane, J. ed. *Civil Society and the State*. London, Verso, pp. 177-198.

Elias, N. (1994) *The civilizing process.* Oxford, Blackwell ltd.

Elias, N. (2001a) *The society of individuals.* London, Continuum Publishing.

Elias, N. (2001b) *The loneliness of the dying.* London, Continuum Publishing.

Elias, N. (2009) Figuration. In: Elias, N. ed. *Essays III: On sociology and the humanities, 16, collected works*. Dublin, University College Dublin Press, pp. 1-3.

Emmel, N. (2013) *Sampling and choosing cases in qualitative research: A realist approach*. London, Sage.

Faulkner, G. and Duncan, M. (2017) Physical activity and mental health: A focus on depression. In: Piggin, J., Mansfield, L. and Weed, M. ed. *Routledge Handbook of Physical Activity Policy and Practice*. Routledge, pp. 171-185.

Fletcher, J. (2013) *Violence and Civilization: An Introduction to the Work of Norbert Elias*. Cambridge, Polity Press.

Flick, U. (1998) *An introduction to Qualitative research.* London, Sage.

Flick, U. (2009) *An introduction to Qualitative research.* 4th ed. London, Sage.

Flyan, F. (2005) Semi-structured interviewing. In: Miles, J. and Gilbert, P. ed. *A Handbook of Research Methods for Clinical and Health Psychology*. New York, Oxford University Press, pp. 65-79.

Fogaca, J.L. (2019) Combining Mental Health and Performance Interventions: Coping and Social Support for Student-Athletes. *Journal of Applied Sport Psychology*, pp. 1-16.

Fraser-Thomas, J.L., Côté, J. and Deakin, J. (2005) Youth sport programs: An avenue to foster positive youth development. *Physical education & sport pedagogy*, 10 (1), pp. 19-40.

Furnham, A. and Swami, V. (2018) Mental health literacy: A review of what it is and why it matters. *International Perspectives in Psychology: Research, Practice, Consultation*, 7 (4), pp. 240-257.

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J. and Sartorius, N. (2015) Toward a new definition of mental health. *World Psychiatry*, 14 (2), pp. 231-233.

Galletta, A. (2013) *Mastering the semi-structured interview and beyond: From research design to analysis and publication*. New York, NYU Press.

Geidne, S., Quennerstedt, M. and Eriksson, C. (2013) The youth sports club as a health-promoting setting: An integrative review of research. *Scandinavian journal of public health*, 41 (3), pp. 269-283.

George, M. (2013) Teaching focus group interviewing: Benefits and challenges. *Teaching Sociology*, 41 (3), pp. 257-270.

Gonzalez, J.M., Alegria, M. and Prihoda, T.J. (2005) How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of community psychology*, 33 (5), pp. 611-629.

Gorczynski, P., Gibson, K., Thelwell, R., Papathomas, A., Harwood, C. and Kinnafick, F. (2019) The BASES Expert Statement on mental health literacy in elite sport. *The Sport and Exercise Scientist*, 59, pp. 6-7.

Goudsblom, J. and Mennell, S. eds. (1998) *The Norbert Elias reader*. Oxford, Blackwell ltd.

Gratton, C. and Jones, I. (2004) *Research methods for sport studies.* London, Routledge.

Gratton, C. and Jones, I. (2014) *Research methods for sports studies*. 3rd ed. London, Routledge.

Gratton, C. and Jones, I. (2015) *Research Methods for Sport Studies*. 4th ed. New York, Routledge.

Green, K. (2002) Physical education teachers in their figurations: A sociological analysis of everyday 'philosophies'. *Sport, Education and Society*, 7 (1), pp. 65-83.

Green, K. (2003) *Physical Education Teachers on Physical Education: A sociological study of philosophies and ideologies*. Chester, University of Chester Academic Press.

Griffiths, M. and Armour, K. (2014) Volunteer sports coaches as community assets? A realist review of the research evidence. *International journal of sport policy and politics*, 6 (3), pp. 307-326.

Gronholm, P.C., Thornicroft, G., Laurens, K.R. and Evans-Lacko, S. (2017) Mental health-related stigma and pathways to care for people at risk of psychotic disorders or experiencing first-episode psychosis: a systematic review. *Psychological medicine*, 47 (11), pp. 1867-1879.

Gryglewicz, K., Childs, K.K. and Soderstrom, M.F. (2018) An evaluation of youth mental health first aid training in school settings. *School mental health*, 10 (1), pp.48-60.

Guba, E.G. and Lincoln, Y.S. (1994) Competing paradigms in qualitative research. In: Norman K. Denzin, N.K. and Lincoln, Y.S. ed. *Handbook of qualitative research*. London, Sage, pp. 163-194.

Guest, G., MacQueen, K.M. and Namey, E.E. (2011) *Applied thematic analysis*. London, Sage.

Gulliver, A., Griffiths, K.M. and Christensen, H. (2012) Barriers and facilitators to mental health help-seeking for young elite athletes: a qualitative study. *BMC psychiatry*, 12 (1), p.157.

Gulliver, A., Griffiths, K.M., Christensen, H., Mackinnon, A., Calear, A.L., Parsons, A., Bennett, K., Batterham, P.J. and Stanimirovic, R. (2012) Internet-based interventions to promote mental health help-seeking in elite athletes: an exploratory randomized controlled trial. *Journal of Medical Internet Research*, 14 (3), p.69.

Hadlaczky, G., Hökby, S., Mkrtchian, A., Carli, V. and Wasserman, D. (2014) Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. *International Review of Psychiatry*, 26 (4), pp. 467-475.

Haggerty, D., Carlson, J.S., McNall, M., Lee, K. and Williams, S. (2019) Exploring Youth Mental Health First Aider Training Outcomes by Workforce Affiliation: A Survey of Project AWARE Participants. *School Mental Health*, 11 (2), pp. 345-356.

Haggerty, R.J. and Mrazek, P.J. (1994) *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, D.C., National Academies Press.

Halliday, A.J., Kern, M.L. and Turnbull, D.A. (2019) Can physical activity help explain the gender gap in adolescent mental health? A cross-sectional exploration. *Mental Health and Physical Activity*, *16*, pp. 8-18.

Hart, L.M., Bourchier, S.J., Jorm, A.F., Kanowski, L.G., Kingston, A.H., Stanley, D. and Lubman, D.I. (2010) Development of mental health first aid guidelines for Aboriginal and Torres Strait Islander people experiencing problems with substance use: a Delphi study. *BMC psychiatry*, 10 (1), p.78.

Harwood, C., Drew, A. and Knight, C.J. (2010) Parental stressors in professional youth football academies: A qualitative investigation of specialising stage parents. *Qualitative research in sport and exercise*, 2 (1), pp. 39-55.

Hatzenbuehler, M.L., Phelan, J.C. and Link, B.G. (2013) Stigma as a fundamental cause of population health inequalities. *American journal of public health*, 103 (5), pp. 813-821.

Hayden, L., Silva, M.R. and Gould, K. (2017) Revealing School Counsellors' Perspectives on Using Physical Activity and Consulting with Coaches. *Professional School Counselling*, 21 (1), pp. 1096-2409.

Henderson, C., Evans-Lacko, S. and Thornicroft, G. (2013) Mental illness stigma, help seeking, and public health programs. *American journal of public health*, 103 (5), pp. 777-780.

Hennink, M.M., Hutter, I. and Bailey, A. (2011) *Qualitative research methods.* London, Sage.

Henriksen, K., Schinke, R., Moesch, K., McCann, S., Parham, W.D., Larsen, C.H. and Terry, P. (2020) Consensus statement on improving the mental health of high performance athletes. *International Journal of Sport and Exercise Psychology*, 18 (5), pp. 553-560.

Hermens, N., Super, S., Verkooijen, K.T. and Koelen, M.A. (2017) A systematic review of life skill development through sports programs serving socially vulnerable youth. *Research quarterly for exercise and sport*, 88 (4), pp. 408-424.

Hill, A., MacNamara, Á. and Collins, D. (2015) Psychobehaviorally based features of effective talent development in rugby union: A coach's perspective. *The Sport Psychologist*, 29 (3), pp. 201-212.

Hinshaw, S.P. and Cicchetti, D. (2000) Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy. *Development and psychopathology*, 12 (4), pp. 555-598.

Hofisi, C., Hofisi, M. and Mago, S. (2014) Critiquing Interviewing as a Data Collection Method. *Mediterranean Journal of Social Sciences,* 5 (16), pp. 60-64.

