Mental Health Awareness in Sport: Perceptions of Mental Health Training in Community Roles.

A Grounded Theory.

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

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Abstract

Mental health is positively influenced by physical activity and sport, a well-documented relationship. Furthermore, this can be developed by a sports coach being able to support their participants who are experiencing mental ill health. However, mental health literacy within coaches is noted to be low, through possible lack of completed training. Therefore, this study employed a grounded theory approach to investigate mental health training within coaches, examining the impact and understanding of where the training lies within the sector. By adopting a grounded theory approach, it allowed a theory to emerge from the data, producing a concept specific to this study. 21 semi structured interviews were conducted with a range of personnel from community sport. The findings of this study discovered that there is a demand in the sector for those at grassroots level to receive mental health training, although it was observed that there is a lack of current training available. Furthermore, while both face-to-face and online training were considered, face-to-face training was deemed the preferred method to employ, relating it to a coach's interactive nature. This study further concluded the possibility of implementing mental health training within coaching qualifications, as many participants argued for the application of the training to be a requirement from level one coaching qualifications upwards. This led to determine that the majority of the participants agreed that mental health training should be a mandatory requirement. However, despite this, the participants noted that the training was too expensive to be able to frequently implement, and this cost acted as a barrier to participation. The theory produced concluded that funding was the underlying factor which influences the implementation of mental health training. As argued, a lack of available and completed training within the sector is a possible consequence of absent investment directed towards mental health training.

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List of Abbreviations

DCMS - Department for Culture, Media and Sport

DDCMS - The Department of Digital, Culture, Media and Sport

GT – Grounded theory

MHFA – Mental health first aid

MHFA England – Mental Health First Aid England

MHL – Mental health literacy

MHT – Mental health training

NGB – National governing bodies

WHO – World Health Organisation

Chapter One

Introduction

Health is an umbrella term, all elements of health intertwine: mental, physical and social health are interdependent, and therefore, cannot exist alone (World Health Organisation (WHO), 2004; Department of Health, 2015). In modern society there is an ever-growing emphasis on mental health, as displayed through the increasing amount of public, academic and governmental attention placed upon the health sector. Within physical activity and sport, this was shown by mental health becoming a key objective within the governmental aims for the sector (DDCMS, 2015).

Mental health literacy (MHL) as first proposed by Jorm, Korten, Jacomb, Christensen, Rodgers and Pollitt (1997) is an individual's knowledge about mental health illness, recognition, aid prevention and management. Within this study, there is a focus upon how MHL can be improved by individuals undergoing and completing mental health training (MHT). MHT is a concept which originated from Australia in 2000, however only came to the United Kingdom in 2007, launched under the Department of Health (MHFA England, 2018). MHT is now recognised and implemented across various locations around the world (Wong, Lau, Kwok, Wong and Tori, 2017; MHFA England, 2018). The most well-known and utilised MHT within the United Kingdom is produced by Mental Health First Aid England. MHT was created to educate and aid the general public in providing initial help within mental health illnesses (Wong *et al*., 2017). The time taken to complete MHT is dependent on the course itself, for example Mental Health First Aid England offer three main courses: awareness, champion and first aid (MHFA England, 2019). These courses are a way of improving MHL through interactive programmes and interventions, with each programme slightly different dependent on the audience. Although, the majority of MHT programmes follow the same purposes: increase knowledge, enable recognition of mental health illnesses, develop the confidence so they can approach the individual, understand how to offer help and support, while lastly being aware of the treatment options available to refer an individual to (Morgan, Ross and Reavely, 2018). With attention placed on mental health first aid, it is given to someone when they are experiencing a mental health illness or crisis, and continued until professional help and care is received (Morgan, Ross and Reavley, 2018). Moreover, is it of particular prominence because it is the first type of aid which is given to the individual who is suffering (Morgan, Fischer, Hart, Kelly, Kitchener, Reavley, Yap, Cvetkovski and Jorm, 2019).

With emphasis upon MHL in sport coaches, studies conducted by Ferguson, Swann, Liddle and Vella (2019) and Street Games (2019) concluded that although coaches witness participants within their sessions experiencing poor mental health, they felt like they lacked the necessary knowledge in mental health to assist. However, in coaches who had completed MHT, they reported an increase in skills and empowerment in their role (Pierce, Liaw, Dobell and Anderson, 2010). This suggests that the level of MHL is impacted by MHT, that an increase in MHL can positively affect a coach, and them to support their participants when needed. There is a large amount of literature focused upon

MHL, but only recently is there a growing number of studies investigating MHL and MHT in sporting environments. Therefore, this study aims to contribute to this knowledge, expand upon the impact that MHL has upon those who partake, while further investigating the importance MHT has within the physical activity and sport sector.

To explore MHT, a grounded theory (GT) approach has been adopted. To generate a theory which emerges from the data, semi structured interviews were employed. In subsequent to this chapter, a literature review was conducted to identify and lay the foundations for the rest of the thesis. Chapter three explores GT, understanding how the study created and developed a theory through a specific set of guidelines. Chapter four examines the methodology implemented, justifying the methodological position, sample selection and data analysis. Chapters five, six and seven outline and present the findings of this study, separated to show the development of the produced GT. Chapter five explores the connection between mental health, physical activity and sport. While further investigating what role a coach plays within this, and how their responsibilities have evolved over time. To advance this, chapter six investigates MHT, understanding the different forms of delivery and exploring the impact that they have. Chapter seven summarises the training in comparison to physical first aid and safeguarding, while determining if it belongs amongst coaching qualifications. Furthermore, this chapter allows for the discovery of perceptions on whether the training should be made a mandatory requirement for coaches, and considering the expense this carries. As Sandelowski (1993) understands, although not exclusive to GT, a theory can be introduced at various points within a qualitative study. Although they further state that it is important that the researcher is then able to coherently express why they chose to place it at that certain point (Sandelowski; 1993; Holt and Tamminen, 2010). Therefore, chapter eight concludes with the constructed grounded theory. Presenting a theory which has been established through the examination and development of previous chapters, consequently allowing for the readers to witness and understand the gradual progression of the GT. Lastly, chapter nine concludes the study, in addition to providing limitations and possible direction for future research.

Chapter Two

Literature Review

This chapter will aim to explore and discuss key literature within the field of mental health, and its connection to physical activity and sport. The beginning of the chapter explores the concept of mental health, laying the foundation and enabling the reader to gain important base knowledge to be able to apply it throughout the study. This chapter also examines the relationship that mental health has within the physical activity and sport sector, investigating its impact at policy and grassroots level. Furthermore, the role of a coach is discussed, gaining an understanding of how a coach and the environment they produce can impact sport participants' mental health. Lastly this chapter will consider MHT and its application within community roles.

2.1 Mental Health within Society

To understand how MHT can be utilised and applied within practice, it is important to gain an understanding of mental health itself. As defined by the World Health Organisation (WHO), mental health is '…a state of well-being in which an individual realises 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, 2018). Furthermore, understanding that it is fundamental to the collective and personal abilities to think, interact, emote, form relationships, work and pursue interests (WHO, 2013). Additionally, each individual is affected by their own experiences, family, culture, societal structures, resources available and their social interactions, all of which can have a significant effect on mental health (WHO, 2004; Galderisi, Heniz, Kastrup, Beezhold and Sartorius, 2015; Carless and Douglas, 2016). However, Manwell, Barbic, Roberts, Durisko, Lee, Ware and McKenzie (2015) conducted a study with 50 participants who were either experts in and/or had experience of mental health. They created a survey which compared numerous mental health definitions against one another, inclusive of the WHO (2001) definition which differs only slightly from the one cited above. The survey concluded that only 20% of the participants chose the WHO (2001) definition as their preferred choice (Manwell *et al*., 2015). Furthermore, it was established that there was dissatisfaction with all the definitions included within the study, determining there to be no mutual consensus between the participants on a common definition (Manwell *et al*., 2015). Accordingly, Manwell *et al*. (2015) detail that a mental health definition may depend on individual's physical, social and biology aspects. They suggest that a definition based solely upon physical factors can be more applicable across diverse populations, whereas a definition which encompasses social and mental domains may vary dependent on individual values such as different cultures, religions and practices (Manwell *et al*., 2015). This suggests that should a mental health definition be inclusive of physical, social and mental factors, then it must be examined on an individual basis, taking into account the whole picture. Manswell *et al*. (2015) further understood that a physical global definition has the potential to be analysed independently from local definitions of mental health which is inclusive of

social and mental aspects. Nevertheless, this form of separating a definition is not currently utilised within mental health, although as the knowledge surrounding mental health is continually growing there is opportunity for it to be employed within the future.

Similar to the conclusion of Manwell *et al*. (2015), Galderisi, *et al*. (2015) argue that the recognised WHO definition simply does not do the intricacy of mental health justice. They contend that the definition leads to possible misunderstandings when recognising positive feelings as key factors for mental health (Galderisi *et al*., 2015). They suggest that people who have good mental health regularly feel unhappy, angry and sad, arguing this to be a part of living a full life (Galderisi *et al*., 2015). Through their adverse opinion on mental health, they produced a definition of their own,

> '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 recognise, express and modulate one's own emotions, as well as empathise 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' (Galderisi *et al*., 2015, p. 233).

The definition refers to an individual's own perception, culture and life events. They indicate that the definition reflects separate life periods, from childhood, marriage, becoming a parent and retirement. That throughout each life stage, a person will re-evaluate their mental health, to understand and accept that it is likely to differ and change from the stage before (Galderisi *et al*., 2015). In addition to this notion, Shannon, Breslin, Haughey, Sarju, Neill, Lawlor and Leavey (2019) suggest that individuals are susceptible to developing poor mental health during their life transitions, using growth from teenage years into early adulthood (18-25 years old) as an example.

The definitions discussed help to give mental health a foundation, to contextualise and understand the subject. Nevertheless, mental health as suggested is not always a positive, progressive and straight forward journey, it exists on a continuum. This continuum is dynamic and can fluctuate, ranging from high to low well-being, the majority of people find themselves at various points on the continuum throughout their lives (Teixeira, Coelho, Sequeira, Lluch I Canut and Ferré-Grau, 2018; WHO, 2019). The most cited author for the concept of a mental health continuum is Keyes (2007), understanding individuals who experience high levels of well-being as 'flourishing' in life whereas those who are experiencing low levels of well-being are 'languishing' in life (Keyes, 2007). Furthermore, those who do not fit in the criteria for either flourishing or languishing are understood to be 'moderately mentally healthy' (Keyes, 2007).

When at low well-being, or languishing as Keyes (2007) describes, is when an individual is most likely to be experiencing a mental health illness. A mental health illness stated by WHO (2013) refers to a disability, suffering and/or sickness because of neurological, mental and/or substance use.

Further, these can develop from the biological, psychological and/or genetic make-up of a person, together with environmental and social factors (WHO, 2013). Under the bracket of mental illness, there are numerous mental health conditions, each ranging in severity and duration dependent on the person (WHO, 2019). When experiencing a mental health problem, it can alter a person's way of thinking, feeling and their behaviour (Mason, Hart, Rossetto and Jorm, 2015). Consequently, this can have a significant impact upon the individual's day to day life, whether it be within a social, work, education, family setting or community participation (Lawrence, Johnson, Hafekost, Boterhoven De Hann, Sawyer, Ainley and Zubrick, 2015; WHO, 2020). This leads to conclude that when an individual is experiencing poor mental health, accessible structures need to be place to allow them to seek help. As explored throughout this chapter, the physical activity and sport sector is one of these significant structures.

Various people all over the world can be affected by poor mental health, whether this be children, teenagers, adults, parents or older people (Mental Health Taskforce, 2016). In the majority of the literature, there is a running theme that focuses upon the age range of children through to young adulthood, ranging from 6-25 years old. Barry, Clarke, Jenkins and Patel (2013) denote in their study that childhood and adolescence (6-18 years old) is vital for laying the fundamental foundations for happy and healthy development, inclusive of good mental well-being. The reason behind this age range having such substantial weight is due to the development of individuals, especially as mental health illnesses often first arise within this crucial time frame (Rickwood, Deane, Wilson and Ciarrochi, 2005; Kelly, Jorm and Wright, 2007). Mazzer and Rickwood (2015a) report that there is a troubling amount of young people who experience and suffer mental health illnesses. As published by NHS Digital (2018), one in eight 5-19-year olds had a mental illness within 2017. They further revealed that one in twenty 5-19-year olds met the criteria for two or more individual mental health illnesses at the same time (NHS Digital, 2018). The Department of Health (2015) and Mansfield (2019) both revealed that by the age of 14, half of long-term mental health illnesses have become established. NHS Digital (2018) explained that mental health disorders become more common with increasing age, from 9.5% reported in 5-10-year olds, to 16.9% in 17-19-year olds. In addition, the percentage of children experiencing a mental health illness has also increased over time, from 9.7% in 1999, to 11.2% in 2017 (NHS Digital, 2018; Wu, Bathje, Kalibartseva, Sung, Leong and Collins-Eaglin, 2017).

However, this is not only reported in children, as mental health conditions are increasing internationally, and present a worldwide public health challenge (Shannon and Breslin, 2020; WHO, 2020). Therefore, in response NHS England (2020) states that it has increased the investment directed towards mental health, with overall funding reaching 1.4 billion pounds. Further affirming that 120,000 more people are getting specialist mental health treatment in comparison to three years ago (NHS England, 2020). Nevertheless, WHO (2020) argue that numerous mental health illnesses can be treated effectively at comparatively low cost, however the gap between individuals with

access to care and those needing care remains large and unbalanced. They suggest that an increase in funding is required in all aspects of mental health, inclusive of growing mental health awareness to reduce stigma by an increase in understanding (WHO, 2020). Taking this into account, this study aims to explore the notion of increasing mental health awareness through the implementation of MHT within grassroot roles. This study has the intention to examine how MHT can affect individuals surrounding their mental health knowledge, confidence and how they could impact wider society through this.

Mental health illnesses are widespread, often disabling and regularly hidden, with mental health problems representing the leading single cause of disability in the United Kingdom (Mental Health Taskforce, 2016; NHS, 2019). As NHS (2019) uncovers that one in four adults experience at least one diagnosable mental health problem within a given year. However, Mental Health Foundation (2016) explain that despite there being an increasing amount of people accessing mental health care and treatment, around one third of adults who suffer from a mental illness sought no professional help at all. One given reason for this may be due to the relationship between stigma and mental health. Stigma is a well-documented frequent reason and concern for people who experience mental illnesses, with damaging effects (Hack, Muralidharam, Brown, Drapalski and Lucksted, 2019). WHO (2019) offer stigma to be a mark upon an individual, this negative 'mark' establishes separation and isolation between the stigmatised person and others, overtly setting them apart. Stigma which coincides with mental health illness can regularly lead to discrimination and social exclusion, creating a further burden for the affected individual (WHO, 2019). Due to this relationship between stigma and mental health illnesses, people choose to avoid seeking professional help as they do not want to receive the label of being mentally ill and the added stigma that unavoidably comes with that (Corrigan, 2004; Wu *et al.*, 2017). Stigma encourages those who live with poor mental health to hide their illness and bypass seeking help (Story, Kirkwood, Parker and Weller, 2016). By avoiding seeking help, the individual evades being labelled mentally ill, therefore, escaping the statements and presumptions which could lesson self-esteem (Corrigan, 2004). It is probable that people recognise and realise they have reached a point with their mental health that they know it would be beneficial to seek professional help, however, are unlikely to actively seek the help due to the perceived stigma which comes with it (Crowe, Averett and Glass, 2016). This widespread effect of stigma acts as a barrier for help-seeking, individuals are consciously deterred and discouraged away from seeking treatment (McNair, Highet, Hickie and Davenport, 2002; Hack *et al*., 2019). The cited literature above ranges from 2002 to 2019, with both studies analysing data from participants aged 15 or above who have experienced poor mental health. This range in dates visibly shows that stigma has consistently prevailed to have a negative impact on help-seeking with people who experience poor mental health. In addition, a correlation of interest was between stigma and individuals who have low levels of education. As implied by Alonso, Buron, Rojas-Farreras, de Graff, Hara, de Girolamo, Bruffaerts, Kovess, Matschinger and Vilagut (2009) people who have low levels of

education are more likely to receive stigma. As further explained by Hack *et al*. (2019) this is because those who have received higher education can better critically evaluate stigmatising behaviours, and may have more knowledge surrounding mental health, its care and what treatment is available. Suggesting that through an absence of education, there is a low level of knowledge concerning mental health, therefore the inability to recognise, consider and assess stigma. Therefore, this leads to suggest that education in mental health is fundamental to tackle stigma and increase awareness.