Hossain, D., Gorman, D. and Eley, R. (2009) Enhancing the knowledge and skills of Advisory and Extension Agents in mental health issues of farmers. *Australasian Psychiatry*, 17 (1), pp. S116-S120.

Houghton, A.M. and Anderson, J. (2017) Embedding mental wellbeing in the curriculum: maximising success in higher education. *Higher Education Academy*, 68, pp. 1-43.

House of Commons Health Committee (2014) *Children's' and adolescents' mental health and CAMHS.* London, Stationary Office.

Huberman, M. and Miles, M. B. (2002) *The qualitative researcher's companion*. London, Sage.
Hurley, D., Allen, M.S., Swann, C., Okely, A.D. and Vella, S.A. (2018) The Development, Pilot, and Process Evaluation of a Parent Mental Health Literacy Intervention Through Community Sports Clubs. *Journal of Child and Family Studies*, 27 (7), pp. 2149-2160.

Hurley, D., Swann, C., Allen, M.S., Okely, A.D. and Vella, S.A. (2017) The role of community sports clubs in adolescent mental health: the perspectives of adolescent males' parents. *Qualitative research in sport, exercise and health*, 9 (3), pp. 372-388.

James, S.L., Abate, D., Abate, K.H., Abay, S.M., Abbafati, C., Abbasi, N., Abbastabar, H., Abd-Allah, F., Abdela, J., Abdelalim, A. and Abdollahpour, I. (2018) Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, 392 (10159), pp. 1789-1858.

Jarvis-Beesley, P. (2018) *Into the Open: exploring the connections between young people's mental health and community sport.* MSc thesis, Cass Business School City University of London.

Joffe, H. and Yardley, L. (2004) Content and thematic analysis. *Research methods for clinical and health psychology*, 56, p. 68.

Johnson, R.B. and Onwuegbuzie, A.J. (2004) Mixed methods research: A research paradigm whose time has come. *Educational Researcher,* 33 (7), pp. 14-26.

Jones, I. (2015) *Research methods for sports studies.* 3rd ed. Abingdon, Routledge.

Jones, J., O'Keeffe, H. and Smith, A. (2019) Tackling the Blues: A sport and education based mental health programme for children and young people. In: Breslin, G. and Leavey, G. eds. *Mental health and well-being interventions in sport: Research, theory and practice.* London, Routledge, pp. 91-106.

Jones, L., Tones, S. and Foulkes, G. (2020) Associate teachers' learning networks: a figurational analysis of initial teacher education. *International Journal of Mentoring and Coaching in Education*, 9 (2), pp. 205-218.

Jorm, A.F. (2000) Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, 177 (5), pp. 396-401.

Jorm, A.F. (2012) Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, 67 (3), p. 231.

Jorm, A.F. and Kitchener, B.A. (2011) Noting a landmark achievement: mental health first aid training reaches 1% of Australian adults. *Australian and New Zealand Journal of Psychiatry,* 45, pp. 808–813.

Jorm, A.F. and Wright, A. (2008) Influences on young people's stigmatising attitudes towards peers with mental disorders: national survey of young Australians and their parents. *The British journal of psychiatry*, 192 (2), pp. 144-149.

Jorm, A.F., Kitchener, B.A., Fischer, J.A. and Cvetkovski, S. (2010b) Mental health first aid training by e-learning: a randomized controlled trial. *Australian and New Zealand Journal of Psychiatry*, 44 (12), pp. 1072-1081.

Jorm, A.F., Kitchener, B.A., O'Kearney, R. and Dear, K.B. (2004) Mental health first aid training of the public in a rural area: a cluster randomized trial. *BMC psychiatry*, 4 (1), p. 33.

Jorm, A.F., Kitchener, B.A., Sawyer, M.G., Scales, H. and Cvetkovski, S. (2010a) Mental health first aid training for high school teachers: a cluster randomized trial. *BMC psychiatry*, 10 (1), p. 51.

Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., Rodgers, B. and Pollitt, P. (1997) "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical journal of Australia*, 166 (4), pp. 182-186.

Jowett, S. (2005) The coach-athlete partnership. *The psychologist*, 18 (7), pp. 412-415.

Jowett, S. and Cockerill, I.M. (2003) Olympic medallists' perspective of the athlete–coach relationship. *Psychology of sport and exercise*, 4 (4), pp. 313-331.

Kaiser, K. (2012) Protecting confidentiality. In: Gubrium, J.F. ed. *The Sage handbook of interview research*. 2nd ed. London, Sage, pp. 457-464.

Kanowski, L.G., Kitchener, B.A. and Jorm, A.F. (2008) Aboriginal and Torres Strait Islander Mental Health First Aid Manual. *Melbourne, ORYGEN Research Centre*.

Kaushik, A., Kostaki, E. and Kyriakopoulos, M. (2016) The stigma of mental illness in children and adolescents: A systematic review. *Psychiatry Research*, 243, pp. 469-494.

Kelly, C.M., Jorm, A.F. and Wright, A. (2007) Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Medical Journal of Australia*, 187 (S7), pp. S26-S30.

Kelly, C.M., Mithen, J.M., Fischer, J.A., Kitchener, B.A., Jorm, A.F., Lowe, A. and Scanlan, C. (2011) Youth mental health first aid: a description of the program and an initial evaluation. *International Journal of Mental Health Systems*, 5 (1), p. 4.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R. and Walters, E.E. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, 62 (6), pp. 593-602.

Keyes, C.L. (2006) Mental health in adolescence: Is America's youth flourishing? *American journal of orthopsychiatry*, 76 (3), pp. 395-402.

Keyes, C.L. (2014) Mental health as a complete state: How the salutogenic perspective completes the picture. In: Bauer, G.F. and Hämmig, O. eds. *Bridging occupational, organizational and public health*. Dordrecht, Springer, pp. 179-192.

Kitchener, B.A. and Jorm, A.F. (2002) Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behavior. *BMC psychiatry*, 2 (1), pp. 1-6.

Kitchener, B.A. and Jorm, A.F. (2004) Mental health first aid training in a workplace setting: a randomized controlled trial. *BMC psychiatry*, 4 (1), p. 23.

Kitchener, B.A. and Jorm, A.F. (2006) Mental health first aid training: review of evaluation studies. *Australian & New Zealand Journal of Psychiatry*, 40 (1), pp. 6-8.

Kitchener, B.A. and Jorm, A.F. (2008) Mental Health First Aid: an international programme for early intervention. *Early Intervention in Psychiatry*, 2 (1), pp. 55-61.

Kitchener, B.A., Jorm, A.F. and Kelly, C.M. (2012) *Youth Mental Health First Aid USA for adults assisting young people.* Washington, D.C., National Council for Behavioural Health.

Kitchener, B.A., Jorm, A.F. and Kelly, C.M. (2016) *Mental Health First Aid Manual*. 3rd ed. Melbourne, Mental Health First Aid International.

Kitchener, B.A., Jorm, A.F. and Kelly, C.M. (2018) *A Whole Organisation Approach to Young People's Mental Health.* London, Mental Health First Aid England.

Kitchener, B.A., Jorm, A.F. and Kelly, C.M. (2019) *Youth Mental Health First Aid Manual*. 1st ed. London, Mental Health First Aid England.

Kleszczewska, D., Mazur, J. and Siedlecka, J. (2019) Family, school and neighbourhood factors moderating the relationship between physical activity and some aspects of mental health in adolescents. *International Journal of Occupational Medicine and Environmental Health*, 32 (4), pp. 423-439.

Kohn, R., Saxena, S., Levav, I. and Saraceno, B. (2004) The treatment gap in mental health care. *Bulletin of the World health Organization*, 82, pp. 858-866.

Kokko, S. (2014) Sports clubs as settings for health promotion: Fundamentals and an overview to research. *Scandinavian journal of public health*, 42 (15), pp. 60-65.

Kokko, S., Green, L.W. and Kannas, L. (2013) A review of settings-based health promotion with applications to sports clubs. *Health promotion international*, 29 (3), pp. 494-509.

Kroshus, E., Chrisman, S.P., Coppel, D. and Herring, S. (2019) Coach support of high school student-athletes struggling with anxiety or depression. *Journal of Clinical Sport Psychology*, 13 (3), pp. 390-404.

Kuhn, T.S. (2012) *The structure of scientific revolutions*. Chicago, University of Chicago press.

Kumar, R. (2005) *Research Methodology: a step-by-step guide for beginners*. 3rd ed. London, Sage.

Kumar, R. (2014) *Research Methodology: a step-by-step guide for beginners.* 4th ed. London Sage.

Kumar, R. (2019) *Research Methodology: A step-by-step guide for beginners*. 5th ed. London, Sage.

Kutcher, S., Bagnell, A. and Wei, Y. (2015) Mental health literacy in secondary schools: a Canadian approach. *Child and adolescent psychiatric clinics of North America*, 24 (2), pp. 233-244.

Kutcher, S., Wei, Y., McLuckie, A. and Bullock, L. (2013) Educator mental health literacy: a programme evaluation of the teacher training education on the mental health & high school curriculum guide. *Advances in school mental health promotion*, 6 (2), pp. 83-93.

Kvale, S. (2008) *Doing interviews*. London, Sage.

Lalitha, K. (2009) *Mental health and psychiatric nursing*. New Delhi, CBS Publishers & Distributors.

Lam, A.Y., Jorm, A.F. and Wong, D.F. (2010) Mental health first aid training for the Chinese community in Melbourne, Australia: effects on knowledge about and attitudes toward people with mental illness. *International journal of mental health systems*, 4 (1), p. 18.

Lamers, S.M., Westerhof, G.J., Bohlmeijer, E.T., ten Klooster, P.M. and Keyes, C.L. (2011) Evaluating the psychometric properties of the mental health continuum-short form (MHC-SF). *Journal of clinical psychology*, 67 (1), pp. 99-110.

Lau, R.W.K. and Pretorius, L. (2019) Intrapersonal Wellbeing and the Academic Mental Health Crisis. In: Pretorius, L., Macaulay, L. and de Caux, B.C. eds. *Wellbeing in Doctoral Education.* Singapore, Springer, pp. 37-45.

Lauber, C., Nordt, C., Falcato, L. and Rössler, W. (2003) Do people recognise mental illness? *European archives of psychiatry and clinical neuroscience*, 253 (5), pp. 248-251.

Lavanya, A.S. (2019) Assess the Attitude Regarding Mental Illness among the Community Residents in Meppur. *Journal of Pharmaceutical Sciences and Research*, 11 (5), pp. 1731-1732.

Law, G. and Bloyce, D. (2019) Game Models as a framework for understanding power in the male football figuration. In: Malcolm, D. and Velija, P. ed. *Figurational Research in Sport, Leisure and Health*. Abingdon, Oxon, Routledge, pp. 34-44.

Lawrence, D., Hafekost, J., Johnson, S. E., Saw, S., Buckingham, W. J., Sawyer, M. G., Zubrick, S. R. (2016) Key findings from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry*, 50 (9), pp. 876-886.

Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer, M., Ainley, J. and Zubrick, S.R. (2015) *The mental health of children and adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing.* Department of Health, Canberra, Australia.

Lebrun, F., MacNamara, À., Collins, D. and Rodgers, S. (2020) Supporting Young Elite Athletes With Mental Health Issues: Coaches' Experience and Their Perceived Role. *The Sport Psychologist*, 34 (1), pp. 43-53.

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R. and Suárez-Orozco, C. (2018) Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *American Psychologist*, 73 (1), p. 26.

Lewis, S. (2015) Qualitative inquiry and research design: Choosing among five approaches. *Health promotion practice*, 16 (4), pp. 473-475.

Liddle, S.K., Deane, F.P. and Vella, S.A. (2017) Addressing mental health through sport: a review of sporting organizations' websites. *Early intervention in psychiatry*, 11 (2), pp. 93-103.

Liddle, S.K., Deane, F.P., Batterham, M. and Vella, S.A. (2019b) A Brief Sports-Based Mental Health Literacy Program for Male Adolescents: A Cluster-Randomized Controlled Trial. *Journal of Applied Sport Psychology*, pp.1-25.

Liddle, S.K., Hurley, D., Schweickle, M., Swann, C. and Vella, S.A. (2019a) Ahead of the Game: A Sports-Based Mental Health Literacy Program for Male Adolescents. In: Breslin, G. and Leavey, G. eds. *Mental health and well-being interventions in sport: Research, theory and practice.* London, Routledge, pp. 74-90.

Lincoln, Y S. and Guba, G E. (1985) *Naturalistic Inquiry.* Beverly Hills, Sage.

Livingston, J.D., Tugwell, A., Korf-Uzan, K., Cianfrone, M. and Coniglio, C. (2013) Evaluation of a campaign to improve awareness and attitudes of young people towards mental health issues. *Social psychiatry and psychiatric epidemiology*, 48 (6), pp. 965-973.

Loewen, O.K., Maximova, K., Ekwaru, J.P., Faught, E.L., Asbridge, M., Ohinmaa, A. and Veugelers, P.J. (2019) Lifestyle behavior and mental health in early adolescence. *Pediatrics*, 143 (5), p. e20183307.

Mackenzie, C.S., Gekoski, W.L. and Knox, V.J. (2006) Age, gender, and the underutilization of mental health services: the influence of help-seeking attitudes. *Aging and mental health*, 10 (6), pp. 574-582.

Maguire, J. (2005) *Power and global sport: Zones of prestige, emulation, and resistance.* London, Routledge.

Maguire, J.A. (2011) 'Real politic' or 'ethically based': Sport, globalization, migration and nation-state policies. *Sport in Society*, 14 (7-8), pp. 1040-1055.

Malcolm, D. (2008) *The SAGE dictionary of sports studies*. London, SAGE Publications.

Malcolm, D. (2018) Norbert Elias and the Sociology of Sport. In: Giulianotti, R. ed. *Routledge Handbook of the Sociology of Sport*. Abingdon, Oxon, Routledge, pp. 50-60.

Malcolm, D. and Mansfield, L. (2013) The quest for exciting knowledge: Developments in figurational sociological research on sport and leisure. *Politica y Sociedad*, 50 (2), pp. 397-419.

Mammen, G. and Faulkner, G. (2013) Physical activity and the prevention of depression: a systematic review of prospective studies. *American journal of preventive medicine*, 45 (5), pp. 649-657.

Mansfield, L., Kay, T., Anokye, N. and Fox-Rushby, J. (2018) A qualitative investigation of the role of sport coaches in designing and delivering a complex community sport intervention for increasing physical activity and improving health. *BMC Public Health*, 18 (1), p. 1196.

Marmot, M. (2020) Health equity in England: the Marmot review 10 years on. *British Medical Journal Institute of Health Equity,* 368.

Marmot, M. and Allen, J.J. (2014) Social determinants of health equity. *American Journal of Public Health,* 4, pp. S517-S519.

Martinsen, E.W. and Raglin, J.S. (2007) Themed review: anxiety/depression: lifestyle medicine approaches. *American Journal of Lifestyle Medicine*, 1 (3), pp. 159-166.

Maslowski, A. (2018) *Examination of the Effectiveness of Mental Health First Aid Among the Public: A Meta-Analysis.* MA thesis, University of Minnesota.

Mason, R.J., Hart, L.M., Rossetto, A. and Jorm, A.F. (2015) Quality and predictors of adolescents' first aid intentions and actions towards a peer with a mental health problem. *Psychiatry Research*, 228 (1), pp. 31-38.

Massey, J., Brooks, M., Burrow, J. and Sutherland, C. (2010) Increasing mental health literacy among student affairs staff: Assessing 'Mental Health First Aid'. *Queens University*.

Maxwell, J.A. (2012) *Qualitative research design: An interactive approach.* 3rd ed. London, Sage.

Mazzer, K.R. and Rickwood, D.J. (2009) Community gatekeepers' advice to young people to seek help from mental health professionals: Youth workers and sport coaches. *International Journal of Mental Health Promotion*, 11 (2), pp. 13-23.

Mazzer, K.R. and Rickwood, D.J. (2015a) Teachers' and coaches' role perceptions for supporting young people's mental health: multiple group path analyses. *Australian Journal of Psychology*, 67 (1), pp. 10-19.

Mazzer, K.R. and Rickwood, D.J. (2015b) Mental health in sport: coaches' views of their role and efficacy in supporting young people's mental health. *International Journal of Health Promotion and Education*, 53 (2), pp. 102-114.

Mazzer, K.R., Rickwood, D.J. and Vanags, T. (2012) Teachers and sports coaches supporting young people's mental health: promotion, prevention, and early intervention. *World Academy of Science, Engineering and Technology*, 66, pp. 489-494.

McAllister, D.J., Kamdar, D., Morrison, E.W. and Turban, D.B. (2007) Disentangling role perceptions: How perceived role breadth, discretion, instrumentality, and efficacy relate to helping and taking charge. *Journal of Applied Psychology*, 92 (5), pp. 1200-1211.