However, despite the common notion of avoiding help, there are also opportunities where a person actively looks for help from others. This communication known as help-seeking, can either be advice, guidance, understanding, support, information and treatment (Rickwood *et al*., 2005). Help-seeking can range, whether it is through informal sources such as peers and family, or through professionals who have a recognised role such as general practitioners (Rickwood *et al*., 2005). It is highlighted that within adolescence, informal support is favourable and preferred over professional care (Rickwood *et al*., 2005; Rickwood, Mazzer and Telford 2015). As suggested, individuals seek informal support first because the relationship is already established, they are a known source of trust, respect and security (Rickwood *et al*., 2005; Rickwood, Deane and Wilsone, 2007; Gulliver, Griffiths and Christensen, 2010; Mazzer and Rickwood, 2015a). Furthermore, in relation to this study, Swann, Telenta, Draper, Liddl, Fogarty, Hurley and Vella (2018) discovered that sport coaches are a significant informal source to aid help-seeking and support mental health. They are understood to be individuals who are not associated with institutional structures such as school, in addition they are individuals who are connected to people who may not have been in contact with other common gatekeepers such as GPs and teachers (Rickwood, Deane and Wilson, 2007; Swann *et al.,* 2018). Furthermore, it is understood that the physical activity and sport environment is viewed as a key vehicle through which inventions can be delivered to facilitate and encourage engagement with traditional professional forms of mental health care (Vella, Swann, Batterham, Boydell, Eckermann, Ferguson, Fogarty, Hurley, Liddle, Lonsdale, Miller, Noetel, Okely, Sanders, Schweickle, Telenta and Deane, 2020). However, it is argued that these common and accessible sources of help are more than likely inadequate in comparison to the professional care that is available (Mason *et al*., 2015). In agreement Jorm (2012) understands that although help-seeking through social support can be useful, it does highlight concern when this is done instead of seeking professional support. One reason for this may be due to a lack of education surrounding mental health within the general public.

Education is the key to reducing stigma, providing information to the public so they can make informed opinions on mental health, educating people on the purpose and objectives of mental health support (Corrigan, 2004; Crowe, Averett and Glass 2016). Through this education, via interventions and programmes, there is potential to align public stigma and perceptions with personal perceptions, as personal opinions are significantly less stigmatising (Reavley and Jorm, 2011). Through learning about mental health and the support that is available, this serves to reduce stigma and normalise

poor mental health, aiding it to be viewed in a much less damaging light by the public (Crowe, Averett and Glass, 2016). As Crowe, Averett and Glass (2016) imply, if a 'culture of wellness' is achieved throughout the population, the use of mental health treatment would be understood to be necessary and help-seeking would be encouraged rather than stigmatised. WHO (2018) define certain settings which can be utilised to promote mental health; these environments range from schools, community settings, places of work, day centres and educational schemes. With relevance to this study, the community environment was of particular importance. Jané-Llopis and Barry (2005) identified that within the community setting, the opportunity to engage community members in the journey of promoting mental health is viable through settings such as workplaces, youth clubs and community centres. Partnerships with other sectors of health such as sport, recreations and arts were identified as essential to successful promotion of well-being (Teixeira *et al*., 2018). In relation to this study, Bapat, Jorm and Lawrence (2009) understand that programmes delivered within a sporting environment can be an effective way of improving mental health knowledge. As shown through the study conducted by Pierce, Liaw, Dobell and Anderson (2010) who concluded that sport coaches were much more knowledgeable surrounding mental health after the completion of a training programme. Therefore, to help contribute to the education of the public, it could be suggested that it is productive and worthwhile implementing programmes for people within community roles. This is supported by Teixeira *et al*. (2018) who explain that engagement from the community results in effective and sustainable promotion of mental health. Collaborative partnerships between various community environments are argued to be key in developing mental health promotion, allowing for the implementation, endorsement and support of positive mental health to target different social groups, ages and settings (Jané-Llopis and Barry, 2005). This suggests that when different community groups such as sport clubs, art classes and youth centres work together towards a common goal, the notion of supporting and promoting mental health is more likely to be achieved and received by a collective amount of people. The most important aspect of these collaborative partnerships is the opportunity for the continued sustainability of positive mental health (Jané-Llopis and Barry, 2005).

2.2 Physical Activity and Sport; the Relationship with Mental Health

Mental health as explored above, impacts everyone individually on their own involuntary continuum, whereas physical activity is seen as an individual's choice. Sport England (2019a) through their Active Lives Survey report that just over six in ten adults (28.6 million individuals) complete 150+ minutes of activity a week, an increase from the previous year. When looking at the connection between mental and physical health, Sport England (2019a) understood that those who are active have a higher better life satisfaction score compared to those who are 'fairly active' and/or 'inactive'. Concluding there is a clear positive link between being more active and better mental well-being (Sport England, 2019a). Similarly, active people also reported to be more likely to achieve their personal goals and persevere when things get difficult (Sport England, 2019a).

Physical activity has been proven to have an impact on a variety of mental health illnesses, ranging from common mental health problems like anxiety to some less common mental health illnesses like dementia (Mental Health Foundation, 2016). As Breslin and McCay (2012) propose participating in regular physical activity and sport is the most likely activity to be adopted by individuals to improve their mental health. As Street (2013) explains, exercise is well-recognised for having a positive effect on mental health. In connection with physical activity being widely accepted as a referral, preventative and an aiding mechanism to combat mental health illnesses (Street, James and Cutt, 2007). In support, Mansfield (2020) understands that physical activity has always been a leading prescription and promotion for public health. Shannon and Breslin (2020) agree, sport is often perceived to be an effective vehicle for mental health promotion and awareness. Mansfield (2019) produced a report based upon training the sport grassroots workforce to support young people's mental health. Within this report, it was concluded that a community approach within physical activity and sport can help individuals to realise the positive connection between physical participation and addressing mental health issues (Mansfield, 2019). Further supported by Breslin, Haughey, Donnelly, Kearney and Prentice (2017) who indicate that participating within community physical activity and sport has been shown to be a useful vehicle for aiding mental health, creating a social network of support. In agreement, Street, James and Cutt (2007) suggest that this environment encourages the opportunity to build and maintain social systems, as well as continuing to participate within physical activity and sport. They further discovered that participation increased when the social environment was supportive (Street, James and Cutt, 2007), suggesting this relationship to be two-fold. DCMS (2008) published their acknowledgement of this connection, expressing how sport can have a significant impact on community cohesion, enabling individuals from differing backgrounds to come together, labelling sport to often be the 'heart' of a community'. Hurley, Swann, Allen, Okely and Vella (2017) conducted a study examining parent perceptions, and their opinions on the role that a community sports club has in health promotion. The parents reported how they could see a clear link between mental and physical health, and appreciated that their children felt the benefits and were having fun as a result. They further described the potential for sport to promote positive well-being, especially through the social support networks that exist within community clubs (Hurley, *et al*., 2017).

However, even people who regularly partake within sport are affected by mental illnesses. A study conducted by Edge Hill University in association with DOCIA Sport (2018), revealed that 57% of their respondents had experienced a mental health illness, with the highest percentage located within the activity, lifestyle and recreation sector. In addition, they also uncovered that 23% of their participants currently experience mental health illnesses, with the highest percentage of those participants in the grassroots and community sport sector. This suggests that although sport is part of the solution to support better mental health, it does not mean that it is free of poor mental health. Carless and Douglas (2016) suggest that physical activity and sport can have both positive and negative effects on mental health dependent on the cultural environment of the sessions. The factors that influence

it are the objective specifics of the activity; form, intensity and participation level (Carless and Douglass, 2016). Furthermore, Swann *et al*. (2018) suggest that a coach's attitude towards physical activity and sport whether it be for enjoyment or performance can further impact their participants. This suggests that there are numerous factors which impact a sport participant's mental health which are related to the sporting environment alone. Therefore, it is important to understand and appreciate how a sporting environment can either negatively contribute or positively support the participants.

2.3 Mental Health Objectives in Sport Policy

The physical activity and sport sector is inclusive of various organisations, charities and clubs who collaborate to reach shared goals. The department of Digital, Culture, Media and Sport (DDCMS), a division of the United Kingdom's government who oversee the targets and progression of the sector, which has seen many changes over the years. Examining the sector from 2008, there has been a large shift in attention placed on the outcomes of participating within activity. 2008 saw the Labour government release a document called 'Playing to win: a new era for sport' by the then division of government, Department for Culture, Media and Sport (DCMS). This document issued the notion of 'sport for sports sake', entertaining a large emphasis on the competition element of sport. As stated, 'sports power to captivate is unlocked in the thrill and drama of competition. I want people of all backgrounds and ability levels to experience the joy and friendship that competitive sport brings' (DCMS, 2008, p. 2). This document highlighted the ambition to become a world leading sporting nation, through the drive for competitive opportunities (DCMS, 2008). This ambition coincided with the successful bid for the London 2012 Olympic Games, Green (2009) states that this further confirmed the significance placed upon sport, with emphasis on elite. As suggested by Houlihan and Green (2009), there was an increase in policy direction and funding for elite sport development. This emphasis was shown through a substantial increase of investment of public money, an extra 200 million pounds (Green, 2009). However, it was argued that this would also benefit grassroots by creating sporting legacies from the 2012 Olympic Games (Green, 2009). This focus of elite development overshadowed complex issues around sustainable participation, social capital and club development within the sector (Houlihan and Green, 2009). Targets were reduced to aiming only 1% increase in active participation over the next five years (Houlihan and Green, 2009). Examining funding with a lens upon NGBs, in the DCMS (2012) release of 'Creating a Sporting Habit for Life' it was a simple 'payment by result' strategy. The understanding that if a NGB failed to perform on the targets set by DCMS, then their designated funding would be withheld and offered to other NGBs who could put forward a strong case for extra funding (DCMS, 2012). Furthermore, for those who performed well, they would have access to increased funding to continue to develop their work (DCMS, 2012). This notion responds with the competitive characteristic of the government at the time, NGBs were in competition with each other to access necessary funds for their sport.

However, this competitive push gradually altered with the release of DDCMS 'Sporting future: a new strategy for an active nation' (2015). This document determined five objectives which the sector

would work towards, these are inclusive of: physical well-being, mental well-being, individual development, social and community development and economic development. The DDCMS (2015) state that all organisations whether they are publicly funded or not, can strive towards five clear objectives within their work. Halkyard (2019) indicated that this document directed sport policy away from competition and medals to a wider commitment to consistent participation, volunteering and experiencing live sport. Further supported by Brunton and Mackintosh (2017) who imply the policies main aims are to secure additional participation, with sustainable effects. In line with the governmental change, Crisp (2020) suggests there is growing evidence that physical activity and sport can contribute to social policy objectives. As shown, this document release paved the way for a change in remit and utilising the sector to achieve wider outcomes.

It was also within Sporting Future that the DDCMS (2015) declared their choice of funding direction, a complete shift from DCMS (2012). '…we will change sport funding so it is no longer merely about how many people take part, but rather how sport can have a meaningful and measurable impact on improving people's lives' (DDCMS, 2015, p. 6). They further expanded that they would target funding to sports who traditionally have a lower participation rate, in addition to working alongside non-Olympic sports to develop long-term elite success. (DDCMS, 2015). However, Halkyard (2019) claims that Sporting Future was hesitant to comment as to who would actually receive the investment funding. Although it was addressed further within the 2016 release of 'Towards an active nation: strategy 2016-2021' they announced a 'clear line of sight' for investment to each of the overarching outcomes which were published in Sporting Future. They state that through this investment, they are able to make a broader impact on individual's lives through the five outcomes, instead of 'simply driving numbers' (Sport England, 2016a, p. 10). Halkyard (2019) agreed that this showed a clear indication that funding decisions are evidently aligned with the DDCMS objectives. Halkyard (2019) understands that although there has been interest and literature on community sport policy, there to be a lack of academic literature based on NGBs within community sport. Therefore, it is difficult to extend and analyse this further, this study however aims to examine NGB's perception of funding within the sector surrounding MHT.

For this study, emphasis will be placed upon the objective of mental well-being. Within the year of 2017, the DDCMS published the first annual report of Sporting Future, with the information of how they would collect the data of mental health well-being. Mental health well-being would be measured via the reporting of positive subjective well-being and be collected via the Sport England's' Active Lives survey (DDCMS, 2017). Within both the adult and children active lives survey (Sport England, 2019a; 2019b), it reported a positive association between activity levels and mental well-being. As participation continued to increase, more individuals were receiving benefits in regards to their mental well-being (Sport England, 2019a). This contributed to the second annual report where Sport England stated they had already invested 9.89 million pounds of the governments' and National Lottery funding in 126 physical activity and sport projects which emphasise a focus on mental health

outcomes (DDCMS, 2018). However, the two annual reports do not provide much data in terms of progress but simply reiterate what the original document stated. The latest DDCMS document release was published in 2019, 'Changing Lives: The social impact of participant in culture and sport'. This document reinforced the five outcomes as first announced in 2015. Therefore, there is a clear drive towards the sector achieving more than simply physical participation.

In the latest publication by Sport England (2020) they acknowledged issues that those within the sector believed they played a role within. With emphasis upon this study's aims, one of the issues indicated by the sector was the grassroots workforce; how to grow, develop, diversify and sustain the professional workforce and volunteers. This is a noteworthy identification, if those within the sector indicate that the workforce is an issue to which Sport England can assist in, they must believe that the current workforce is not working to its full potential. An example of where the workforce has already been addressed, is through developing training for coaches in mental health. UK Coaching (2020) offer an online course through their website for the chance for people to participate within a mental health awareness training, tailored to physical activity and sport. Throughout the summer of 2020, this course was free of charge, to encourage coaches and other grassroot roles to enhance their knowledge on mental health. Nevertheless, this course is one segment to developing the workforce, as the Sport England (2020) report shows, there needs to be a greater push to achieve this.

2.4 The Evolved Role of a Coach

We understand that sport helps to build social networks between participants, but also with the coaches who facilitate the sessions (Street, James and Cutt, 2007). In the past, sport culture has promoted mental toughness and criticised emotion which showed 'weakness' (Breslin, Shannon, Haughley and Leavey, 2016). To align with this environment, the traditional way of coaching as suggested by Cushion (2010) concentrated on the behavioural elements of coaching rather than considering the 'why' or 'what' meaning behind the behaviour. However as discussed, the remit for the sector has altered, and there is a large focus on supporting and promoting mental health. Through this, Sport England (2016b) published a document regarding a coach's role, stating the role to have changed and evolved to be responsive to the needs of the sport participants. As defined by Sport England (2016b, p. 6), a coach's role is 'improving a person's experience of sport and physical activity by providing specialised support and guidance aligned to their individual needs and aspirations'. They expand on this, clarifying that there needs to be a greater emphasis and priority placed upon identifying and developing individuals' values, attitudes and behaviours through 'soft' coaching skills (Sport England, 2016b). Further published within 'Towards an Active Nation' Sport England (2016a) reinforced the notion that coaches need to be knowledgeable and skilful in delivery so they are conscious of physical and mental well-being, in addition to their technical ability. As Jeanes, Rossi, Magee Lucas (2019) argue, a coach's role has progressed from face-to-face engagement, to being a 'critical actor' who influences and supports multi-sectional working. Crisp

(2020) who investigated how sport coaches can affect change within their participants behaviour, suggests that it is now simply not enough to employ traditional coaching practices to be able to ensure participants success, but rather encompassing their interpersonal capabilities and other soft coaching skills. Swann *et al*. (2018) investigated male perspectives on how a sporting environment could be used as a setting to support mental health. Their participants understood the physical activity and sporting environment to be an engaging atmosphere where mental health could be supported. They further discovered that coaches are seen to be a significant contributor towards supporting mental health (Swann *et al*., 2018). Consequently, sport coaches are argued to be in a unique position, they can promote, prevent and act as an intervention for the benefit of individuals' mental health (Vella, Gardner and Liddle, 2016). Within a report published by Mansfield (2019), it was uncovered that 43% of young people stated that they would reach out to a sport coach for support and advice. This opportunity for coaches to significantly influence an individual's mental health can help explain why they are considered key mental health facilitators within the literature. This study aims to expand on this, generate further understanding on the role of the coach in relation to their sport participant's mental health, while further examining how MHT training can benefit a coach in this.

Physical activity and sport coaches are argued to be crucial gatekeepers to those who participate within their sessions (Mazzer and Richwood 2015b; Brown, Vella, Deane and Liddle 2017). Brown *et al*. (2017) discovered within their study, that parents believed a coach to be a suitable person to act as a gatekeeper. Gulliver, Griffiths and Christensen (2012) conducted a study which contained 15 athletes aged 16-23. The study aimed to uncover and understand what the athletes perceived the facilitators and barriers to be for help-seeking in relation to common mental health problems. Within the study, they highlighted that the participants within their study felt that it was of high importance that those around them, inclusive of their coach, had positive attitudes towards help-seeking. That this attitude acted as a powerful facilitator for the participants and their mental health (Gulliver, Griffiths and Christensen, 2012). This suggests that if coaches were to have an open mind and an encouraging belief towards help-seeking, then their participants would be more reassured to seek the coaches support and guidance. To promote help-seeking within a physical activity and sport environment, key factors included: constructive interactions, already established relationships, encouragement from others and a positive outlook from surrounding people, specifically their coach (Gulliver, Griffiths and Christensen, 2012). Through this emphasis on help-seeking, as suggested by Gulliver, Griffiths and Christensen (2012), it can provide a necessary preventative, management and treatment strategy for reducing mental health illnesses. Carless and Douglass (2016) stated that in order to support and help long-term mental health, those who work within the physical activity and sport sector must produce opportunities that allow individuals to explore themselves; help them to negotiate the different roles and identities that may come as a result of that.

One area within the literature which highlighted the significant role in which coaches play within people's lives, was within low income populations. WHO (2004) revealed that there is a global association between low income areas and poor mental health; worldwide research has shown that the risk of developing a mental health illness is positively correlated by social disadvantage, low levels of education and hardship (WHO, 2004; Murphy and Fonagy, 2013). Murphy and Fonagy (2013) report that young people within the poorest households are three times more likely to develop and experience a mental health illness in comparison to more fortunate households. There is a growing amount of evidence that suggests there is a strong connection between a low socio-economic status and an increased risk of developing and experiencing mental health illnesses (Mental Health Foundation, 2016). Social factors which are associated within low socio-economic groups, such as debt and unemployment can harmfully affect mental health (Mental Health Foundation, 2016). Sport England (2018) categorise individuals in low socio-economic groups as ranging from 16 to 74 years old who work in routine occupations (cleaners or waiters), semi-routine occupations (hairdressers or bus drivers), those who are long-term unemployed or have never worked. As Sport England (2020) revealed, around 12 million people, nearly one third of the adult population in England fall into the board category of lower socio-economic groups.

As reported, it is these individuals who are located within the low socio-economic groups are the ones who are more likely to be inactive (Sport England, 2018). Within both the Adult (Sport England, 2019a) and Children and Young Peoples Survey (Sport England, 2019b), people from less affluent households are the most likely to be inactive. Within the adult population (aged 16 and above), they are the least likely to be active with only 54% taking part within activity, this is compared to the 72% of a higher socio-economic group (Sport England, 2019a). Their lack of participation within activity has remained the same percentage over the past two years (Sport England, 2019a). The survey for children and young people (aged 5-16 years old) similarly reported that the least affluent families are the least likely to be active, with only 42% in comparison to 54% of the higher affluent families. This further supported by Wheeler, Green and Thurston (2019) who examined the relationship between social class and sport participation within children aged 9-11. They understood that the higher the social class (ranging from underclass, lower-middle class, mid-middle class to upper-middle class) the more and wider ranging physical activities and sport the children partook within. Furthermore, this progression from each social class also impacted the frequency to which the children participated within the chosen activities (Wheeler, Green and Thurston, 2019). Breslin and McCay (2012) imply that individuals within low socio-economic groups reported lower levels of perceived control over their mental health. This was further explored by the group being less aware of activities they could participate within to positively benefit their mental health in comparison to other socio-economic groups. This suggests that individuals who fall into the category of low socio-economic groups have less education regarding their mental health, and are not informed and/or knowledgeable in either the protective or risk factors. It is also within this category, that Sport

England (2019b) reported that children and young adults from the least affluent families are less likely to report positive attitudes to physical activity and sport.

Despite these low participation and attitude rates, the community physical activity and sport sector has an important role to play. Mansfield (2019) reports that more 14-25-year olds, who were living in a household of an annual income less than 20,000 pounds described how they would turn to a coach or community leader alike to confide in them about their mental health, compared to higher annual income social groups. Furthermore, it was determined that the one in five participants who would talk openly about their worries, 21% of them said that they would turn to their coach for motivation (Mansfield, 2019). The literature and the activity level statistics offer an interesting comparison. This social group are the most likely to turn to a sports coach in terms of help-seeking, however, they are the social group which are least likely to partake within physical activity and sport. These statistics suggest that the help-seeking attitudes of the community workers who provide sport activities and provisions within such areas are vital to aid the mental health of those who live there (Rickwood *et al*. 2005). Due to the large-scale amount of individuals who fall into the category of low socio-economic groups, there is a mass amount of individuals who rely on their community coaches to aid and support them with their mental health.

Coaches have expressed that they understand the significant role that they could play within a child and young person's life regarding their mental health (Mazzer and Rickwood 2015b). Mazzer and Rickwood (2015a) state that coaches and volunteers report that mental health illnesses are becoming more prevalent and recognised within the sporting environment. In a recent study by Ferguson *et al*. (2019) they investigated how 20 grassroot coaches, across five popular sports perceived their role and responsibilities with regard to the mental health of their participants. The study conducted by focus groups understood that the majority of the coaches identified their lack of necessary knowledge in mental health, and expressed how they would like to learn more. In particular, the coaches spoke about the importance of being able to identify and recognise the signs of mental health illnesses, and wanted to learn how to approach their participants to talk about it (Ferguson *et al*., 2019). One concern which was highlighted by the coaches was the uncertainty of how to follow up and support a participant after they discussed a mental health problem, this led to feelings of inadequacy by the coaches (Ferguson *et al*., 2019). A further study which examined the impact which coaches could have upon their participants was the inquiry by Mazzer and Rickwood (2015a). They conducted semi structured interviews with 13 community coaches across a range of sports. The coaches within this study recognised that they have a role to play, however it is not the main focus of their role as a coach. Discussing how it is of importance that a coach acknowledges the limits of their responsibility and capability within the mental health of their participants (Mazzer and Rickwood, 2015a). In agreement, Lebrun, MacNamara, Collins and Rogers (2020) reported that their coaches did not agree it was within a coach's role to 'deal' with mental health illnesses. Nevertheless, the participants within their study further commented how they felt 'duty bound' to

support their sport participants with their mental health (Lebrun *et al.*, 2020). Further denoted is how they are aware that their support, advice and actions could have an opposite effect on the participants, with a potential negative impact leading to a severe consequence (Mazzer and Rickwood, 2015a; Vella *et al*., 2020). The coach's acknowledgment of their own self-protection could discourage them from being part of a support network for their participants (Mazzer and Rickwood, 2015a). In agreement, Bissett, Kroshus and Hebard (2020) expressed how it is significant to remember that a coach is only one individual in the promotion of mental health, while still important, it is limited.

Nevertheless, Mazzer and Rickwood, (2015a) concluded that the coaches recognised they could positively impact their participants mental health, that the coach athlete relationship lead to respect and trust. The coaches understood and showed willingness to communicate and care for their participants regarding their mental health problems (Mazzer and Rickwood, 2015a). Mansfield (2019) suggests that sport coaches and volunteers within community sport clubs would benefit from investment to develop understanding and skills to support mental health well-being. Nonetheless, Ferguson *et al*. (2019) revealed within their study, that some coaches felt that their influence and help could be limited due to the short amount of time spent with their participants. Additionally, they revealed that coaches do not feel sufficiently trained in MHL, therefore, lacked the confidence and knowledge to support their participants (Ferguson *et al.* 2019; Vella *et al.,* 2020). Street Games (2019) state that sport coaches frequently report seeing children and young people with signs of mental illness, however, they do not feel like they have the appropriate training, skills or confidence to step in. In addition, Kroshus, Chrisman, Coppel and Herring (2019) discovered that around two thirds of the coaches within their study were concerned about their participants mental health. One way in which this could be addressed is through MHT, as Mazzer and Rickwood (2015b) suggest training in mental health would enhance a coach's capability to support children and young adults, leading to more effective assistance and benefits for the participants' mental health.

2.5 Mental Health Training

A method which aims to tackle the statistics of people experiencing mental health illnesses, and to better the knowledge, understanding and confidence within the public is the concept of 'mental health 'literacy' (MHL). MHL has a relatively short history as a matter of academic research and active public attention (Jorm, 2012). To give this some context, Jorm (2012) stated that it has a record of 15 years, therefore, as of this current writing, it has been a growing concept for around 23 years. MHL contains many components: a) an individual's knowledge of how to prevent a mental health illness, b) the ability to recognise them if they do occur, c) have knowledge of help-seeking possibilities, and d) be aware of the treatments available (Jorm *et al*., 1997; Jorm, 2012; Hurley, Allen, Swann, Okely and Vella, 2018). Although in short, Jorm *et al*. (1997) devised that MHL signifies a person's knowledge about mental health illnesses, how to aid prevention, recognition and

management. As noted by Rickwood *et al*. (2015); Rothi and Leavey (2006); Mazzer and Rickwood (2013) and Sebbens, Hassmén, Crisp and Wensley (2016) increased MHL provides the opportunity for early intervention. However, Kitchener and Jorm (2008) and Patterson and Pearson (2013) argue, there seems to be a reluctance to educate the public surrounding mental health, therefore many lack the skills to facilitate early intervention.

Jorm *et al*. (1997) argued that if mental illnesses are to be prevented, recognised and managed, the level of MHL needs to be greater. MHL has a direct relationship to help-seeking attitudes, by providing information, it enables someone to make the transition from intention to actual help-seeking (Breslin *et al*., 2017; Jung, von Sterburg, and Davis, 2017). A reoccurring assumption in relation to MHL is in connection to stigmatic attitudes, as discovered by Hart, Mason, Kelly, Cvetkoski and Jorm (2016) and Scantlebury, Parker, Booth, McDaid and Mitchell (2018). These stigmatic attitudes are reduced by individuals improving their knowledge and understanding about mental health; therefore, they are more willing to interact and support someone who is experiencing poor mental health (Breslin *et al*., 2017; Jung, von Sternburg and Davis, 2017). Thompson, Hunt and Issakidis (2004) argue that a lack of public MHL contributes to slow recognition of poor mental health. One way to address low MHL is through the implementation of MHT, either face-to-face or online, with MHFA England offering their face-to-face first aid training at a cost of 300 pounds, and their online first aid training at 150 pounds. Within the study carried out by Scantlebury *et al*. (2018), their participants explained that MHT challenged the common preconceptions against people with mental health illnesses. MHT helped participants to appreciate the myths within society regarding mental health and how to break these down and normalise mental health illnesses (Wong *et al*., 2017). From this, Scantlebury *et al (*2018) proposed the idea that MHT should not just be purely based upon crisis scenarios, but rather include the policies, laws and measures which are inclusive to mental health. This notion is further relevant to the individual themselves, those who have higher levels of MHL are more willing and inclined to seek professional help if they needed it (Jorm, 2012; Wong *et al*., 2017). Moreover, Jung, von Sternburg and Davis (2017) offer that the more people learn, the less humiliated they will feel about their peers knowing about their mental health service use. However, in spite of this, Jung, von Sternburg and Davis (2017) also found that although people are more likely to be objective and interactive after increasing their MHL, that within some, their new knowledge does not shift the feeling of shame and embarrassment of their personal use of the professional services. Implying some individuals could be too ashamed to use the services due to fear of judgement and potential responses they might receive (Jung, von Sternburg and Davis, 2017).

As discussed in the previous chapter, MHT is now commonly employed throughout many countries. Across the literature, MHT interventions and programmes all reported increased MHL upon completion. These expected results are in direct correlation to the aims and objective of MHL, however, MHT assertively improved on each goal. Improved MHL was inclusive of gaining more

knowledge, greater confidence, improved positive attitudes towards people experiencing poor mental health, opinions on stigma, information on treatments available and an increase in self-efficacy to promote mental health (Kitchener and Jorm, 2004; Bapat, Jorm and Lawrence, 2009; Hadlaczy *et al*., 2014; Dimoff, Kelloway and Burnstein, 2016; Hart *et al*., 2016; Mohatt, Boeckmann, Winkel, Mohatt and Shore, 2017). As suggested by MacDonald, Cosquer and Flockton (2008) MHT results in individuals being able to implement their new skills and knowledge in various environments inclusive of the workplace. In agreement, Maindonald, Attoe, Gasston-Hales, Memon and Barley (2020) discovered that the participants within their study were employing new ways of working as a result of their positively changed perspective. As the participants expressed, the training had increased their understanding, allowing for better communication and listening. However, Shannon *et al*. (2019) contend that the majority of MHT programmes focus upon concepts related to mental health illness, instead of addressing management of daily life stressors and positive health. Furthermore, Kitchener and Jorm (2004) indicate that MHT could lead to excessive labelling of life problems or temporary poor mental health as illnesses by members of the public. This suggests, that while MHT has many positive results, there is still room for improvement.

Although the literature supports the immediate increase in MHL after MHT, the impact that MHT has comes when applied in practice. This application could be weeks, months or years after the completion of MHT. Therefore, it is vital to know whether the expanded knowledge, confidence and positive attitudes are sustained. Six months after the training programme, Brett-Jones (2010); Jorm, Kitchener, Sawyer, Scales and Cvetkovski (2010); Pierce *et al*. (2010) and Kelly, Mithen, Fischer, Kitchener, Jorm, Lowe and Scanlan (2011) found the knowledge had been sustained and applied within practice. Kelly *et al*. (2011) found a higher percentage of people discussing mental health illnesses with young people compared to before the training. Dimoff, Kelloway and Burnstein (2016) and Mohatt *et al*. (2017) also reported sustained increased MHL, eight to nine months after training. The longest reported follow-up from MHT came from Svensson and Hansson (2014) who uncovered that after two years post training, MHT still had a prominent impact on the participants awareness and knowledge of mental health. As discussed above, if MHT is employed nationwide, the public have the potential to be key facilitators of the promotion of mental health within communities. Rossetto, Jorm and Reavley (2014) indicate that MHT would be valuable for educating the public on even simple behaviours, enabling people who are experiencing poor mental health to feel accepted, supported and encouraged to seek help. The MHT programmes could be integrated into existing communities, societal structures and organisations, with the possibility to have a great public health impact (Hurley *et al*., 2018; Morgan, Ross and Reavley, 2018). As supported by Teixeira *et al*. (2018) who indicates robust evidence from their study shows mental health programmes can have significant effect, and could be implemented effectively into community settings. Although as signified by Morgan *et al*. (2019), there is scarce evidence on how it improves the mental well-being of the recipient who received the aid.