Mendenhall, A.N. and Frauenholtz, S. (2015) Predictors of mental health literacy among parents of youth diagnosed with mood disorders. *Child & Family Social Work*, 20 (3), pp. 300-309.

Mennell, S. (1992) *Norbert Elias: An introduction.* Dublin, University College Dublin Press.

Mental Health First Aid Australia (2017) *Mental health first aid international manual*. Parkville, Mental Health First Aid Australia.

Miles, M.B. and Huberman, A.M. (1994) *Qualitative data analysis: An expanded sourcebook.* 2nd ed. London, Sage.

Miles, M.B., Huberman, A.M. and Saldana, J. (2013) *Qualitative data analysis*. London, Sage.

Milnes, A., Pegrum, K., Nebe, B., Topfer, A., Gaal, L., Zhang, J. and Hunter, N. (2011) *Young Australians: their health and wellbeing.* Australian Institute for Health and Welfare, Canberra, Australia.

Minas, H., Colucci, E. and Jorm, A.F. (2009) Evaluation of Mental Health First Aid training with members of the Vietnamese community in Melbourne, Australia. *International journal of mental health systems*, 3 (1), p. 19.

Mojtabai, R., Olfson, M. and Han, B. (2016) National trends in the prevalence and treatment of depression in adolescents and young adults. *Pediatrics*, 138 (6), p. 20161878.

Morawska, A., Fletcher, R., Pope, S., Heathwood, E., Anderson, E. and McAuliffe, C. (2013) Evaluation of mental health first aid training in a diverse community setting. *International Journal of Mental Health Nursing*, 22 (1), pp. 85-92.

Morgan, D. L. (2010) Reconsidering the role of interaction in analyzing and reporting focus groups. *Qualitative health research*, 20 (5), pp. 718-722.

Morton, D.P. (2018) Combining lifestyle medicine and positive psychology to improve mental health and emotional well-being. *American journal of lifestyle medicine*, 12 (5), pp. 370-374.

Mountjoy, M. (2011) Health and fitness of young people: what is the role of sport? *British Journal of Sports Medicine,* 45, pp. 837-838.

Murphy, P., Sheard, K. and Waddington, I. (2000) Figurational Sociology and its application to sport. In: Coakley, J. and Dunning, E. eds. *The Handbook of Sports Studies.* London, SAGE Publications, pp. 92- 105.

Murray, C.J., Vos, T., Lozano, R., Naghavi, M., Flaxman, A.D., Michaud, C., Ezzati, M., Shibuya, K., Salomon, J.A., Abdalla, S. and Aboyans, V. (2012) Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. The lancet, 380 (9859), pp. 2197-2223.

Nash, C. and Sproule, J. (2012) Coaches perceptions of their coach education experiences. *International journal of sport psychology*, 43 (1), p. 33.

Neuman, W. L. (2014) *Social Research Methods: Qualitative and Quantitative Approaches.* 7th ed. London, Allyn and Bacon.

Nind, M. and Weare, K. (2011) Mental health promotion and problem prevention in schools across Europe: the evidence and messages for inclusive education. *Health Promotion International Journal*, 26 (1), pp. 29-69.

Noltemeyer, A., Huang, H., Meehan, C., Jordan, E., Morio, K., Shaw, K. and Oberlin, K. (2019) Youth mental health first aid: Initial outcomes of a statewide rollout in Ohio. *Journal of Applied School Psychology*, pp. 1-19.

O. Nyumba, T., Wilson, K., Derrick, C. J. and Mukherjee, N. (2018) The use of focus group discussion methodology: Insights from two decades of application in conservation. *Methods in Ecology and evolution*, 9 (1), pp. 20-32.

O'Leary, Z. (2017) *The essential guide to doing your research project*. London, Sage.

O'Reilly, C.L., Bell, J.S., Kelly, P.J. and Chen, T.F. (2011) Impact of mental health first aid training on pharmacy students' knowledge, attitudes and self-reported behaviour: a controlled trial. *Australian & New Zealand Journal of Psychiatry*, 45 (7), pp. 549-557.

O'Connor, M., Casey, L. and Clough, B. (2014) Measuring mental health literacy–a review of scale-based measures. *Journal of mental health*, 23 (4), pp. 197-204.

O'Malley, M., Wendt, S.J. and Pate, C. (2018) A view from the top: Superintendents' perceptions of mental health supports in rural school districts. *Educational Administration Quarterly*, 54 (5), pp. 781-821.

Olive, L.S., Byrne, D., Cunningham, R.B., Telford, R.M. and Telford, R.D. (2019) Can physical education improve the mental health of children? The LOOK study cluster-randomized controlled trial. *Journal of Educational Psychology*, 111 (7), pp. 1331-1340.

Olsson, D.P. and Kennedy, M.G. (2010) Mental health literacy among young people in a small US town: recognition of disorders and hypothetical helping responses. *Early Intervention in Psychiatry, 4* (4), pp. 291-298.

Oltmann, S. M. (2016) Qualitative Interviews: A Methodological Discussion of the Interviewer and Respondent Contexts. *Qualitative Social Research,* 17 (2), pp. 15-25.

Page, A.N. and Fragar, L.J. (2002) Suicide in Australian farming, 1988–1997. *Australian & New Zealand Journal of Psychiatry*, 36 (1), pp. 81-85.

Paluska, S.A. and Schwenk, T.L. (2000) Physical activity and mental health. *Sports medicine*, 29 (3), pp. 167-180.

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P.Y., Cooper, J.L., Eaton, J. and Herrman, H. (2018) The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392 (10157), pp. 1553-1598.

Paulle, B., van Heerikhuizen, B. and Emirbayer, M. (2012) Elias and Bourdieu. *Journal of Classical Sociology*, 12 (1), pp. 69-93.

Pedersen, B., Delmar, C., Falkmer, U. and Gronkjaer, M. (2016) Bridging the gap between interviewer and interviewee: developing an interview guide for individual interviews by means of a focus group. *Scandinavian Journal of Caring Sciences,* 30, pp. 631-638.

Pierce, D., Liaw, S.T., Dobell, J. and Anderson, R. (2010) Australian rural football club leaders as mental health advocates: an investigation of the impact of the Coach the Coach project. *International journal of mental health systems*, 4 (1), p. 10.

Pluhar, E., McCracken, C., Griffith, K.L., Christino, M.A., Sugimoto, D. and Meehan III, W.P. (2019) Team sport athletes may be less likely to suffer anxiety or depression than individual sport athletes. *Journal of sports science & medicine*, *18* (3), pp. 490-496.

Public Health England (2015) *Promoting children and young people's emotional health and wellbeing: A whole school and college approach*. London, Public Health England.

Public Health England (2016) *The mental health of children and young people in England.* London, Public Health England.

Rafal, G., Gatto, A. and DeBate, R. (2018) Mental health literacy, stigma, and help-seeking behaviors among male college students. *Journal of American college health*, 66 (4), pp. 284-291.

Reavley, N. and Jorm, A.F. (2010) Prevention and early intervention to improve mental health in higher education students: a review. *Early intervention in psychiatry*, 4 (2), pp. 132-142.

Rebar, A.L., Stanton, R., Geard, D., Short, C., Duncan, M.J. and Vandelanotte, C. (2015) A meta-meta-analysis of the effect of physical activity on depression and anxiety in non-clinical adult populations. *Health psychology review*, 9 (3), pp. 366-378.

Repp, A.I., Watson, A.C., Burns, J. and Jones, L.R. (2019) The west side community outreach pilot project: A mental health outreach initiative in urban communities of color. *Social Work in Mental Health*, pp. 1-20.

Richardson, R., Dale, H.E., Wellby, G., McMillan, D. and Churchill, R. (2018) Mental Health First Aid as a tool for improving mental health and well-being. *Cochrane Database of Systematic Reviews*, (9), pp. 1-17.

Rickwood, D. and Thomas, K. (2012) Conceptual measurement framework for help-seeking for mental health problems. *Psychology research and behavior management*, 5, p. 173.

Rickwood, D., Deane, F.P., Wilson, C.J. and Ciarrochi, J. (2005) Young people's help-seeking for mental health problems. *Australian e-journal for the Advancement of Mental health*, 4 (3), pp. 218-251.

Rickwood, D.J., Mazzer, K.R. and Telford, N.R. (2015) Social influences on seeking help from mental health services, in-person and online, during adolescence and young adulthood. *BMC psychiatry*, 15 (1), p. 40.

Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. (2003) Qualitative Research Practice: A guide for social science students and researchers. 2nd ed. London, Sage.

Ritchie, J., Lewis, J., Nicholls, C.M. and Ormston, R. eds. (2013) *Qualitative research practice: A guide for social science students and researchers*. London, Sage.

Roberts, C.M., Faull, A.L. and Tod, D. (2016) Blurred lines: Performance enhancement, common mental disorders and referral in the UK athletic population. *Frontiers in psychology*, 7, p. 1067.

Roberts, K. (2009) *Key Concepts in Sociology*. Basingstoke, Palgrave Macmillan.

Roderick, M., Smith, A. and Potrac, P. (2017) The sociology of sports work, emotions and mental health: Scoping the field and future directions. *Sociology of Sport Journal*, 34 (2), pp. 99-107.

Rohrer, J.E., Pierce Jr, J.R. and Blackburn, C. (2005) Lifestyle and mental health. *Preventive medicine*, 40 (4), pp. 438-443.

Ross, A.M., Hart, L.M., Jorm, A.F., Kelly, C.M. and Kitchener, B.A. (2012) Development of key messages for adolescents on providing basic mental health first aid to peers: a Delphi consensus study. *Early intervention in psychiatry*, 6 (3), pp. 229-238.

Ross, A.S. (2019) *Understanding Secondary Educators' Knowledge of Mental Health and Their Perceptions of Their Role in Addressing Student Mental Health*. PhD thesis, University of Maryland.

Royal Colleges of Paediatrics and Child Health (2017) *State of child health report 2017.* London, Royal Colleges of Paediatrics and Child Health.

Sandelowski, M. (2004) Qualitative Research. In: Lewis-Beck, M., Bryman, A. and Liao, T. ed. *The Sage Encyclopaedia of Social Science Research Methods*. Thousand Oaks CA, Sage.

Sarris, J., O'Neil, A., Coulson, C.E., Schweitzer, I. and Berk, M. (2014) Lifestyle medicine for depression. *BMC psychiatry*, 14 (1), pp. 1-13.

Sartore, G.M., Kelly, B., Stain, H.J., Fuller, J., Fragar, L. and Tonna, A. (2008) Improving mental health capacity in rural communities: Mental health first aid delivery in drought-affected rural New South Wales. *Australian Journal of Rural Health*, 16 (5), pp. 313-318.

Saunders, M.N.K., Thornhill, A. and Lewis, P. (2009) *Research Methods for Business Students.* 5th ed. London, FT Prentice-Hall.

Saxena, S., Thornicroft, G., Knapp, M. and Whiteford, H. (2007) Resources for mental health: scarcity, inequity, and inefficiency. *The lancet*, 370 (9590), pp. 878-889.

Schaal, K., Tafflet, M., Nassif, H., Thibault, V., Pichard, C., Alcotte, M., Guillet, T., El Helou, N., Berthelot, G., Simon, S. and Toussaint, J.F. (2011) Psychological balance in high level athletes: gender-based differences and sport-specific patterns. *PloS one*, 6 (5), p. e19007.

Sebbens, J., Hassmén, P., Crisp, D. and Wensley, K. (2016) Mental health in sport (MHS): improving the early intervention knowledge and confidence of elite sport staff. *Frontiers in psychology*, 7, p. 911.

Sharpe, H., Ford, T., Lereya, S.T., Owen, C., Viner, R.M. and Wolpert, M. (2016) Survey of schools' work with child and adolescent mental health across England: a system in need of support. *Child and Adolescent Mental Health*, 21 (3), pp. 148-153.

Shonkoff, J.P., Garner, A.S., Siegel, B.S., Dobbins, M.I., Earls, M.F., McGuinn, L., Pascoe, J., Wood, D.L., Committee on Psychosocial Aspects of Child and Family Health and Committee on Early Childhood, Adoption, and Dependent Care (2012) The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129 (1), pp. e232-e246.

Sickel, A.E., Seacat, J.D. and Nabors, N.A. (2014) Mental health stigma update: A review of consequences. *Advances in Mental Health*, 12 (3), pp. 202-215.

Silverman, D. (2013) *Doing qualitative research.* 4th ed. London, Sage.

Silverman, D. (2016) *Qualitative research*. 5thed. London, Sage.

Simms, C., Scowcroft, E., Isaksen, M., Potter, J. and Morrissey, J. (2019) *Suicide statistics report: Latest statistics for the UK and Republic of Ireland.* Surrey, Samaritans Registered Office.

Singh, N.A., Stavrinos, T.M., Scarbek, Y., Galambos, G., Liber, C., Fiatarone Singh, M.A. and Morley, J.E. (2005) A randomized controlled trial of high versus low intensity weight training versus general

practitioner care for clinical depression in older adults. *The Journals of Gerontology: Series A*, 60 (6), pp. 768-776.

Singh, S., Zaki, R.A. and Farid, N.D.N. (2019) A systematic review of depression literacy: Knowledge, help-seeking and stigmatising attitudes among adolescents. *Journal of Adolescence*, 74, pp. 154-172.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. and Whitley, R. (2014) Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13 (1), pp. 12-20.

Smith, B. and Caddick, N. (2012) Qualitative methods in sport: A concise overview for guiding social scientific sport research. *Asia Pacific journal of sport and social science*, 1 (1), pp. 60-73.

Smith, H.M. (1991) *Strategies of social research*. 3rd ed. Orlando, FL, Holt, Rinehart and Winston.

Smithson, J. (2000) Using and analysing focus groups: limitations and possibilities. *International journal of social research methodology*, 3 (2), pp. 103-119.

Sparkes, A. and Smith, B. (2013) *Qualitative research methods in sport, exercise and health: From process to product*. Abingdon, Routledge.

Sparkes, A. and Smith, B. (2014) *Qualitative Research Methods in Sport, Exercise and Health: From Process to Product.* Oxon, Routledge.

Spencer, L. and Ritchie, J. (2002) Qualitative data analysis for applied policy research. In: Sport England (2016) *Towards an Active Nation Strategy 2016-2021* [Internet]. Available from https://www.sportengland.org/media/10629/sport-england-towards-an-active-nation.pdf [Accessed 26th February 2019].

Spiker, D.A. and Hammer, J.H. (2019) Mental health literacy as theory: current challenges and future directions. *Journal of Mental Health*, 28 (3), pp. 238-242.

Sport for Development and Peace International Working Group (2008) *Harnessing the Power of Sport for Development and Peace: Recommendations to Governments.* United Nations, Geneva.

Sreevani, R. (2016) *A guide to mental health & psychiatric nursing.* 4th ed. New Delhi, Jaypee Brothers Medical Publishers.

Stewart, D. W. and Shamdasani, P. N. (2014) *Focus groups: Theory and practice*. London, Sage.

StreetGames and Brunel University London (2018) *Sport for Better Mental Health Report* [Internet]. Available from https://network.streetgames.org/sites/default/files/StreetGames_Brunel_Youth%20Sport%20%26%20Mental%20Health%20Report.pdf [Accessed 1st October 2019].

Svensson, B., Stjernswärd, S. and Hansson, L. (2013a) UTBILDNING I FÖRSTA HJÄLPEN VID PSYKISK OHÄLSA. En effektstudie i två län. *Mental Health First Aid education. An evaluation study in two counties. Socialstyrelsen,* pp. 15-17.

Svensson, B., Stjernswärd, S. and Hansson, L. (2013b) UTBILDNING I FÖRSTA HJÄLPEN VID PSYKISK OHÄLSA. En effektstudie i två län. *Mental Health First Aid education. An evaluation study in two counties. Socialstyrelsen,* pp. 15-17.

Swann, C., Telenta, J., Draper, G., Liddle, S., Fogarty, A., Hurley, D. and Vella, S. (2018) Youth sport as a context for supporting mental health: Adolescent male perspectives. *Psychology of sport and exercise*, *35*, pp. 55-64.

Symonds, J.E. and Gorard, S. (2010) Death of mixed methods? Or the rebirth of research as a craft. *Evaluation & Research in Education*, 23 (2), pp. 121-136.

Tariq, S. and Woodman, J. (2013) Using mixed methods in health research. *JRSM short reports*, 4 (6), pp 1-8.

Thanh, N.C. and Thanh, T.T. (2015) The interconnection between interpretivist paradigm and qualitative methods in education. *American Journal of Educational Science,* 1 (2), pp. 24-27.

Thorne, S. (2000) Data analysis in qualitative research. *Evidence-based nursing*, 3 (3), pp.68-70.