MHT can be presented in two forms; face-to-face or online training. E-learning appears to have increased momentum within the literature, as this growing motion corresponds with the advancement in technology, and the increase in use (Griffiths, Lindenmeyer, Powell and Thorogood, 2006; Lamph, Sampson, Smith, Williamson and Guyers, 2018). Correspondingly, Christensen, Griffiths and Jorm (2004) and Jorm (2012) both note how the internet is becoming a leading tool in the enabling access of health information, interventions and programmes for the public. Consequently, it is of rising popularity as a form of delivery for the MHT programmes (Griffiths *et al*., 2006; Lamph *et al*., 2018). Online interventions and programmes were inclusive of integrative styles, similar to face-to-face training to ensure the participants remain engaged (Deitz, Cook, Billings and Hendrickson, 2009; Lamph *et al*., 2018). E-learning can be delivered through different ways: audio, text, images, interactive activities, with the participant completing the course within their own time, at their own pace (Davies, Beever and Glazebrook, 2018). Furthermore, Rickwood, Mazzer and Telford (2015) understand that using online resources removes barriers which could stop individuals from seeking help. As noted, these include: anonymity, confidentially and stigma for experiencing poor mental health (Rickwood, Mazzer and Telford, 2015). Results of studies which have looked at online programmes for MHT have reported that it is an effective mode of delivery, with similar positive outcomes to those reported with the face-to-face training (Davies, Beever and Glazebrook, 2018; Lamph *et al*., 2018). Nevertheless, Lamph *et al*. (2018) comments on the literature available, indicating that although there are positive results shown for online MHT, there are still questions asked about the long-term effectiveness and sustainability. Furthermore, Gayed, Tan, LaMontagne, Milner, Deady, Milligan-Saville, Madan, Calvo, Christensen, Mykletun, Glozier and Harvey (2019) observed that while there was improvement through both forms of training, there was a greater change within the learners of face-to-face training.

MHT has also been proven to not only increase MHL with the purpose to aid others, but additionally help the learner understand their own mental health. Kitchener and Jorm (2004) and MacDonald, Cosquer and Flockton (2008) both concluded that as a result of the face-to-face training their participants reported a positive effect upon their own mental health. As Kitchener and Jorrm (2004) indicate such training would be highly applicable across the community. Similarly, Davies, Beever and Glazebrook (2018) who conducted a study based upon the impact of online training also found the training to have beneficial impacts upon the participants their own mental health. This suggests that through both forms of MHT, the learners are not only able to apply their increase MHL to others, but to themselves. Online training has increased popularity as it has been substituted for face-to-face training because of its more accessible nature. Griffiths *et al*. (2006) and Bond, Jorm, Kitchener and Reavley (2016) both acknowledge online MHT to be a more manageable form of training due to issues regarding time, cost, mobility and geography. In addition, Hurley *et al*. (2017) also revealed that their participants considered e-learning to be the most suitable form of MHT, signifying that online training allows for accessibility and convenience. This leads to insinuate that online MHT is the most realistic form of training, since it is able to accessed via the internet within their own home.

For an individual to complete a course, they do not need to travel, which consequently reduces the time and cost. Furthermore, online training as described is more often than not the least expensive form of training. Therefore, for those who would like to complete MHT but at a lower cost, it is more likely for them to employ e-learning as their preferred choice. Gayed *et al*. (2019) furthered this concept by understanding that financial factors often play a role within organisations who want to deliver MHT to their staff, stating that face-to-face training has the potential to be an unviable option for smaller organisations (Gayed *et al*., 2019). However, despite a beneficial impact, there is some literature which has stated a preference towards face-to-face MHT. Although the growing popularity within e-learning is apparent within the literature, some argue that it should not act as a replacement for face-to-face training. Davies, Beever and Glazebrook (2018) claim that although there are interactive tasks, participants described how they had difficulties in being able to rehearse their new skills. Furthermore, Gayed *et al*. (2019) contended that there appeared to be a challenge with online MHT and the ability for learners to remain focused and adhered to the programme. Therefore, allowing the opportunity for the reinforcement of problems which the training is designed to aid with (Griffiths *et al*., 2006)

2.6 Mental Health Training Within Community Roles

For MHT to be effective, Mazzer and Rickwood (2013) imply that the interventions do not need to be restricted to conventional professional health services. Instead as community clubs are extremely popular within grassroots sport, they offer themselves to be a strong and convenient opportunity to promote mental health (Liddle, Deane and Vella, 2017; Hurley *et al*., 2018). This environment is considered to be of value, with coaches, athletes and volunteers all working together in unison as support networks (Hurley *et al*., 2017). Mazzer and Rickwood (2013) suggest that within these community clubs early action can be taken to aid mental health, through reducing concerns and strengthening the pathways available which can assist individuals in their well-being journey. In agreement, Jorm (2012) who examined MHL as a way to empower communities, noted that early recognition allows for earlier and more appropriate treatment. Moreover, Mansfield (2019) reported that community clubs, coaches and volunteers are fundamental to enhancing the mental well-being of individuals within disadvantaged areas. The central position they play within such settings is significant, but this is of even more value due to the low level of MHL amidst this population (Sebbens *et al*., 2016). Nevertheless, Jorm (2012) stated that surveys conducted in communities across various countries, inclusive of the United Kingdom, showed that there was a low level of MHL within many individuals. Although accurate at the time of writing, as displayed MHL and MHT has become an increasingly popular phenomenon within the United Kingdom, therefore there is potential for this to have changed.

Physical activity and sport coaches occupy a crucial position to aid the promotion, prevention and intervention of their participants' mental health (Vella, Gardner and Liddle, 2016). Due to their pre-established relationship with their participants, they are in an opportune position to promote well-

being within their daily sessions (Sebbens *et al*., 2016). To ensure that coaches take advantage of this opportunity, training is required. Through coach education, their knowledge, confidence and recognition would encourage better coach involvement (Mazzer and Rickwood, 2013). MHT within coaches can influence the mental health of the participants, allowing for greater independence, support and development of skills which are key to underpinning future well-being (Vella, Gardner and Liddle, 2016). Breslin *et al*. (2016) debate the idea that through training within mental health, improving MHL, the coaches could improve the emotional environment of their sessions. Therefore, attracting valuable discussions, interactions and relationship between themselves and their participants (Breslin *et al*., 2016). Pierce *et al*. (2010) who conducted a study investigating MHT within community football clubs identified that the coaches who had received the training had built upon their existing skills, allowing them to feel empowered within their community role. MHT can be effective in improving MHL and having a positive domino effect (Sebbens *et al*., 2016). To further this notion, this study aims to contribute further knowledge to the field regarding MHT within sport coaches. To help build evidence-based understanding of how training in mental health can support coaches in their role.

MHT is a universal programme, with the exception of a few being adapted for coaches within a sport club setting (Breslin *et al*., 2016). However, parents of male athletes within the study by Hurley *et al* (2017) failed to agree on the subject of how sport clubs could be used as a suitable environment to facilitate mental health interventions. Some participants expressed how they did not think a community sports club would be an appropriate place to discuss or even influence mental health (Hurley *et al*., 2017). Conversely, in the study conducted by Hurley *et al*. (2018) who examined parent MHL through MHT in community sport clubs, showed that it was a useful method for improving their MHL and enabling positive mental health outcomes for the sport participants. They further expressed that parents are often coaches and volunteers within community clubs, therefore this allows the opportunity to extend promotion and intervention of mental health within the given environment (Hurley *et al*., 2018). Additionally, creating an argument that community clubs are an effective and feasible way to integrate MHT to develop parent MHL (Hurley *et al*., 2018). This implies that not only are grassroot clubs a beneficial way to promote mental health within sport participants, but also within the parents and families.

While MHT provides extensive evidence of benefitting all those involved, it is of substance to note that MHT is not currently employed or implemented within coaching structures, frameworks or qualifications, nor is it mandatory for coaches to complete any form of MHT to ensure the right to coach. This notion has been commented on by several pieces of literature as a recommendation for MHT in the sector. Bissett, Kroshus, and Hebard (2020) suggest as interest in mental health promotion continues to increase within physical activity and sport settings, there is opportunity for policy level approaches to introduce mandatory MHT for coaches. In agreement, Jorm (2012) implies

that for MHL to increase in communities, there needs to be a greater focus at national policy. In addition, Schinke, Stambulova, Si and Moore (2018) argue that coach education in MHL is paramount to remove barriers which currently exist, such as stigmatisation within sport participants. As discussed, the role of the physical activity and sport sector now has a larger emphasis placed upon it to achieve wider objectives (Sport England, 2016a). Furthermore, as stressed by Sport England (2016b) a coach's role has now evolved to also attend and support individual needs and aspirations. Jeanes *et al*. (2019) argues that for sport coaches to be able to perform and fulfil their new role requirements, thought needs to be given to equipping them with the correct education to develop these skills, enabling them to have access to education which exceeds sport-specific knowledge. In agreement, Breslin *et al*. (2017) also identifies there to be a requirement for coaches to complete MHT to support the athletes and themselves. However, as argued by Bissett, Kroshus and Hebard (2020) the current educational resources available for coaches do not sufficiently address and/or inform all the ways in which they can appropriately promote mental health. In addition to this, Bissett, Kroshus and Hebard (2020) further contend that coach education is only one element to a multilevel approach of creating and developing sporting environments which support mental health. Considering these recommendations, and the impact that MHT can have on the physical activity and sport environment, this study aims to explore this notion further, to discover perceptions of where MHT belongs.

When considering the literature within the physical activity and sport field in relation to mental health, there appears to be a breadth of knowledge which stems from various theoretical approaches and perspectives. The academic knowledge within this literature includes journals articles published within sport psychology journals (see Vella, Gardner and Liddle, 2016; Breslin *et al*., 2017), in addition to multi and interdisciplinary journals (see Mazza and Rickwood, 2015a; Hurley *et al*., 2018). Furthermore, when examining the literature, the articles which considered recommendations for MHT within the physical activity and sport sector were exploratory in their approach (see Jeanes *et al*., 2019; Bissett, Kroshus and Hebard, 2020). These exploratory research studies were of particular significance due to their recent date of publishing and references to MHT which related to this study. Therefore, considering the aims of this research and the audience to which this study is targeted at, it appealed to the researcher to make this study one which was exploratory and applied in nature. Complementing the work of Jeanes *et al*. (2019) and Bissett, Kroshus and Hebard (2020) by adopting a similar stance, allowing for comparison of recent findings.

In addition to the previous literature being of various disciplines, it became clear through the course of the literature review that there was a lack of research collected and therefore developed on the concept of MHT within coaching frameworks and structures for grassroots sport. Consequently, there is an absence of theoretical relevance and explanation for this topic. This study aims to create a foundation for this gap, investigate the prospect of MHT alongside physical first aid and

safeguarding. To further this, explore the notion of implementing different forms of MHT within coaching qualifications and investigate whether MHT should become mandatory for those who work within the sector. However, due to the range of theories used throughout the literature, and a lack of knowledge base on the issues surrounding this topic, there was no automatic theory which resonated with this study. Consequently, considering the absence of literature and multiple theories employed, this research project adopted a ground theory (GT) approach.

GT is an exploratory method, at which Salkind (2010) indicates is well suited for examining areas of subject matter which have minimal research attention placed upon them. They further suggest that GT is useful when research is absent of depth and breadth (Salkind, 2010). Utilising an exploratory design emphasises the development of theory from the data collected, rather than be guided by a predetermined theory, enabling the focus to be upon the relevance of the research results (Stebbins, 2001; Ponelis, 2015). The concept of GT will be fully examined within the following chapter; however, it is significance to highlight its application within this study. By adopting such an approach, it allows for the theory to be directly related to the research collected. Subsequently, it can be clearly applied to the field to inform and assist with evidence-based practices. Adopting such an approach enables this research project to create and contribute new and progressive knowledge, at which the physical activity and sport sector can utilise to enhance their policies and practices.

To conclude, it is evident that there is an abundance of growing literature surrounding the concept of mental health, and how physical activity and sport is a well-known contributor to benefitting well-being. As explored, there is an increasing attention placed upon the sector at how they can develop their polices and aims to encourage wider benefits, now inclusive of how coaches are required to extend their role beyond the traditional expectations. MHT as discussed is shown to impact MHL within community roles, however there is a lack of movement for implementing MHT for coaches. Therefore, this provides a rationale for this study to uncover differing perspectives regarding this, leading to examine where MHT belongs within the physical activity and sport sector.

Chapter Three

Grounded Theory

This chapter examines 'Grounded Theory' (GT) and where is it applied within this study, discussing the foundation of GT and how it differs from other qualitative methods. Furthermore, the chapter outlines and argues the location of the literature review, while exploring each guideline of the GT methodology.

3.1 Introduction to Grounded Theory

Within academic research there are numerous theories which can be applied to address different hypotheses and research questions. Amongst the various theories available, GT is becoming an increasingly more popular research design (Birks and Mills, 2015). Used within qualitative research, GT is an approach which allows academics to learn about the world they study, and consequently establish theories to understand it (Charmaz, 2014). Researchers employ GT due to several recognised reasons, these as argued by Urquhart (2013) and Flick (2018) can range from: there being an identified gap in the field, therefore there is a lack of previous research, explanations and theoretical models. On the other hand, GT can be used due to a researcher's own curiosity or personal experience (Urquhart, 2013). In addition, there is also the possibility of the emergence of a new discovery or phenomenon which warrants the GT approach to be applied (Urquhart, 2013).

GT is a method which generates theory directly from raw data, through the continual process of analysis (Glaser, 1978; Wisker, 2008; Jones, Brown and Holloway, 2013). Unlike other qualitative research methods, GT starts the analytic process as soon as the first piece of data has been collected (Corbin and Strauss, 1990). This unique method to GT allows for theoretical thinking from the start, encouraging the researcher to strive for theoretical understanding throughout the study (Holt and Tamminen, 2010). The notion of GT is to create a theory, rather than test an existing one (Gibson and Brown, 2009; Birks and Mills, 2015; Patton, 2015). Flick (2018) furthers that GT prioritises the data collected over any theoretical assumptions, and that this priority enables the discovery of a theory rather than a previous one being applied. Instead, due to the direct relationship with the data, the categories which are produced are 'grounded' in the data (Charmaz, 2006; Gibson and Hartman 2014). Gibson and Hartman (2014) extend this by considering GT to be a method which produces a theory closely related, useful and practical in the field to which it was examined within. They further understand GT to be a building process' (Gibson and Hartman, 2014). In agreement, Glaser (1978) argues that because the production of a theory is a progression, accordingly it takes time. Likewise, the noteworthy theoretical understandings come with the development and growth in the data (Glaser, 1978). From this, GT has become a reputable and established methodology, which is known for its process and in-depth analysis (Queshi and Ünlü, 2020).

GT gradually builds up analytic ideas, theories and frameworks from an inductive analysis (Glaser, 1978; Charmaz, 2006; 2014). Inductive reasoning is initially used as the researcher does not start with a hypothesis (Oktay, 2012). However, Holton and Walsh (2017) suggest deductive elements are located within the study as the researcher questions and probes participants in relevance to theoretical ideas and notions that they have established. As the development of a theory grows, the method adopted become more deductive as the researcher generates a working hypothesis (Piggott, 2010; Jones, Brown and Holloway, 2013). The working hypothesis is then tested against the data; therefore, GT integrates both forms of reasoning dependent on the stage of the research process (Green and Thorogood, 2018).

3.2 Branches of Grounded Theory

GT was developed in the mid 1960s, at a time when qualitative research was falling subordinate to quantitative (Charmaz, 2006; Dunne, 2011). Qualitative research was suggested to 'impressionistic, anecdotal, unsystematic, and biased' (Charmaz, 2006, p. 5). In order to change the way that the academic field had started to view qualitative research, Barney Glaser and Anselm Strauss, two researchers who came together with a common goal (Flick, 2018). GT emerged from their first collaborative book, 'The discovery of grounded theory: strategies for qualitative research' (Glaser and Strauss, 1967). Urquhart states that this was a 'revolutionary book in revolutionary times' (2013, p. 14). In agreement, Charmaz (2006) describes how this book was a formidable argument in legitimising qualitative research, validating it as a credible approach in its own right. As suggested by Glaser and Strauss, their creation of GT was aimed to improve a researcher's capability to generate a theory which would be relevant to their data (Glaser and Strauss, 1967). However, since their initial collaboration, the two researchers have taken GT in differing directions (Gibson and Brown, 2009). They have each changed and modified GT, so it became a methodology with several different approaches, multiple explanations and various interpretations (Dunne, 2011; Jones, Brown and Holloway, 2013). Glaser continued to contend that GT was a method of discovery, that the categories were emergent from the data (Charmaz, 2006). Whereas Strauss, who co-authored with Corbin released books which took the direction of GT towards emphasising practical procedures instead of placing significance on the emergence of theoretical categories (Charmaz, 2014). Charmaz (2006; 2014) suggests that Glaser claims that Strauss and Corbin's interpretation contradicts the fundamentals of GT, stating that it forces data into preconceived categories and disregards emergence from the data, which therefore results in 'full conceptual description'. Nevertheless, Strauss and Corbin's books containing their adaptation of GT gained far-reaching popularity (Charmaz, 2014).

One of the most recognised branches of GT, known as 'constructivist grounded theory' was developed by Kathy Charmaz, which addresses the researcher's position within the research process. As described by Charmaz herself, she became dissatisfied with the notion that researchers in the 1980s and early 1990s would treat '…their analyses as accurate renderings of these worlds

rather than as constructions of them' (Charmaz, 2014, p. 14). Further implied was why the term 'constructivist' was adopted, suggesting it to acknowledge the researcher and their engagement within the involvement, construction and interpretation of the data (Charmaz, 2014). The constructivist approach emphasises the constant interaction between the data and the researcher, a process where the data and theories are not discovered but rather constructed through the researcher's past and present interactions with individuals and different perspectives (Charmaz, 2006; Qureshi and Ünlü, 2020). Mruck and Mey (2019) understand the researcher to be actively involved, shaping and playing a central role within the research process through their position and beliefs. This approach assumes that people construct the realities in which they are a part of, and rejects the notion of an unbiased observer (Charmaz, 2006; 2014). Furthered by Priya (2019) who claims this form of GT discards claiming neutrality and generalised concepts but rather allows the researcher to reach closer to the participant's understanding of their realities. Charmaz aimed to create a branch of GT which highlights the method as progressive and flexible, resisting any prescriptive or practical procedures of it (Jones, Brown and Holloway, 2013; Charmaz, 2014). Jones, Brown and Holloway (2013) believe that Charmaz created a workable and practical version of GT. Therefore, this study has chosen to adopt Charmaz's constructivist GT method, to allow for the researcher to identify and understand their position when analysing the data and developing a theory.

The identification and acknowledgement of the researcher's position within this study was managed through the implementation of reflexivity, and assuming a reflexive stance. As defined by Charmaz (2006), this is when the researcher is able to scrutinise and examine their own research experiences, interpretations and decisions during the research process. Furthered by Engward and Davis (2015) who indicate that reflexivity requires the researcher to be evident and transparent about their decisions within the research process. Dunne (2011) understands memo writing which is discussed later within this chapter to be an important element to reflexivity based on the reflective thinking it can prompt. Implementing a reflexive stance is an effective instrument to which the likelihood of imposing existing theories into the study is reduced (Dunne, 2011). This implies that when the researcher assumes reflexivity, they are able to understand and determine what previous theories already exist and can therefore distinguish if they are influencing the GT process, especially within the theory development. However, Pillow (2003) and Gentles, Jack, Nicholas and McKibbon (2014) both claim that the adoption of reflexivity has the potential for the researcher to become 'narcissistic or self-indulgent' while describing their influence on the research. Furthermore Finlay (2002) argues that researcher can become excessive on their own self-analysis at the expense of the research participants. Therefore, to prevent this, the researcher has regularly discussed with their supervisor their position and influence, enabling an outside perspective and allowing for a critical outlook.

3.3 Location of the Literature Review

In GT the topic of the literature review concerning how and where it should be conducted within the research process is an issue which has long been disputed (Charmaz, 2006). With particular emphasis on 'when' the researcher should engage with existing literature, this controversial matter continues to spark debate (Dunne, 2011; Queshi and Ünlü, 2020). Unlike other qualitative methodologies, within the original design of GT, Glaser and Strauss (1967) reasoned that the literature review should be conducted after the collection of data and analysis. Glaser (1978) stated that once the data has been analysed and a theory generated, researchers can then review previous literature and relate it back to their theory through an integration of ideas. The arguments behind why the original GT design specified that the literature review should be one of the last steps was linked to the idea of not 'contaminating' the researcher. Glaser (1978) explains that by not contaminating the researcher with preconceived concepts, ideas or theories, it avoids leading the researcher and therefore, the data in the wrong direction. They further discussed that in order for a researcher to increase their theoretical sensitivity, they should read literature but only in unrelated fields as to prevent contamination. He believed this to help increase the way that a researcher could conceptualise data, and therefore, expand their capability (Glaser, 1978). This allows for the researcher to be as open as possible when discovering new theories, and not relating the data with concepts which do not work, relate or fit (Glaser, 1978; Thornberg, 2012).

Conversely, Dunne (2011) and Thornberg (2012) state that to ignore previous literature, theories and findings implies a lack of knowledge, leaving the researcher open to criticism. Thornberg (2012) goes on to propose that the use of reading existing literature can in fact encourage the researcher to adopt an increased critical stance, and question emergent ideas or concepts. Researchers should appreciate that engagement with existing literature in the early stages of the study can offer benefits and do more than summarise previous works (Charmaz, 2006; Thornberg and Dunne, 2019). Dunne (2011) claims that reading in an unrelated field is an ineffective use of time. Further, without the knowledge from the field gained through reading, the researcher will not be aware of what has been covered and possible theories already produced (Dunne, 2011). Therefore, as a result this has the potential to repeat old problems, and dismiss existing literature (Thornberg, 2012; Charmaz, 2014). Although, it is still encouraged and recommended that a researcher should approach a new topic with an open mind and allow for new or contradictory conclusions to emerge from the data (Dunne, 2011). Dunne (2011) and Thornberg and Dunne (2019) argue the notion that a researcher conducts a study without having any prior knowledge is simply unrealistic. As Charmaz (2014) suggests, researchers naturally possess knowledge within a specific field before they choose to study a certain area within. In support, Dunne (2011) implies that if the researchers were to possess no previous knowledge about the research area, then it would be impossible for academics to conduct projects in their own area of expertise. Thornberg (2012) claims that the idea of delaying the literature review

has the possibility to deter researchers away from employing GT. Hence, concluded by Flick (2018) it is out of date to ignore the existing research within the research process.

Taking all arguments into consideration, this study employed an early literature review. Alongside the strong arguments in favour of early reading within the field, this particular study is for a Masters by Research. Therefore, to secure the opportunity to complete this study, a research proposal was conducted. Within this proposal, the researcher needed to demonstrate existing knowledge already in the field, and display where this study would contribute and advance to this. Furthermore, understanding needed to be shown to a research board in order to gain ethical approval. Therefore, this study rejected the notion of a late literature review. However, the researcher remained aware of their position within the study through their employed reflexive stance.

3.4 Application of Grounded Theory

The production of GT reasoned by Charmaz (2006; 2014) and Hutchison, Johnston and Breckon (2010) consists of an orderly yet flexible set of guidelines. Glaser (1992) suggests that if the researcher follows the guidelines then they will always generate a theory. However, Weed (2009) disputes that GT is not a 'pick and mix box', but the researcher who is engaging in GT must complete the whole set. In agreement, Holt and Tamminen (2010, p. 407) understand 'if researchers simply pick methods at will and claim to have conducted grounded theory research they may unwittingly end up creating their own, unproven, methodologies'. Therefore, the guidelines reviewed below are considered the foundation of GT, and are examined by Glaser and Strauss (1967), Glaser (1978), Charmaz (2006; 2014) within their publications. This study adopted the basic principles within the chronological order as they are set out below.

The first stage implemented within this study was for the researcher to gain theoretical sensitivity. Jones, Brown and Holloway (2013) and Thistoll, Hooper and Pauleen (2016) confer that theoretical sensitivity is when the researcher is conscious to the underlying meanings within data and can enhance their awareness of them. Further supported by Owen Lo (2016) who deems theoretical sensitivity to be the researcher's capability of conceptualising data, understanding insights and conclusions. A researcher can develop their theoretical sensitivity by conducting a literature review, as reading can help the researcher to identify gaps within the knowledge, and increase their ability to recognise and connect concepts (Owen Lo, 2016; Thistol, Hooper and Pauleen, 2016). Weed (2009) suggests that through theoretical sensitivity, the researcher is able to acknowledge their understanding of data already in the field, but also enter the research process without any preconceived ideas or notions. This was an important concept for Glaser (1978) who stresses that the research process must be entered with minimal assumptions. Furthermore, developing theoretical sensitivity as soon as possible reduces the risk of the researcher developing a theory too soon, and then being selective and bias with the remaining data (Thistol, Hooper and Pauleen,

2016). Glaser and Strauss (1967) state once theoretical sensitivity has started, it is continually developed by the researcher.

The second stage which was employed within this study is known as theoretical sampling, an essential part of GT (Charmaz, 2006). Theoretical sampling is the process of where the researcher collects and analyses their initial data, and then subsequently seeks correlated data to develop their emerging theory (Glaser and Strauss, 1967; Glaser, 1978; Charmaz, 2006). Morse and Clark (2019) agree, as the analysis develops then the selection of research participants become more theoretically driven and purposeful. The implementation of theoretical sampling helps the researcher to focus and refine the data, allowing for more specific emergence on the developing theory (Weed, 2009; Birk and Mills, 2015). The natural interaction between data collection and analysis is unique and central to GT, while being deliberately blurred together (Charmaz, 2006; Urquhart, Hans and Myers, 2010). Further noted as not being a linear process unlike other qualitative methods (Weed, 2009; Dunne, 2011). This unique relationship between data collection and analysis means that they occur simultaneously throughout the majority of the research process (Dunne, 2011). The constant movement between data and analysis allows for the study to gain analytic depth and accuracy (Charmaz, 2006). Flick (2018) opposes that if a theoretical sampling is located too early within the research process, then it can lead to premature direction, dismissed and/or vague categories. Therefore, within this study, theoretical sampling was employed after the researcher had gained and analysed data from six research participants. This then allowed for a broad range of categories to be identified and directed the researcher onto the path to developing the emerging theory.

From the start of theoretical sampling, then throughout the rest of the GT process, the practice of memo writing was exercised (Corbin and Strauss, 1990). Memo writing is produced when the researcher writes down ideas about codes and categories that develop when they are analysing the data (Glaser, 1978). A document, known as the ‘memo fund’ is constructed, this is where the researcher catches their thoughts, ideas, questions and connections they make in their GT journey (Glaser, 1978; Charmaz, 2006; Flick, 2018). The notion of memo-writing helps to guide theoretical sampling, directing the researcher to explore other relevant data (Glaser, 1978; Charmaz, 2006). Charmaz claims that memo writing helps to ‘…make the analysis progressively stronger, clearer, and more theoretical’ (2006, p. 115). The memo fund has the potential to contain simple sentences and/or paragraphs of various intensity or content; the researcher must interrupt their analysis to write down their memo before the idea is lost (Glaser, 1978; Birks and Mills, 2015). The process of memo writing as argued by Dunne (2011) is an essential part of the researcher’s reflexive stance, helping the researcher to identify their involvement within the process. Corbin and Strauss (1990) argue that if the memo writing is not conducted, a large amount of conceptual ideas and details are left undeveloped. However researchers choose to display their memos, both Charmaz (2006) and Flick (2018) contend that memos are fundamental to the creation of developing a theory and will drive the researcher’s work forward.

When the process of theoretical sampling closes, it is due to the occurrence of saturation. Saturation is the point in which the data collected is no longer producing any new theoretical insights, nor any new properties around the developing theory (Charmaz, 2006; Holton and Walsh, 2017; Flick, 2018). Glaser and Strauss (1967) describes saturation to have occurred when the researcher can no longer add data to develop the theory, and is confident that the categories within the data are saturated. Furthermore because of the individual categories, the depth of data, insight and point of saturation will differ. (Glaser and Strauss, 1967). Charmaz (2006) and Jones, Brown and Holloway (2013) state a common misconception that a researcher can make is when they believe they have reached saturation due to the repetition of the same information or events within the data. However, it is stressed by Charmaz, (2006), Oktay (2012) and Birk and Mills (2015) that saturation only occurs when there are no new theoretical insights, no new concepts and the developing theory is continually supported by the data. Hence, if the researcher were to collect more data, it would be unnecessary as the theory has already developed (Flick, 2018). Within this study it would be bold to say saturation was accomplished. Due to the short time frame of this study, the likelihood and confidence of the research having gained full saturation of all the categories is low.

Within the original works of Glaser and Strauss (1967), they described the constant comparative method to be where coding and analysis worked simultaneously together. It is designed to ensure that the developing theory is consistent, integrates and remains close to the data (Glaser and Strauss, 1967). Furthermore, it is through this element of GT that the impression of natural rigor is developed, as the researcher is forced to continually check their theoretical ideas against the data (Piggott, 2010; Urquhart, Hans and Myers, 2010). The analysis is developed by the researcher through comparing '…data with data, data with code, code with code, code with category, category with category, and category with concept' (Charmaz, 2014, p. 342). This process is also described by Weed (2009) and Birks and Mills (2015) as how to employ the comparative method. Further explained by Oktay (2012) who implies that this process makes the similarities and differences between the data apparent. By these comparisons, the researcher's analytic awareness starts to take form, and the process is continued until a complete GT is produced (Charmaz, 2006; Birks and Mills, 2015).

When analysing the data, coding is employed to give the researcher a more focused way of viewing the data, allowing for the continual stimulation of ideas (Glaser, 1978; Charmaz, 2006). Charmaz (2006) expresses how active coding within GT is more than simply sorting through data like standard qualitative methodology, but instead it allows for the process of analytic ideas to emerge and develop. Employed within this study, as described in several pieces of literature, GT coding can be carried out in three consecutive stages. The first stage is known as initial coding, the researcher is able to engage and identify significant features within the data (Charmaz, 2014; Birks and Mills, 2015; Flick, 2018). Urquhart (2013) and Belgrave and Seide (2019) argue that it is vital that the researcher remains open to any possible theoretical direction the data indicates. The second stage

of coding employed was focused coding. Focused coding is when the researcher discovers the recurrent and significant codes, driving the research with codes which have strong analytic direction (Charmaz, 2006; Urquhart, 2013; Belgrave and Seide, 2019). Lastly, theoretical coding is the last stage of coding, the codes identified within the previous two steps can form an analytic foundation which has coherence, and moves in a direction towards creating a GT (Charmaz, 2006; 2014).

The last guideline of GT adopted within this study is the discovery of the theory, as Glaser (1978) states the theory is a gradual build up from all the stages of analysis. Urquhart, Hans and Myers (2010) state that theories which have been produced via a GT method and developed within a particular area or field of enquiry are labelled as ‘substantive’ theories. Within this study, it started with implementing ‘sorting’, the process of placing all the data back together (Glaser, 1978). Through the sorting of the analysed data, the researcher is able to create structure and theoretical integration to create an analytic frame (Charmaz 2006; Flick, 2018). This analytic frame is able to initiate the theoretical writing, the point at which all of the work comes together to create a GT (Glaser, 1978). As argued by Glaser (1978), the credibility of the developed theory is based on its relevance, workability and integration with the data. As the researcher generates a substantive theory, they are actively developing and validating their theory against the data (Piggott, 2010). Therefore, it is important to note that the theory produced within this study is specific to this research, while further produced by interpretation of the researcher (Charmaz, 2014).

This chapter aimed to explore and set out the GT process adopted within this study. As displayed, the process of GT can vary dependent on which branch is adopted. However, throughout these differing branches, the research process follows and integrates a set of guidelines to develop a GT. These stages of the methodology help the researcher to begin and remain involved in the study until the final theory has been produced (Charmaz 2014). In chapter five, six, seven and eight, it allows for presentation of the data, and the discovery of the substantive theory.

Chapter Four

Research Methods

Throughout this chapter, there will be a detailed reasoning for the employment of qualitative methods, discussing and understanding the rationale for this approach. The separate segments of the chapter examine and explain each methodological process. This is inclusive of the methodological position; research design; sample size and selection; ethical stance and data analysis utilising the NVivo software.

4.1 Methodological Position

To understand how this study will gain the data and evidence needed, an interpretivist approach will be adopted. An interpretivist position within research understands the social world through the explanation and interpretation of the people who experience it (Bryman, 2012). This approach challenges the knowledge which is based upon an unbiased and objective view of the world (Keegan, 2009). Williman (2011) furthers this by arguing that an interpretivist application rejects the notion that society and the world can be studied from an objective viewpoint, while furthermore dismissing the idea that an individual can be codified into numeric data. This methodology acknowledges individuals and their ability to attach their own meanings to a certain phenomenon (Lapan, Quartaroli and Riemer, 2012). Seeking to uncover and understand people's lived experiences and interactions, through their own perceptions or 'inside perspective' (Hennink, Hutter and Bailey, 2011). An interpretivist researcher should appreciate that there is no single reality, that each individual constructs their own unique views and experiences (Lapan, Quartaroli and Riemer, 2012). This method recognises that these perceptions are subjective, allowing the researcher to explore multiple perspectives from various individuals (Hennink, Hutter and Bailey, 2011; Sparkes and Smith, 2014). However, Green and Thorogood (2018) suggest that it is the researcher's responsibility to recognise that the research collected is from contextual accounts, and not to be simply taken as the one truth. Additionally, Keegan (2009) states that when the subjective views of participants align, and agreement occurs, it does not necessarily mean that this agreement makes it factually correct.