Tracy, S.J. (2013) *Qualitative Research Methods: collecting evidence, crafting analysis, communicating impact*. Sussex, Wiley Bakewell.

Tremblay, M.S., Barnes, J.D., González, S.A., Katzmarzyk, P.T., Onywera, V.O., Reilly, J.J. and Tomkinson, G.R. (2016) Global matrix 2.0: report card grades on the physical activity of children and youth comparing 38 countries. *Journal of physical activity and health*, 13 (2), pp. 343-366.

Trochim, W.M.K. and Donnelly, J. (2007) *The Research Methods Knowledge Base*. 3rd ed. Mason, Thomson Custom Publishing.

Trojian, T. (2016) Depression is under-recognised in the sport setting: time for primary care sports medicine to be proactive and screen widely for depression symptoms. *British journal of sports medicine*, 50 (3), p. 137.

Vaillant, G.E. (2012) Positive mental health: is there a cross-cultural definition? *World Psychiatry*, 11 (2), pp. 93-99.

Van Krieken, R. (1998) *Norbert Elias.* London, Routledge.

Vargas-Tonsing, T.M. (2007) Coaches' preferences for continuing coaching education. *International journal of sports science & coaching*, 2 (1), pp. 25-35.

Veal, A.J. (2018) *Research methods for leisure and tourism: a practical guide*. Harlow, Financial Times Prentice Hall.

Vella, S., Oades, L. and Crowe, T. (2011) The role of the coach in facilitating positive youth development: Moving from theory to practice. *Journal of applied sport psychology*, 23 (1), pp. 33-48.

Vella, S.A., Cliff, D.P., Magee, C.A. and Okely, A.D. (2015) Associations between sports participation and psychological difficulties during childhood: a two-year follow up. *Journal of science and medicine in sport*, 18 (3), pp. 304-309.

Vella, S.A., Swann, C., Batterham, M., Boydell, K.M., Eckermann, S., Fogarty, A., Hurley, D., Liddle, S.K., Lonsdale, C., Miller, A. and Noetel, M. (2018) Ahead of the game protocol: a multi-component, community sport-based program targeting prevention, promotion and early intervention for mental health among adolescent males. *BMC public health*, 18 (1), p.390.

Vella, S.A., Swann, C., Boydell, K.M., Eckermann, S., Fogarty, A., Hurley, D., Liddle, S.K., Lonsdale, C., Sanders, T., Schweickle, M.J. and Telenta, J. (2019) Sports-based mental health promotion in Australia: Formative evaluation. *Psychology of Sport and Exercise*, 45, p. 101560.

Vuori, J., Toppinen-Tanner, S. and Mutanen, P. (2012) Effects of resource-building group intervention on career management and mental health in work organizations: randomized controlled field trial. *Journal of Applied Psychology*, 97 (2), p. 273.

Waddington, I. and Malcolm, D. (2008) Eric Dunning: This sporting life. In: Malcolm, D. and Waddington, I. eds. *Matters of sport. Essays in honour of Eric Dunning*. London, Routledge, pp. 1-11.

Walford, G. (2005) Research ethical guidelines and anonymity. *International Journal of Research and Method in education,* 28 (1), pp. 83-93.

Walliman, N. (2017) *Research methods: The basics*. London, Routledge.

Wasserman, D. and Wasserman, C. eds. (2009) *Oxford Textbook of Suicidology and Suicide Prevention: A Global Perspective*. Oxford, Oxford University Press.

Wasserman, D., Rihmer, Z., Rujescu, D., Sarchiapone, M., Sokolowski, M., Titelman, D., Zalsman, G., Zemishlany, Z. and Carli, V. (2012) The European Psychiatric Association (EPA) guidance on suicide treatment and prevention. *European psychiatry*, 27 (2), pp. 129-141.

Waterman, A.S. (1993) Two conceptions of happiness: Contrasts of personal expressiveness (eudaimonia) and hedonic enjoyment. *Journal of personality and social psychology*, 64 (4), p. 678.

Watkins, D. and Gioia, D. (2015) *Mixed methods research*. New York, Oxford University Press.

Williams, J., Pill, S. and Hewitt, M. (2020) 'I think everyone is on board with changing how we do things, but we are yet to find a best fit model': A figurational study of assessing games and sport in physical education. *Sport, Education and Society*, pp. 1-14.

Williams, J.M., Kenow, L.J., Jerome, G.J., Rogers, T., Sartain, T.A. and Darland, G. (2003) Factor structure of the coaching behavior questionnaire and its relationship to athlete variables. *The Sport Psychologist*, 17 (1), pp. 16-34.

Wong, E.C., Collins, R.L. and Cerully, J.L. (2015) Reviewing the Evidence Base for Mental Health First Aid: Is There Support for Its Use with Key Target Populations in California? *Rand health quarterly*, 5 (1), pp. 1-8.

World Health Organisation (2011*) Promoting sport and enhancing health in European Union countries: a policy content analysis to support action.* Copenhagen, Regional Office for Europe.

World Health Organisation (2013) *Mental health action plan 2013–2020.* Geneva, WHO Press.

World Health Organisation (2014) *Mental Health: A State of Well-being.* Geneva, WHO Press.

World Health Organisation (2018) *Mental Health Atlas*. Geneva, WHO Press.

World Health Organisation (2019a) *Field test version: mhGAP community toolkit: Mental Health Gap Action Programme (mhGAP).* Geneva, WHO Press.

World Health Organisation (2019b) *Environmental health inequalities in Europe.* Copenhagen, Regional Office for Europe.

Wright, A., Jorm, A.F., Harris, M.G. and McGorry, P.D. (2007) What's in a name? Is accurate recognition and labelling of mental disorders by young people associated with better help-seeking and treatment preferences? *Social psychiatry and psychiatric epidemiology*, 42 (3), pp. 244-250.

Yang, Y. and Cornelius, L.F. (2004) Students' perceptions towards the quality of online education: A qualitative approach. *Association for Educational Communications and Technology*.

Appendices

Appendix A – Participant Information

Interview	Pseudonym	Age Category	Gender	Geographic Location	Years Coaching Experience	Sports / Physical Activities	Coaching Employment Status	Form of MHFA Training
01	Josh	35-44	Male	Newcastle upon Tyne	23 years	Various team sports Multi-Sports	Employed and Voluntary	Two Day MHFA
02	Sarah	25-34	Female	Newcastle upon Tyne	12 years	Football Futsal Multi-Sports Yoga Personal Trainer	Employed and Voluntary	Two Day MHFA
03	Alex	25-34	Male	Newcastle upon Tyne	12 years	Various team sports Gym and Circuit sessions Table Tennis Multi-Skills	Employed and Voluntary	Two Day MHFA
04	Anna	18-24	Female	York	6 years	Swimming Multi-Skills	Employed and Voluntary	Half Day MHFA
05	Patrick	18-24	Male	York	7 years	Football Multi-Skills Rugby Hockey	Employed and Voluntary	Half Day MHFA
06	Emma	25-34	Female	Cardiff	9 years	Dance Olympic Weightlifting	Employed	Two Day MHFA
07	Billy	65 and over	Male	Middlesex	22 years	Football Rugby Golf	Employed and Voluntary	Online MHFA
08	Max	25-34	Male	Colchester	12 years	Football Multi-Sports Basketball Rugby	Employed	Two Day MHFA
09	Hannah	18-24	Female	Leicester	8 years	Various team sports Multi-Skills	Employed	Half Day MHFA
10	John	25-34	Male	Cardiff	16 years	Gymnastics Trampoline	Employed and Voluntary	Two Day MHFA
11	Claire	25-34	Female	Manchester	15 years	Multi-Sports Hockey	Voluntary	Two Day MHFA

12	Scott	25-34	Male	Guildford	7 years	Multi-Sports Football	Employed	Online MHFA
13	Mark	55-64	Male	Northampton	30 years	Football Rugby Tennis Athletics	Employed	Two Day MHFA
14	Nick	35-44	Male	Durham	3 years	Badminton	Employed and Voluntary	Online MHFA
15	Richard	18-24	Male	Fulham	8 years	Multi-Skills Football	Employed	Online MHFA
16	Ben	55-64	Male	Selby	8 years	Fitness training Hill Walking Team building	Voluntary	Two Day MHFA

Appendix B – Interview Guide

Semi-Structured Interview Guidance Sheet

This thesis will adopt interview protocol advised by Kvale (2007) when completing semi-structured interviews. This protocol and guidance involve several different parts including:

Pre-interview briefing information:

- Introduce self and explain that I am currently studying my MSc by research at York St John University.
- Hand out participation information sheet and gain signatures for consent forms, run through and explain confidentiality etc. as well as reiterating that although you have volunteered to take part and provided your consent, you have the right to withdraw at any point.
- Explain about the interview guide and how it is a semi-structured guide meaning it is not rigid and can expand. Meaning that you could ask for clarification of a question at any point. Also explain about the recording of the semi-structured interviews and how some of these topics may have already been discussed informally.
- Please feel free to talk openly. I am looking forward to hearing your thoughts and opinions.
- There are no 'right' or 'wrong' answers to any of the questions, so you don't need to worry about saying the wrong thing.
- If there is anything that you don't want to answer, that is fine, please just say so.
- Do you have any questions before we start?