Qualitative data collection lies within the interpretivist approach, a form of social inquiry which endeavours to examine, understand and interpret society from the participants' point of view (Lapan, Quartaroli and Riemer, 2012; Sparkes and Smith, 2014). Keegan (2009) supports this, reasoning that qualitative research is person-centred, placing an emphasis on opinions, thoughts and perspectives alike. This study has chosen to employ qualitative research as the process of data collection due to the attention it places upon 'text' being the principal form of data (Guest, MacQueen and Namey, 2012). This use of empirical evidence through the form of words, creates rich, in-depth and holistic data, consequently helping the researcher to explain and justify an interpretation or theory (Tracey, 2013). Throughout the literature, regularly highlighted is the notion that qualitative data is primarily about understanding a phenomenon, rather than measuring it (Keegan, 2009; Green

and Thorogood, 2018). Recognising that a qualitative researcher is interested in the meaning that is attached to an experience rather than a measurement (Sparkes and Smith, 2014). This study employed qualitative data collection due to the researcher wanting to develop reflection and gain insight rather than generalisation and using assessed measures which are traditionally conducted in quantitative research (Lapan, Quartaroli and Riemer, 2012). This form of data collection rejects the use of applying numbers to develop a theory, and is opposed to the idea of using 'variables' that are already determined by the researcher (Lapan, Quartaroli and Riemer, 2012; Sparkes and Smith, 2014). Sparkes and Smith (2014) signify that if the use of predetermined variables is employed, this would influence the researcher's interpretation and prevent the true documentation of the participants' meaning behind the experience.

4.2 Research Design

As examined within the previous chapter, a constructive GT method with a reflexive stance was implemented throughout this study. As shown, it influenced the researcher's approach towards the overarching methodology of the study; mainly shaping the sampling and data analysis. As detailed, the simultaneous interaction between data collection and analysis leads the researcher within their study (Jones, Brown and Holloway, 2013; Charmaz, 2014; Patton, 2015).

This study chose to employ GT due to the lack of literature available within an area of interest regarding MHT within the sphere of sport community roles, as discussed in chapter seven. Therefore, due to the nature of building theory from the data, it allowed the opportunity to develop and contribute evidence-based research to the field, while additionally providing a theory to correspond. Furthermore, the range of the participants occupations varied, therefore, it seemed unviable to consider and analyse previous theories against a diverse range of roles.

4.3 Sample Size and Selection

Traditionally qualitative data collection focuses upon collecting information from a small-scale number of participants, aiming to gain in-depth data rather than overall generalisation (Jones, Brown and Holloway, 2013). Consequently, this study collected data from 21 voluntary participants, helping to preserve the individuality of each participant (Sparkes and Smith, 2014). An amount in line with Creswell and Creswell (2018) who suggest a GT should collect data from 20-30 participants. The attention placed on a limited number of participants, as Patton (2015) suggests, can be very valuable as the data collected is knowledge-rich. The age of the participants varies; however, all are over the age of 18. Each of the participants were chosen due to their previous or current involvement in mental health training within the physical activity and sport sector. This occurred as a result of the project adopting the criterion sampling approach. This method of sampling allows for the researcher to choose participants who have understanding and experience in the chosen research topic (Creswell and Poth, 2018). The participants selected within this research had the desired characteristics, knowledge and involvement to best inform the researcher on MHT. (Gibson and

Brown, 2009; Hennink, Hutter and Bailey 2011). Palinkas, Horwtitz, Green, Wisdom, Duan and Hoadwood (2015) imply that the employment of criterion sampling has been able to facilitate the study with data which is of both detail and scope. To begin the criterion sampling, the researcher identified stakeholders within sport organisations, as displayed in Table 1 below, the range of roles then expand. Criterion sampling worked in conjunction with theoretical sampling, as the researcher was able to choose the participants based on data which could further test their theoretical ideas and working hypothesis. As Morse and Clark (2019) suggest as the analysis develops, the selection of research participants becomes increasingly focused and theoretically driven. The use of criterion sampling offered up the opportunity for snowball sampling to also be utilised within this study. Snowball sampling occurred when the chosen research participants were able to nominate potential other research participants and assist with putting them into contact with the researcher (Jones, Brown and Holloway, 2013; Green and Thorogood, 2018). These potential research participants shared the same desired traits that the researcher wanted in relation to the study (Bryman, 2012).

One of the issues faced in the recruitment of the participants was limited correspondence due to the COVID 19 pandemic. Through the period of data collection, the United Kingdom experienced a nationwide lockdown. During this period, a large amount of the population experienced a break from their profession and entered the furlough scheme. The implementation of furlough resulted in a lack of communication by not receiving correspondence back from potential research participants. Furthermore, some research participants who had already volunteered and booked in for an interview also entered the furlough scheme. This had the potential to affect theoretical sampling through not being able to access and gain data from individuals who may have contributed to theoretical ideas and the working hypothesis. Although there was a number of potential participants which were not able to partake, the study still collected a sufficient amount of rich data to continually analyse and develop a theory.

Table 1

Participant Allocation	**Job Role of Participant**
Participant 1	Stakeholder - sport organisation
Participant 2	MHT instructor and past coach
Participant 3	Stakeholder - sport organisation
Participant 4	Stakeholder - sport organisation
Participant 5	MHT instructor and past coach
Participant 6	Stakeholder - sport organisation
Participant 7	Stakeholder - sport organisation
Participant 8	Stakeholder - mental health organisation
Participant 9	Stakeholder - sport organisation
Participant 10	Stakeholder - mental health organisation
Participant 11	Coach

Participant 12	Coach
Participant 13	NGB and coach
Participant 14	MHT instructor and coach
Participant 15	Stakeholder - sport charity
Participant 16	MHT instructor
Participant 17	MHT instructor
Participant 18	Stakeholder - active partnership
Participant 19	Stakeholder - sport organisation
Participant 20	NGB
Participant 21	Ex athlete and lead of a mental health support group

Due to the commitment and respect of confidentiality and anonymity, this is the only information disclosed about the research participants.

4.4 Data Collection

Between the dates of February 10th to May 19th 2020, all the one-to-one interviews were conducted. This study chose to implement semi-structured interviewing, due to the degree of flexibility it allows for the interviewees to express their experiences, ideas and opinions (Sparkes and Smith, 2014). From this, the participants were able to reveal more about the study topic, therefore, providing the researcher with deeper knowledge (Sparkes and Smith, 2014). However, Gibson and Brown (2009) argue that this form of interviewing requires the interviewees to produce answers straight away and does not permit them sufficient time to reflect long enough on their answers. The semi-structured interviews in this study comprised of asking open-ended questions, providing a space for the interviewee to answer in their own words. Utilising open-ended questions allows for the participant to explore and develop the conversation, reducing the probability of bias interpretation from the researcher (Keegan, 2009; Kumar, 2014). However, due to the scope that they give to the interviewee, Sparkes and Smith (2014) reason that this could lead to a large amount of data which is unrelated to the interview question and therefore of no use to the study's aims.

The first seven interviews were on a face-to-face basis, lasting no more than 65 minutes. The benefit of using face-to-face interviews was to understand the body language given off by the interviewee alongside their verbal communication. Used by the interviewer and interviewee, body language can encourage rapport through eye contact and smiling (Keegan, 2009). The place and time of each interview was mutually agreed by both the participant and researcher. Since the interviewee was giving up their time to partake within the interview, the chosen times and locations were first suggested by them (Wisker, 2008). Allowing the interviewee to choose the interview location helped to foster a comfortable and reassuring environment, allowing them to share their thoughts and perspectives with the researcher (Keegan, 2009; Sparkes and Smith, 2014). However, due to the nationwide lockdown, the remaining interviews were conducted via telephone. This had the potential

to limit the rapport built between the researcher and participants. Although it would be unfounded to state whether the quality of interviews differed between face-to-face or telephone due to the participants having only been interviewed once. In addition, as oppose to the study conducted by Irvine (2011) who claimed that telephone interviews were typically shorter in length, this study only averaged telephone interviews to be two minutes shorter. Therefore, there was not a significant difference between face-to-face and telephone in terms of length. This was a compulsory change in interviewing to ensure that data was collected for the study.

The interview followed an 'interview guide', providing a framework of pre-determined themes and significant questions that were of importance to the study (see appendix C for the interview guide). Interview guides are an essential part of semi-structured interviewing because they give the interview a clear focus while also allowing for the knowledge to be explored in a flexible manner (Wisker, 2008; Gibson and Brown, 2009; Jones, Brown and Holloway, 2013). The guide permitted the researcher freedom to investigate and probe the participant, asking questions which would explore and deepen the subject matter (Patton, 2002; 2015; Gibson and Brown, 2009). While further allowing for modification and adaptability on the questions dependent on the participants answers and the natural flow of the conversation (Gibson and Brown, 2009; Jones, Brown and Holloway, 2013). This corresponded with theoretical sampling, as the theoretical ideas were developing, it was of interest to pursue these within the interviews. The probing questions were conversational, ranging from silence, head nodding, 'mmm' and follow up questions (Green and Thorogood, 2018). The interview guide itself followed a certain structure: introductions, opening questions, significant questions and closing questions to finish off the interview (Wisker, 2008). As shown in appendix C, the interview started with opening questions which were generalised and the interviewee would automatically be able to answer. However, due to exploration of MHT in community roles, the significant questions explored further within the interview were inclusive of questions to which the interviewee may never have been asked before. Due to the lack of available literature based on an area of MHT in sport coaches, it was of importance to gain initial perspectives to create a foundation for this. Therefore, the guide ensured that the interviewee was settled into interview before the significant questions were asked.

At the beginning of the interview meeting, the rapport between the interviewer and interviewee was established. This was through the clarification of questions regarding the study, making sure that all participants were aware of their rights and understood what it meant to consent to the study (Wisker, 2008). This conversation also reinforced with the participant of their 'cooling off' period, 28 days from the date of their interview, they had the right to withdraw from the study with no given reason. Within this study, no participants chose to withdraw. Forming a rapport between the interviewer and interviewee was of great significance, making sure that it was built within the first few stages of the meeting to prepare and put the interviewee at ease (Bryman, 2008; Green and Thorogood, 2018). This encouraged a trusting relationship where the interviewee could generate detailed answers,

aiming to produce rich data (Bryman, 2008; Green and Thorogood, 2018). For the health and well-being of the participants, no intrusive or inappropriate questions were asked. However, if any of the participants showed signs of distress, the researcher followed a list of steps:

1. Offered to stop the interview.
2. Stopped the audio recording.
3. Took a break from the interview.
4. Given the option to continue, partake within a second interview or termination of the interview process.
5. Provided the debrief sheet (appendix D).
6. Follow up contact made to the participant within 3 hours of the interview.

Each interview was audio recorded through the use of a dictaphone, this allowed for accurate and reliable data collection (Patton, 2002; Green and Thorogood, 2018). The utilisation of a dictaphone permitted the researcher to concentrate and be more attentive towards the interviewee (Patton 2002; Kvale and Brinkman, 2009). Once the interview was completed, the researcher thanked the participant and the debrief sheets were handed out if necessary (see appendix D). At the next available time slot, the researcher uploaded the audio recording onto the secure OneDrive account, and transcribed the data. Transcription transferred the oral data to written data, the active process of transcribing verbatim started the journey of analysis (Kvale and Brinkman 2009). As the process of transcription advanced, the researcher developed an understanding and became familiar with the data, enabling recognition of relevant and significant aspects and features in relation to the research aims (Braun and Clarke, 2006, Gibson and Brown, 2009; Green and Thorogood, 2018).

4.5 Reflection of Interviews

The beginning of the interviews, as described allowed for opening questions to settle the research participant into the interview. In addition to this, the opening questions further permitted the researcher to be able to gain knowledge about a participant's job role and responsibilities, resulting in applicable and appropriate questions to be asked to each participant on an individual basis. Furthermore, through the opening questions, allowing for personalised enquires throughout the interview, it was evident that the research participants felt comfortable within the interviewing setting due to the large amount of rich data collected. The stakeholders of sport organisations are likely to partake and/or conduct regularly meetings on a one-to-one basis in a professional setting. Therefore, the majority of stakeholders appeared relaxed throughout the interviews. Similarly, although coaches may not often partake within interviews, due to the interactive nature of their job role, they appeared to also seem comfortable within the interviews.

In addition, by reiterating the confidentiality and anonymity of the study, and allowing the opportunity for them to ask questions at the beginning led to them expressing possibly more detailed answers as they knew the data would not be traced back to themselves. As Whisker (2008) suggests employing open-ended questions risks leading the interviewee to provide a large amount of data unrelated to the study's aims, resulting in information that the researcher cannot use. Therefore, the researcher made the participants aware of the study's aims and the topics that they wanted to discuss, plus spoke about how the interview would progress. This enabled the majority of participants to remain on track with the study's aims and asked questions, rather than providing unusable data. Furthermore, the researcher disclosed to the participants that they had been on a MHT course so the research participants were able to relate the training back, and create a link between the researcher and themselves.

4.6 Ethical Stance

This project gained ethical approval from the York St John University School of Science, Technology and Health research ethics board (see appendix A). As a qualitative researcher, it is of importance that ethical issues are considered throughout the whole process (Jones, Brown and Holloway, 2013). Jones, Brown and Holloway (2013) reason that it is a researcher's moral responsibility to protect their participants during and after the research process. Therefore, two of the most significant ethical considerations promised to the participants involved was confidentiality and anonymity. Firstly, confidentiality was employed within study by ensuring each participant would not be associated with the thesis. This further extends out to any data that may hint or imply to a name, organisation and/or location. Secondly, anonymity was guaranteed by the use of pseudonyms; names, organisations and locations were changed so they could not be traced back. As Mason (2018) suggests, this was done immediately to ensure both confidentiality and anonymity.

At the beginning of the recruitment process, each participant was given an information sheet regarding all the relevant information and contact details in relation to this study (see appendix B). The interviewees, all of whom were aged 18 or over, provided written consent before the data collection began, this was gained via the consent form (see appendix B). Gaining consent from the participants informs the researcher that the participants understand what subject information you are wanting to gain from them and why, and how they are expected to partake within the project (Kumar, 2014). A debrief sheet was also produced for this project, given to the participants after the interview should they have wanted one (see appendix D). To ensure the health and well-being of the participants, if the participants showed any signs of distress the interview was stopped and the researcher followed a number of steps (as described earlier in the chapter). As soon as possible, all relevant signed forms were scanned into a computer and the digitised version was saved to the password protected OneDrive account, in line with the GDPR regulations currently in place. Once they were safely stored onto the OneDrive account, the physical paper copies were handed to the

study's supervisor for safe and secure destruction. The audio recordings were also stored onto the OneDrive account, accessible only by the researcher and the supervisor.

4.7 Analysis of Data

As described within the GT chapter, the analysis of data is a continual and simultaneous process throughout the study (Morse and Clark, 2019). Accordingly, the study followed each guideline discussed to optimise the analysis. Once the process of transcription was completed, this was followed by the implementation of theoretical coding. As discussed, this study engaged with the three-step process of coding: initial, focused and theoretical. Initial coding allowed for the researcher to stick close to the data and development of codes, while remaining open to all theoretical possibilities (Charmaz, 2006; 2014; Urquhart, 2013; Belgrave and Seide, 2019). Secondly, focused coding enabled the researcher to uncover the most significant codes which drove the analytic direction of the study (Charmaz, 2006; Urquhart, 2013). Charmaz (2006) understands focused coding to allow the researcher to be proactive with their data, instead of passively reading it. Lastly, theoretical coding aims to further develop the theory, following focused coding in order to categorise possible theoretical relationships (Charmaz, 2006; Flick, 2018). Utilising the previous stages to form a foundation and directing the study to generating a GT (Charmaz, 2006; 2014).

This study chose to utilise a computer-based software called NVivo. Using a computer-based programme helps the researcher to reduce their manual labour, although they must still go through each stage of theoretical coding thoroughly (Bryman, 2012). Furthermore Hutchinson, Johnson and Breckon (2010) understand that NVivo can facilitate many of the features employed within a GT approach. Allowing for early integration of data collection and analysis, helping to lead theoretical sampling and consequently theoretical development (Hutchinson, Johnson and Breckon, 2010). However, as stated by Bryman (2012), if the researcher already utilises a word processing software, such as Microsoft Word, then the cost and getting acquainted with NVivo is unnecessary because Microsoft Word can achieve the same goal. Despite this, this study has chosen to employ NVivo because it allows the researcher to learn a new skill which could be acquired in the future. Originally, the researcher had planned to book onto a training course for NVivo supplied by the university. However, due to the nationwide lockdown, this was unable to be accessed so therefore the researcher self-taught.

Chapter Five: Findings

Physical Activity, Sport and Mental health; a Relationship

The following three chapters will explore and discuss the key findings of this study. Firstly, the subsequent chapter establishes the understanding which the participants had when exploring the connection between physical activity, sport and mental health. The topics discussed within this first chapter mainly deprived from the beginning of the interviews, this allowed context and a foundation for the rest of the interview to take place. This chapter examines how mental health can be benefitted and promoted through physical activity and sport participation. Whilst further investigating what role a coach plays within this environment, uncovering how their responsibilities have evolved over time to match policy direction and societal needs.

Chapter six investigates MHT within the sector, considering mental health awareness and MHFA. The chapter discusses the increased demand for MHT, and how this originated from the grassroots workforce. Furthermore, this chapter studies the two forms of MHT, exploring the strengths and weaknesses which come with each of these. Finally, this chapter examines which form of MHT the participants deemed most suitable for grassroot coaches, and the long-term impact that the training has.

Lastly, chapter seven considers topics which are lacking previous research. The beginning of the chapter examines MHT beside physical first aid and safeguarding, discussing the correlation between the three. Secondly this chapter identifies MHT within coaching qualifications, and to what extent is MHT recommended within the coaching framework. The following section explores the notion of whether the training should be a mandated course for coaches to complete. However, as acknowledged, financial restraint can play a significant role within this.

5.1 Relationship between Mental Health, Physical Activity and Sport

WHO (2004) stated that physical and mental health are closely associated, supported Hurley *et al*. (2017) who's participants also recognised the strong link between the two. When speaking with the participants, their views on the relationship between mental health, physical activity and sport became clear. Participant 4 and 18 both termed the relationship between the two to be 'closely linked'. Furthermore, participants spoke about the positive effects that physical activity and sport can have on mental health. Participant 13 proposed that '…anyone that takes part in physical activity will say that they feel better after'. Findings which are in agreement with Street (2013) who acknowledges that exercise has a well-recognised positive effect on mental health. Looking more specifically, Participant 5 who is a MHT instructor, disclosed the impact that it has on their own mental health,

> '… I know that I am probably the best of version of myself when I get up and go for a jog, or get up and do a bit of yoga. I feel better on those days than when I don't.'

Some participants recognised the beneficial and significant impact that physical activity and sport has had upon their own mental health, expressing their knowledge and clearly identifying this. This acknowledgement that by completing exercise not only benefits physical fitness but mental fitness is an encouraging observation from the participants. This identification is in agreement with the findings from Mind (2017) and Sport England (2019a) whose research revealed there is a positive relationship between increased activity levels and improved mental well-being. Additionally, Participant 17 stated,

> 'I think it's hugely important to try and get that to people who are participating in sport because I think if anything, they need to understand that in order for them to look after their physical health, they need look after their mental health as well.'

The above statement draws further on this concept, within this study it was evident that many of the participants understood and appreciated the relationship between mental and physical health. However, Participant 5 asserted '…I want parity between mental health and physical health'. Similarly, Participant 17 agreed '…it is all about creating that, that equality between physical and mental health'. This suggests that although the relationship between the two is well known, the emphasis and attention placed on them is unbalanced. This 'unbalance' is supported by Breslin and McKay (2012) who suggest mental health is not rendered to be as important as physical health by the public, which in turn has contributed to an increased prevalence of people experiencing mental health problems. To further evaluate this, it may be due to mental health as examined, only becoming more widely and openly discussed within recent years. Whereas the interest and importance associated with physical health, as considered by Breslin and McKay (2012) has made it more established and better accepted within society.

This concept has altered the way in which society, and the sector itself approaches physical activity and sport as a whole. As highlighted by Participant 10, who is a stakeholder within a mental health organisation, a change in agenda within the sector now looks at mental and physical health as interwoven.

> 'But very much there is an increase in that over the last few years to not look just at sport per se…. everybody is involved in sport and looking at it for health reasons. And I think there are more and more people that are interested in looking at the whole person, because it isn't just about someone's physical health.'

This implies that physical activity and sport is now viewed as much more than just participation. As previously examined, the governmental shift from 'sport for sports sake' to 'sport as a social tool' contributed to this alteration of physical activity and sport's remit. DDCMS published 'Sporting Future' in 2015, declaring 'social and community development' as one of their key outcomes of success in sport. This outcome has clearly been identified by the participants, with Participant 15 who works within a sport charity, developing this,

> '…the other thing to note is that our brief like many others has changed over the years from purely participation to the social impacts.'

This transformation in the remit has made it a key vehicle in achieving more than just physical participation, but is now understood and appreciated for what it can further accomplish. Throughout the interviews, half of the participants solely discussed how sport can be used as a social setting, with particular emphasis on how it helps individuals connect with each other. Participant 18 stated this most clearly,

> 'So I think for me sport and physical activity is more than just the physical benefit, it is about the social interaction and we are social animals you know we want to interact socially, part of the reason that we do that is for our own mental health.'

Suggested by the participants was how the physical activity and sport environment is a significant place to socialise with others. In agreement with Breslin *et al*. (2017) who understands sport to be a natural environment to develop a social community. Further supporting Street, James and Cutt (2007), who discovered the setting incites opportunity to create and maintain social connections, resulting in an increase in activity levels. In addition, how this social environment can allow for mental health promotion through the support network that is established (Hurley *et al*., 2017).

5.2 Coaches Role

The purpose of this study is to investigate MHT within community roles. However, before that is explored, it is vital to understand what role a coach plays within the lives of their participants. As perceived below, when a coach first enters their coaching career, they interpret their role as simply coaching the physical activity or sport. Participant 11 and 7 suggest,

> 'Yeah I think especially when I started off coaching, I kind of saw myself as going in delivering the Sport O for example or whatever sport I was delivering, and kind of seeing that as my role.' (11)

> '…I think coaches come in, often coaches come in to coach the sport, and that's, that's what they want to do.' (7)

This understanding of their role is to coach the technical and tactical aspects of the sport, with the main focus upon their participant's physical improvement. In agreement with Cushion (2010) who proposes that the traditional way of coaching focused solely upon the behavioural elements and did not consider the 'why' or 'what' meaning behind the behaviour. However, it became evident throughout the study from the perspectives of the participants, that the role of a coach has evolved. Correspondingly, Sport England (2016b) announced a coach's role is changing as a response to the new participant needs. Participant 9 who is a stakeholder within a sporting organisation, details the

role of the coach is now inclusive of much wider responsibilities that go beyond the basic coaching aspects.

> ‘The conversations that we used to have were mainly technical and tactical about an individual. (erm) More over the conversations that we are having with our participants now on all of our projects, is around yeah the technical and the tactical side of things, the skill development, they are still happening. But actually more kind of (er) holistic, and it’s like well ‘so and so wasn’t performing to the usual high standards today, do you think there might be something going on in their lives away from our activity?’ (erm) Whereas before it might have been ‘oh so and so is having an off day today, we will see them again next week’.

This is also highlighted by Participant 11 who is an experienced coach, they understand that under the umbrella of a ‘coach’, more responsibilities have been added. Further expressing that when working as a coach it requires you to have multiple titles, ‘you can actually be a youth worker, a friend, a coach, wearing all those different hats within the same session’. These numerous roles were also identified by Participant 12, similarly a long-term coach. This identification supports Mazzer and Rickwood (2015a) who details that this evolvement of their role allows a growing opportunity for the coaches to be an accessible source of support for the sport participant’s mental health. All the same, Participant 3 and 19, who are both at managerial level within sport organisations recognised the evolved role of coach as well. With focus upon Participant 19, who not only agreed with this but also encouraged the ‘holistic role’ of a coach.

> ‘…we very much advocate the holistic role of the coach, about how they create those lasting positive experiences for people, that means that they will continue a healthy lifestyle.’

This suggests that the multiple roles of a coach are not only recognised by coaches and sport organisations but are promoted and advocated. That this all-inclusive role will contribute to the sport participants experience in and out of the sessions, and in turn will encourage returning participation within physical activity and sport. This signifies that coaches can be influential within their coaching environment, and due to their multiple titles are considered to be impactful upon the participants. Supporting the proposal by Vella, Gardner and Liddle (2016) who understand coaches to be significant and instrumental as someone who can promote and assist mental health within their participants. However, Jeanes *et al*. (2019) proposes that if coaches are expected to be able to provide this holistic role and support their participants with more than just the basic coaching skills, then thought needs to be given to a coach’s education. They suggest that if the sector is to contribute to wider social objectives, as stated by DDCMS (2015) in Sporting Future, then there needs to be support for the workforce to develop their skills.

One selected and reoccurring reason as to why coaches can be instrumental upon individuals' lives is due to trusted relationship which they can build with their participants. Participants 3 and 9 detail this,

> 'It is that trusted relationship and creating that safe space for young people that is of most importance. If you don't have those, essentially, I think you can probably forget everything else, it is not going to happen, young people need to have that trust in someone...actually that one consistent thing…' (3)

> 'Once you build that trust, once you build that credibility and maintain your integrity, people can feel that rapport with you, and tend to kind of show their vulnerability and (er) are quite happy to talk about what is going on in their lives.' (9)

This trusted relationship that they develop allows participants to reach out to their coach with any concerns, questions or problems that they might be having. Participant 3 who is a stakeholder within a community orientated organisation highlights how a coach can be a consistent person within someone's life, and because of this, a rapport is gradually built up. Through this rapport resulting in a trusted relationship, the participants are more likely to disclose information and seek help for what is concerning them. Throughout this study, it was evident that the participants agreed with this. In support, the following literature aligns with this finding, as individuals are more likely to seek help from informal support, as the relationship and foundation of trust is already established (Rickwood *et al*., 2005; Gulliver, Griffiths and Christensen, 2010; Mazzer and Rickwood, 2015a). This outcome is furthered by Sebbens *et al*. (2016) who determined that the established relationship allows for the opportunity for coaches to promote well-being within their sessions. Through the trusted relationship, coaches can encourage and support well-being, which in turn may in increase disclosures made to them from their sport participants.

An interesting notion which was cited by many of the participants as a distinctive position of a coach, especially as a coach of children and young adults is that they are neither family, peers nor school. A coach is not attached to the other major institutes within an individual's personal life. This unattachment from people and places which can sometimes have a negative association with an individual, places the coach in an exclusive position which allows a participant to be more open and willing to discuss any issues which they may have. As explained by Participant 17,

> '…and being the person who wasn't a teacher, and wasn't a parent. So that allows children to have a huge amount of trust in you, and you were able to have conversations with children that either a parent or teacher wouldn't be able to have.'

The participants view the coach as someone who they can reach out to, and confide in. This notion supports Swann *et al*. (2018) who found that their participants perceived the sporting environment to be an engaging setting for supporting mental health in comparison to school. In further agreement

is how the sport coaches are perceived to be a key individual in help-seeking and supporting mental health (Swann *et al*. 2018). This is further shown by Participant 11, a coach who predominately works in disadvantaged areas, denotes that within their experience they are the first person that a participant has approached regarding their mental health.

> '…you do become like another kind of main important figure in their life. So often yeah I was first person they would come to about a problem.'

This demonstrates how important a coach can be to a participant, and how much of a significant role they play within their lives. With particular emphasis on participants from disadvantaged areas, Mansfield (2019) understood the coach to be fundamental in impacting the mental well-being of the participants. This suggests that a coach's role should not be underestimated, as they are viewed as a significant person within a vital position within the lives of many who participate within physical activity and sport.

Chapter Six: Findings

Critical Perspectives of Mental Health Training

This chapter investigates MHT within the sector, exploring and understanding the two forms in which MHT can be implemented as, while examining the impact that it has. Furthermore, this chapter also studies the preferred MHT within the sector, considering factors such as accessibility, involvement and cost.

6.1 Mental Health Training in Physical Activity and Sport

With mental health becoming an increasingly growing topic within society, adjacently MHT has accordingly grown also. As declared by Participant 10, who is employed by one of the leading MHT organisations, they have seen a positive incline in the interest of MHT.

> '… I would say there is a real willingness to look at mental health training (erm), and I would say it has been increasing over a number of years.'

They further state, '…you know I would say five or six years ago, there wouldn't have been that awareness that such training existed'. MHT first arrived in England in 2007 (MHFA England, 2018), nevertheless this study suggests the knowledge that MHT is available is more of a recent occurrence. Participant 11 noted this growth,

> '…the last few years there has been a huge shift (erm) and the importance of the mental health training and supporting young people's mental health is just huge.'

Further indicated by other participants was how this growth resulted in an upsurge of demand for the training, as Participant 3 states '…there is huge demand'. This corresponds with Kitchener and Jorm (2008) who reason that the demand of MHT is pushed by the large prevalence of people experiencing mental ill health. When asked about MHT within the physical activity and sport sector, Participant 1 thought it to be 'excellent'. In addition, Participant 12 who is a grassroots coach is a strong advocate for MHT, they believe it to be 'fundamental' within the sector. Supported by Participant 17 who was extremely encouraging of the training.

> '… I think it plays a huge huge role, I think it is so important that down at the grassroots level (erm) they get as much training as possible and they want it, they are receptive to it.'

Participant 17's perspective on the significance of the training, highlights the emphasis it has on grassroots. The participants suggest that MHT is vital within grassroots, as shown by Participant 12 who as a community coach wants to receive this training. Furthermore, Participant 20, an employee of a national governing body (NGB), stated that the training had been requested by the grassroots workforce.

> '…we have actually looked into it and the reason we looked into it originally (erm) was actually a request from the tutor workforce.'

In addition, Participant 7 noted from research done within their organisation that various sport groups expressed a wish to receive the training, '…a lot of our partners are saying 'we want training'. This suggests that the want from organisations within the sector is there, that MHT is something which is of interest. This notion supports the data from Mazzer and Rickwood (2015a) who concluded that their sport coach participants showed a willingness to communicate and aid their participants regarding disclosures in mental health. Further supported by Kroshus *et al*. (2019) who discovered two thirds of coaches were concerned about their sport participants experiencing mental health problems. To aid this, Mazzer and Rickwood (2015b) imply that by implementing training within the sector, it would enhance the coach's ability to support their participants, resulting in effective aid and benefits for the participant's mental health. However, despite the highly valued perspectives of MHT, this 'request' as described by Participant 15 appeared to be a common perspective throughout the study, suggesting that there is a lack of available and/or completed MHT in the grassroots workforce. Participant 9, who coordinates well-being projects within their organisation, detailed that coaches feedback saying '…that they regularly see young people (er) with mental ill health in the projects and delivery sessions'. As depicted, the coaches often notice their participants experiencing mental illness. This supports Mazzer and Rickwood (2015a) and Street Games (2019) who both affirmed that coaches are reporting a rise in frequency of sport participants who are experiencing mental ill health. Due to the shortage of training, as identified by the requests, this leads to suggest that there is a perceived lack of importance surrounding mental health at grassroots level. That despite the change in remit and a coach's definition, there does not appear to be corresponding action taken to aid the wider objectives set by the government. Although the sector has announced and published the objectives towards mental health, it insinuates the grassroots level is not fully benefitting from the funding, indicating that MHT is not prioritised. However, this study contends that there is a need to employ MHT within the sector to support those within.