Structure the interview in parts to help continuity and format:

- Introduction section - This series of questions aims to ascertain biographical and factual information.
- Context section – This series of questions aims to gather data concerning the context of the individual's biography and experiences.
- Thematic section – This series of questions aims to gather data concerning the specific topics under examination
- Conclusion section – This last series of questions aims to gather data concerning summary themes. They can also be used to ensure that previous answers can be further probed, or participants can add any further contributions or ask any further questions.

Set interview questions within the interview guides that involve a range of question types:

Introducing questions – e.g. Can you tell me about yourself?

Specifying questions - These involve asking for factual information, e.g. When did you complete the #21by21 mental health awareness training?

Direct questions - These are questions that have a yes or no answer.

Indirect questions - These are opposite to direct questions where opinions or interpretations are sought, e.g. What do you think about the #21by21 mental health awareness training?

Interpreting questions – e.g. Do you mean that every coach should experience the #21by21 mental health awareness training?

Potential follow-up questions/prompts:

Follow-up questions – e.g. You mentioned your teachers in your last answer. Can you give me more detail about who they are?

Probing questions - They are used when more in depth information is required, e.g. Can you give further examples of this?

These can also include probes such as:

- Why is that?
- Can you tell me more about that?
- Go on…
- Can you expand on that?
- Could you provide an example…?
- [Staying silent]
- You said …, can you tell me why you think this?

Introductory questions

1. Can you tell me how long you have been coaching?

2. What type of sports and physical activities have you coached?

3. Are you employed as a coach or is your coaching voluntary?

4. In what types of settings have you coached before?
    a. Go on…
    b. Communities, schools, development squads, after school clubs etc.
    c. [Staying silent]

5. Do the participants you have coached range in age, gender, ability?
    a. Can you expand on that?
    b. [Staying silent]

6. And before we go onto the next section, which type/form of mental health training have you completed?
    a. Go on…
    b. [Staying silent]

Section 1: Perceptions and Experiences Before the #21by21 Mental Health Awareness Training

-Explain how there are two sections to the questions regarding their thoughts and perceptions of the #21by21 mental health awareness training, before and after. The first section focuses on the coach's perceptions before the training.

Theme 1: Knowledge and understanding of mental health

1. Before the mental health awareness training, what did the term 'mental health' mean to you?
    a. Can you expand on that?
    b. Why is that?
    c. [Staying silent]

2. Did you know about the prevalence of 'mental health' before the training?
    a. Can you expand on that?
    b. You said …, can you tell me why you think this?
    c. Go on…

3. Prior to the training did you have any knowledge of how to promote positive mental health? How to prevent negative stigma of mental health? Or have any knowledge of intervention techniques or skills?
    a. Go on…
    b. Can you expand on that?
    c. Can you tell me more about that?

4. Have you had previous experiences with your participants where you believed mental health issues or concerns have occurred?

   a. [Staying silent]
   b. Go on…
   c. Can you expand on that?

5. Before the mental health awareness training, were you aware of any mental health first aid or awareness courses?
   a. Go on…
   b. Can you expand on that?
   c. [Staying silent]

6. Before the training, did you feel that there is a stigma and discrimination in society around mental health?
   a. Can you expand on that?
   b. You said …, can you tell me why you think this?
   c. Go on…

Theme 2: Beliefs and perceptions about the coach's role in supporting participants mental health

1. How did you perceive the role of a coach linking to or being involved with participants' mental health?
   a. If so how?
   b. Go on…
   c. [Staying silent]

2. Due to the position of trust and responsibility as a coach did you feel you could positively influence your participants mental health?
   a. If so why and how?
   b. Can you expand on that?
   c. [Staying silent]

3. Would you have been confident in supporting participants' mental health prior to the training?
   a. If so why and how?
   b. Can you expand on that?
   c. Can you provide any examples?

4. Did you believe that coaches have a key opportunity to positively impact participants' mental health?
   a. If so why?
   b. [Staying silent]
   c. Go on…

5. As a coach did you feel comfortable offering guidance or being a role model towards your participants?
   a. Why is that?
   b. Can you expand on that?

6. Did you think that mental health was included in the duty of care a coach has for their participants before the training?
   a. Go on…
   b. Can you expand on that?
   c. Why is that?

7. Did you feel that there was an expectation on coaches to be involved in supporting their participants' mental health?
   a. Go on…
   b. Can you expand on that?
   c. Why is that?

8. Prior to the mental health awareness training what did you think about the use of coaches as implementers for promoting positive mental health?
   a. Why is that?
   b. Can you expand on that?

Theme 3: Perceptions of barriers and restrictions towards supporting mental health

1. Prior to the training did you feel like you had the knowledge or skills to support your participants' mental health?
    a. Why is that?
    b. Can you expand on that?

2. Did you feel like you would know or be able to recognise the signs of a mental health issue before the training?
    a. Go on…
    b. Can you expand on that?
    c. Why is that?

3. Did the stigma around mental health previously dissuade you from supporting participants' mental health?
    a. Can you expand on that?
    b. Can you tell me more about that?
    c. [Staying silent]

4. Before the training did you feel confident in how to offer or provide initial help to a participant experiencing a mental health issue?
    a. If so why?
    b. Can you tell me more about that?
    c. [Staying silent]

5. Prior to the training did you feel confident in guiding a participant experiencing a mental health issue towards appropriate treatment or other sources of help?
    a. If so, how and why?
    b. Go on…
    c. Can you expand on that?
    d. Could you provide an example?

6. As a coach did you feel like you had the accreditation or qualifications to support positive mental health in your participants?
    a. Go on…
    b. Can you expand on that?
    c. Can you tell me more about that?

7. Did you feel that you would have a further negative impact upon your participants' mental health without the correct knowledge and education around mental health?
    a. [Staying silent]
    b. Go on…
    c. Can you expand on that?

8. Prior to the training did you feel you had the knowledge, skills and training to be involved in supporting your participants' mental health?
    a. If so, how?
    b. Can you expand on that?

Section 2: Perceptions and Experiences After the #21by21 Mental Health Awareness Training

-Explain how there are two sections to the questions regarding their thoughts and perceptions of the #21by21 mental health awareness training, before and after. The next section now focuses upon the coach's perceptions after the training.

Theme 1: Knowledge and understanding of mental health

1. After undergoing the mental health awareness training, what does the term 'mental health' now mean to you?
    a. Can you expand on that?
    b. Why is that?
    c. [Staying silent]

2. What do you know about the prevalence of 'mental health' after the #21by21 training?
    a. Can you expand on that?

   b. You said …, can you tell me why you think this?
   c. Go on…

3. After the training what knowledge did you gain on how to promote positive mental health? How to prevent negative stigma of mental health? Or of specific intervention techniques or skills?
   a. Go on…
   b. Can you expand on that?
   c. Can you tell me more about that?

4. Have you had experiences with your participants where you believed mental health issues or concerns have arisen after undergoing the training?
   a. [Staying silent]
   b. Go on…
   c. Can you expand on that?

5. What do you think about the training, are mental health first aid or awareness courses important for coaches?
   d. Go on…
   e. Can you expand on that?
   f. [Staying silent]

6. After the training, did your views around stigma and discrimination in society around mental health change?
   a. Can you expand on that?
   b. You said …, can you tell me why you think this?
   c. Go on…

Theme 2: Beliefs and perceptions about the coach's role in supporting participants mental health

1. How do you now perceive the role of a coach linking to or being involved with participants' mental health?
   a. If so how?
   b. Go on…
   c. [Staying silent]

2. Due to the position of trust and responsibility as a coach do you feel you could positively influence your participants mental health after undergoing the training?
   a. If so why and how?
   b. Can you expand on that?
   c. [Staying silent]

3. Are you confident in supporting participants' mental health after the training?
   a. If so why and how?
   b. Can you expand on that?
   c. Can you provide any examples?

4. Do you believe that coaches have a key opportunity to positively impact participants' mental health?
   a. If so why?
   b. [Staying silent]
   c. Go on…

5. As a coach do you feel comfortable offering guidance or being a role model towards your participants?
   a. Why is that?
   b. Can you expand on that?

6. Do you think that mental health is included in the duty of care a coach has for their participants after the training?
   a. Go on…
   b. Can you expand on that?
   c. Why is that?

7. Do you feel that there is an expectation on coaches to be involved in supporting their participants' mental health?
   a. Go on…

   b. Can you expand on that?
   c. Why is that?

8. After the training what do you think about the use of coaches as implementers for promoting positive mental health?
   a. Why is that?
   b. Can you expand on that?

Theme 3: Perceptions of the #21by21 mental health awareness training

1. After the training do you feel like you now have the knowledge or skills to support your participants' mental health more effectively?
   a. Why is that?
   b. Can you expand on that?

2. Do you feel like you know or could recognise the signs of a mental health issue after the training?
   a. Go on…
   b. Can you expand on that?
   c. Why is that?

3. Does the stigma around mental health still dissuade you from supporting participants' mental health?
   a. Can you expand on that?
   b. Can you tell me more about that?
   c. [Staying silent]

4. After the training do you feel confident in how to offer or provide initial help to a participant experiencing a mental health issue?
   a. If so why?
   b. Can you tell me more about that?
   c. [Staying silent]

5. After the training do you feel confident in guiding a participant experiencing a mental health issue towards appropriate treatment or other sources of help?
   a. If so, how and why?
   b. Go on…
   c. Can you expand on that?
   d. Could you provide an example?

6. As a coach do you feel like you now have the accreditation or qualifications to support or promote positive mental health in your participants?
   a. Go on…
   b. Can you expand on that?
   c. Can you tell me more about that?

7. After the training do you feel that interactions may cause further negative impacts upon your participants mental health?
   a. [Staying silent]
   b. Go on…
   c. Can you expand on that?

8. After the training do you feel you have the knowledge, skills and training to be involved in supporting your participants mental health?
   a. [Staying silent]
   b. Go on…
   c. Can you expand on that?

9. Could you provide any examples or experiences where your coaching practice or behaviour has changed or applied what you have learnt from the training?
   a. If so, how?

   b. Can you expand on that?

10. Have you spoken to your participants about your mental health awareness training?
    a. Why is that?
    b. Go on…
    c. Can you expand on that?

11. Do you have any recommendations for future mental health awareness training courses? How could it be developed further? How it could it be delivered? Do you think it should be a qualification which needs renewing after so long, like first aid and safeguarding?
    a. Why is that?
    b. Go on…
    c. Can you expand on that?

12. Before we finish, is there anything else you would like to discuss regarding the mental health awareness training and the role of a coach?
    a. If so, how?
    b. Can you expand on that?

Appendix C – Debrief Sheet

Debrief Sheet

Title of study: Sports Coaches' and Volunteers' Perceptions of Their Role in Adolescent Mental Health and the #21by21 Mental Health Awareness Training Campaign

If you have any concerns or complaints regarding the research project please contact the York St John School of Sport administrator, Sarah Menys on 01904 876821 or School.Sport@yorksj.ac.uk.

Although we hope it is not the case, sometimes people can become upset talking about their experiences.

If this is the case for you or you would like to discuss any issues that have arisen following the interview, there is a link below with information and guidance.

Thank you for your participation in this study.

MIND

Telephone: 020 8519 2122
email: supporterservices@mind.org.uk
http://www.mind.org.uk

Appendix D – Ethical Approval Letter

Est. 1841 | YORK ST JOHN UNIVERSITY

York St John University,
Lord Mayors Walk,
York,
YO31 7EX

04/02/20

School of Science, Technology, and Health Research Ethics Committee

Dear Luke,

Title of study: Sports Coaches' and Volunteers' Perceptions of Their Role in Mental Health and the #21by21 Mental Health Awareness Training Campaign.
Ethics reference: STHEC0005
Date of submission: 11/12/19

I am pleased to inform you that the above application for ethical review has been reviewed by the School of Science, Technology, and Health Research Ethics Committee and I can confirm a favourable ethical opinion on the basis of the information provided in the following documents:

Document	Date
Application for ethical approval form (including information sheet, consent form, interview transcript).	28/01/20

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval, including changes to recruitment methodology or accompanying documentation. All changes must receive ethical approval prior to commencing your study. You are now free to begin data recruitment and collection for the above approved study.

Yours sincerely,

Dr Daniel Madigan
Chair of the School of Science, Technology, and Health Research Ethics Committee

Appendix E – Participant Information Sheet and Consent Form

Participant Information Sheet and Informed Consent Form

Name of school: School of Sport, York St John University
Title of study: Sports Coaches' and Volunteers' Perceptions of Their Role in Mental Health and the #21by21 Mental Health Awareness Training Campaign

---

Introduction
You have been invited to take part in a research project examining sports coaches, volunteers and participants perceptions, thoughts and practical experiences of the mental health awareness training. Before you decide whether to take part, it is important that you understand why this research is being done and what it will involve. Please take time to read this information carefully and discuss it with others if you wish. If there is anything that is unclear or if you would like more information, please contact me Luke Anthony Clayton, student researcher in the School of Sport, York St John University or my supervisor Dr Graeme Law, School of Sport, York St John University using the contact details on the following page.

What is the purpose of this investigation?
The aim of this investigation is to examine sports coaches, volunteers and participants perceptions, thoughts and practical experiences of the mental health awareness training. In conducting this investigation, I am trying to develop a greater understanding of participants' mental health, the coach's role and physical activity which play a central role and impact people's mental wellbeing.

What will you do in the project?
This study involves a one-to-one interview between me and you that will last 60 minutes. During this interview you will be asked a series of set questions regarding your experiences of, the mental health awareness training. The interview will take place at a time, date and public place (i.e. café or workplace) convenient for you.

Do you have to take part?
No. this is a voluntary study and it is up to you to decide whether you would like to take part, but your contribution would be greatly appreciated.
You will not be treated any differently, whether you choose to take part, or decide not to do so.

Why have you been invited to take part?
You have been invited to take part in this project because you are or have been involved in the #21by21 mental health awareness training.

What are the potential risks to you in taking part?
Given the nature of this research project there are no identifiable risks involved. However, if you feel distressed during the interview process, the interview will be stopped and I will reference sources of support such as Mind https://www.mind.org.uk. No coercion or incentive will be used for recruitment purposes and participation will be voluntary. You do have the right to withdraw from this project at any point, without giving a reason. You can withdraw from the project by informing me (the researcher) via email that you wish to do so. If you withdraw from the research, any words used by you will be removed from the data that has been collected. You may request that the information you have provided is removed from the study at any point until the data has started to be

analysed. This means that you can request that your data be removed from the investigation until four weeks (28 days) after the date that you took part in the study.

What happens to the information in the project?
All interviews will be audio recorded for transcribing purposes, but all answers will remain confidential. Pseudonyms (i.e. fictitious names) will be used for you and any people, places or organisations that you mention in order to maintain anonymity. All data collected whilst conducting this investigation will be stored securely on the password protected OneDrive storage system and password protected computer account, which are used for the storage of research data at York St John University, in line with the requirements of the General Data Protection Regulation. The information collected whilst conducting this project will be stored for a minimum of 6 months. Thank you for reading this information – please ask any questions if you are unsure about what is written in this form.

What happens next?
If you are happy to take part in this project, you will be asked to sign an informed consent form in order to confirm this. It is possible that the results of this research project will subsequently be published. If this is the case, appropriate steps will be taken to ensure that all participants remain anonymous. If you do not want to be involved in the project, I would like to take this opportunity to thank you for reading the information above. This investigation was granted ethical approval by York St John University.

Researcher contact details:

Luke Anthony Clayton
School of Sport,
York St John University,
Lord Mayor's Walk,
York,
YO31 7EX.

Email: luke.clayton@yorksj.ac.uk

Dr Graeme Law
School of Sport,
York St John University,
Lord Mayor's Walk,
York,
YO31 7EX.

Email: g.law@yorksj.ac.uk

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought, please contact:

Dr Daniel Madigan
Chair of School of Science, Technology, and Health Research Ethics Committee
York St John University,
Lord Mayors Walk,
York,
YO31 7EX.

Email: d.madigan@yorksj.ac.uk