During the study, several participants described the communication which they have had with coaches who have dealt with participants approaching them regarding their mental health. The majority of the coaches have given feedback regarding their lack of knowledge and confidence in their ability to deal with given situations. Participant 15 gave one example of this,

> '…we see young people (erm) struggling with some sort of issue, pretty much every day and we don't know what to do. We feel unconfident and we are worried about making things worse, and it is an awkward position for us to be in. If someone sprained their ankle, we would know what to do, but if they start talking to us about their anxiety, we have not a clue'.

The feedback showed that coaches are placed in a position to which they feel like are not equipped enough to deal with. The common theme throughout suggests the coaches felt overwhelmed and helpless due to their absence of knowledge, which consequently results in a lack of confidence. This theme corresponds with Ferguson *et al*. (2019), who revealed that coaches do not feel sufficiently trained in mental health, resulting in an absence of confidence and knowledge to support their participants. This is further supported by Participant 11 who is a long-term coach, '…I suppose I just lacked confidence in myself that the information I was giving was, was correct and up-to-date'. The response from the coaches displays that there is a need for MHT within their job roles. They are regularly approached by participants who are experiencing mental health illness, however unfortunately they feel incompetent in the best way to support their participants with this. This corresponds with the identification of the evolved role of a coach, and the lack of educational opportunities. Reinforcing Jeanes *et al*. (2019) who contend there needs to be sufficient and appropriate education in place to be able to inform and help coaches manage arising situations. As shown above, the role of a coach has evolved, but the skill set to match this has not. Furthermore, this conclusion highly supports Ferguson *et al*. (2019), who identified that the majority of coaches within their study lacked the necessary knowledge regarding mental health to support their participants, leading to them feeling inadequate within their role. This notion of inadequacy was exclusively noted by one of the participants within this study. Participant 2 implies that if the coaches are unable to notice and support their participants who are experiencing mental ill health, then they are not fulfilling and succeeding as their role of a coach.

> 'You know if they are not equipped to spot (erm) spot mental health conditions within the young people that they are working with. Open up a conversation, know where to sign post then you know, we are not doing them a service'.

Furthermore, Sport England (2016b, p. 6) defines a coach's role as 'improving a person's experience of sport and physical activity by providing specialised support and guidance aligned to their individual needs and aspirations'. However, if a coach is unable to provide this support and guideline to individual participants, this again suggests that a coach is incapable of providing what is now expected of them. Taking all perspectives into consideration, there seems to be a want from the coaches to learn more about mental health in order to support their participants. However, due to their current lack of knowledge and educational opportunities, they are not able to provide this full support, therefore unable to achieve this 'holistic' role.

6.2 Delivery of Training

To increase the MHL within coaches, it is apparent that MHT should be widely instilled. However, MHT can come in different forms, durations and styles. The form and duration of training can vary, the three most standardised versions are known as: 'Mental Health Awareness', which is a three-hour course; 'Mental Health Champion'; a one-day course and 'Mental Health First aid, a two-day

course. However, within this study, the participants predominantly referred to either the awareness or first aid courses. Therefore, within this section, the discussion will only take into account these two forms of training. In addition, there is also the style of training which comes in two options: electronic or face-to-face. The form, duration and style of training all interlink and differ depending on each course, discussed below is the exploration of this.

Electronic training as identified by the participants is of more importance than ever. It is of substance to note that during the interviews, the United Kingdom experienced a nationwide lockdown due to the COVID-19 pandemic. Therefore, it was acknowledged that electronic training was more attainable compared to face-to-face. As demonstrated by Participant 9 'at this present moment in the world, the online version is far more attractive…'. Also indicated by Participant 17, '…your online courses are obviously hugely important in times like we are living in now…'. This highlights the accessibility of electronic training, and brought more emphasis upon it. Yet e-learning as suggested by Participant 11, was already growing in popularity before the pandemic '…the way that training is going, it seems to be (erm) a lot more online'. This supports Griffiths *et al*. (2006) and Lamph *et al*. (2018) who propose that the usage increase and development of the internet corresponding matches the increase of interventions being delivered online. Nevertheless, other participants identified the accessibility of electronic training without citing and acknowledging the lockdown. As Participant 16 who is a MHT instructor cited this most clearly,

> '…it can be delivered at a kind of time and place that suits the person (erm) rather committing to be somewhere at a certain amount of time which might not be practical for all people...'

Further suggested by Participant 16, '…I think the major benefits doing that would be kind of you take away all of the travel access barriers'. This identification of easy accessibility concurs with the studies by Griffiths *et al*. (2006) and Bond *et al*. (2016) who both identify e-learning to be a way to access training for those who are unable to attend face-to-face, whether this be due to issues such as mobility, time, cost and/or geography. To evaluate this, online training removes travel, which in turn also eliminates the cost of travel. For people or organisations with limited funds, this is a more encouraging way to partake within a form of MHT. As a result, Participant 10 infers that electronic training '…ticks an awful lot of boxes, for a lot of people…'.

A further reason as to why electronic training was seen as accessible is due to the individual basis to which it relies on. Participant 15 justified that electronic training might suit individuals who are disconcerted by group settings,

> '…I think they are really accessible; they are (erm) very good if you are, you know if you are concerned about, and I think it is quite (erm) can be quite stressful in the first place just to contemplating going into a group activity about mental health training.'

As suggested, the online training allows for individuals who are worried about attending face-to-face sessions to still complete the training, but within an environment which is comfortable for them. This environment has the potential to be more conducive towards learning since the learner is more relaxed and involved within the training. A similar notion comparable to Rickwood, Mazzer and Telford (2015) who understand that using online resources removes barriers which could stop an individual from seeking help. As noted, these include: anonymity, confidentiality and stigma for experiencing poor mental health (Rickwood, Mazzer and Telford, 2015).

Despite many positives being highlighted for the online training, some participants within the study argued that this individual basis to which the training takes place lacks personal interaction with others on the course. This missing personal touch was seen as an obstructive element to e-learning. Participant 19 argued, '…it is difficult to get that personal element and to kind of bring stories into it and narrative into it'. With a likeminded Participant 6, '(erm) I don't think you get the level of traction that you would face-to-face'. This was also furthered by Participant 18, '(erm) because if you are undertaking online training you can't ask questions of the expert'. The concept of not having an instructor there to ask questions if the learner was unsure may lead to confusion and further questions. Participant 2 advances this,

> '…I think some of the concepts to become a mental health first aider are quite complex, you know when you are looking at (erm) stigma and the mental health continuum and when you are looking at (erm) (erm) nuances in different mental health conditions. You know, when you are online completing an online module, you don't necessarily get that, and quite often you can read something and not understand it but still get through to the next module.'

Participant 2 reasons that even if the learner did not fully understand and comprehend all the information given throughout the course, they could still journey through the modules and complete it. This supports Griffiths *et al*. (2006) who insinuate that online learning has the potential to reinforce the problems that it is designed to help with. Furthermore, Davies, Beever and Glazebrook (2018) claim that although online training can contain interactive tasks, the participants within their study had difficulties in being able to rehearse their new skills on their own. To evaluate this, it may lead to further problems in the future for coaches, and has the potential to make an issue worse. As live interactions are a vital part of their role, being unable to rehearse and practice these newly learnt skills could have adverse effects, arguing that online training does not satisfy the learner with the confidence and skills to be able to apply this in a real-life situation. However, almost contradictory Davies, Beever and Glazebrook (2018) further examine within their study to have found online training to be mostly positive, and their participants reported that it helped to clarify previous misconceptions which they had.

Considering the above statement, and other remarks made by the participants, it is suggested that electronic training should not be implemented for anything more than the awareness training. Participants 17 and 6 convey this,

> ‘I think any longer than half a day, and especially for the two-day course because it is so emotive, it is using a lot of social intelligence and educating people around how to be very (erm) empathetic to people’s, to people’s emotions, that has to be in my opinion delivered face-to-face.’ (17)

> ‘I think for that intensity of content you have got to be there face-to-face; you have got to be able to work with other learners.’ (6)

The participants detail that for the intensity of the first aid course, a face-to-face environment is more beneficial and it is understood that working with others is a key part to this. In support, Gayed *et al*. (2019) suggest a challenge to online learning is the attention rate of the programme, and adherence to the learning. Implying that e-learning can reduce retention in comparison to face-to-face, and therefore has the potential for a less involved learner. Which ultimately would result in a decreased amount of information learnt. Therefore, it is important to create that environment where the learners can interact with others to ensure active involvement with the training.

Most face-to-face courses are delivered in a classroom-based environment, with an instructor leading the activities. Both the awareness and first aid courses can be delivered in a face-to-face environment. One of the most influential parts of the face-to-face delivery as argued by the study’s participants was the social interaction between those who partake in the course, the sharing of knowledge and experience. Participant 14, a mental health first aid instructor expressed their opinion of the importance of social interaction within the given environment. ‘… gives people a greater opportunity to also share some of their own experiences and concerns’. Further, Participants 12 and 3 share a similar perspective,

> ‘Hearing people’s experiences, people sharing their experiences, and actually seeing people be open and honest about mental health is part of the value of the training for me.’ (12)

> ‘The whole wealth experience that they bring to the table, as well as being to learn new stuff from a facilitator. That sharing of expertise across the board is like for a lot of people that is how they tend to learn best I think. It sparks an idea and a conversation…’ (3)

Many of the participants within the study passed comment on the notion of learning together, this highlights the significance to which a collective learning environment can make. This study gathered perspectives from mental health instructors, who all deliver face-to-face training. When exploring the topic of face-to-face learning at the first aid two-day courses, the participants described how they could see a difference in the learners from the beginning to completion of the course, with two

instructors describing how learners can experience ‘penny drop moments’. Participant 17 expands on this,

> ‘So they come away on the Tuesday afternoon, I suppose after learning a lot and realising the importance of the course, potentially enlightened, potentially changed, potentially actually going out there to try and make a difference. So yeah there is some people who we see huge changes in, and they are the ones who are reluctant to start with.’

This change in attitude was also noted by Participant 16, ‘…there always tend to be quite a (erm) big improvement from the moment they walk in, to the moment they leave’. This attitude change was further identified by Maindonald *et al*. (2020) who discovered their participants where employing new ways of working, due to their changed perspective. As their participants explained, the training had increased their understanding, therefore allowing for better communication and listening. This attitude change signifies how valuable the course is, coaches are able to adopt and implement better practice, which will benefit the sport participants within.

While face-to-face training has its advantages, it was noted that they are not always manageable for people to attend. In contrast to the accessibility of electronic training, face-to-face was described as being hard to reach and not always achievable when people have other priorities like childcare, full-time careers or working multiple jobs. As justified by Participants 10 and 3,

> ‘Yeah it is so much about practicalities isn’t it, because you know it can be difficult for people to get across to the other side of a city, or you know 20 miles up the road. Or pay for extra childcare on an evening, and it’s just not that easy once you have done a day at work and stuff.’ (10)

> ‘…for a lot of people in our sector and even say the wider community sport sector, they work sessional hours. They are part time, they are juggling lots of different jobs and they are not, they don’t really, will they get paid to take two days off work somewhere else and come on two days training, regardless of how important and meaningful it is?’ (3)

The lack of immediate accessibility, involvement of travelling and forward planning appears to be a large obstacle from the perspectives of the participants. This suggests that even if people are interested, they are discouraged by other factors which they will need to change in order to attend this course. This identification of being unable to reassign their time to a face-to-face course was also acknowledged by Lamph *et al*. (2018). For example, both Participants 13 and 14 are volunteer coaches, therefore their full-time careers will inevitably have an impact on their ability to be able to attend such sessions. Instead both Bond *et al*. (2016) and Lamph *et al*. (2018) identified this as a potential route to introduce e-learning.

When discussing the two styles of training, as shown, both have advantages and disadvantages. Although, the majority of the participants acknowledged that they preferred face-to-face training in comparison to electronic. Similarly, with Maindonald *et al*. (2020) whose study concluded face-to-face was the favoured form of training. Participant 12 claims 'I have always been a big believer in face-to-face training.', additionally Participant 17 had a comparable viewpoint. Similarly, Participants 14 and 11 favoured the interactive style of training,

> '(erm) I think the face-to-face is far more valuable, (erm) largely because you can, you can make a judgement in the room over people's levels of interaction...' (14)

> 'But I don't think you can beat that face-to-face experience; you know like we discussed people sharing their real-life stories and that is what kind of hit home to me.' (11)

Similarly, Maindonald *et al*. (2020) uncovered that all their participants understood face-to-face training to be challenging but valuable. Likewise to this study, Griffiths *et al*. (2006) and Lamph *et al*. (2018) stress that e-learning should not replace face-to-face learning, but instead be used as a form of refresher as discussed later in this section. In addition to this, Participant 19 views face-to-face to be the better form of training for the physical activity and sport sector, '…I see it more beneficial in our setting to actually have it face-to-face'. This was also identified by Participant 9 who understood this style of training to be more beneficial to coaches and those working within the sector due to the interpersonal nature of the job roles. '…I think it depends on your audience, certainly I think sport coaches (er) are a practical bunch'. They further explain,

> 'They're used to working interactively, having conversations, being quite physical in terms of, and practical in their approach to their work.'

This signifies that due to the interactive and collaborative nature of coaches and grassroot community roles, they may learn better within an environment which recreates this. They are custom to settings which contains lots of communication and activity, and as discussed face-to-face training exploits communication between its learners. Therefore, there is the potential for coaches and others community roles to engage better within this form of coaching, and gain a deeper learning. In support, Gayed *et al.* (2019) suggest that if learners do not regularly utilise online technology as a part of their work, then face-to-face training would be a better fit of implementation. However, this study's preference of face-to-face training disagrees with the study conducted by Hurley *et al*. (2017). They concluded that their participants considered e-learning to be the most suitable form of MHT, signifying that online training allows for accessibility and convenience. This study however, looked at the parents of sport participants, therefore did not consider the favoured form of training for coaches. As it is understood, coaches are regularly face-to-face with their participants as part of their job. Whereas parents of sport participants have a large variety of job roles, and potentially utilising online technology on a day to day basis. Therefore, through their perspective, online training is favoured because of their regular contact with it and do not consider how a coach's role is mainly

face-to-face. Although providing a counterargument for a preferred overall form of training, it does not provide an equivalent argument.

Both styles were identified to have a place within MHT, although face-to-face was deemed to be the preferred method. Nevertheless, face-to-face training was also noted to be the most expensive style of training, and as a result organisations and individuals are potentially deterred away from it. A finding in line with Gayed *et al*. (2019) who state that because of the cost of face-to-face training, it has the potential to not be a viable option for many organisations. Participant 20, a stakeholder within a NGB denotes, 'I think the challenge with face-to-face delivery is that it is expensive.' This was also further suggested by Participant 15,

> 'And I think (erm) unless it is funded, (erm) you know then the bias nature of the physical face-to-face training is going to occur greater cost… I mean to set up the online there is lots of cost involved in getting that set up in the first place, but then the actual unit delivery of it is pretty cheap.' (15)

In agreement, Participant 8 implies that although they prefer face-to-face training, they would rather people complete the awareness as it is cheaper, instead of being put off by the expense of face-to-face. '…it's much cheaper, I would rather people got online learning (erm) than nothing, but I certainly prefer face-to-face'. This infers that should face-to-face training be affordable for all, that would be the chosen style. Although since it is not, electronic training is the next best thing, rather than completing no MHT at all. A similar conclusion is made by Lamph *et al*. (2018) who work from the viewpoint that contact with some form of training is better than no training. Furthermore, supporting Gayed *et al*. (2019) who understand that due to the expense of face-to-face training, it has led organisations and individuals to employ online training as an alternative. Through analysis, the preference of training alongside Participants 15 and 8 both noting how electronic training is 'cheap' in comparison, leads to insinuate that the quality of online training is not as good or effective as its face-to-face counterpart. A notion supported by Gayed *et al*. (2019) whose study found a greater change in the participants who completed face-to-face training in comparison to online. This creates a conclusion which is unbalanced, although face-to-face training is better quality, it is too expensive for many to employ.

Participants introduced the idea of the first initial training being face-to-face, and continuing the learning with future refresher electronic sessions. Over half of the participants identified the importance of partaking within refreshers, further examined was how online refreshers were viewed as the preferred way of employing them. In agreement with Lamph *et al*. (2018) who indicate how e-learning can be provided as an alternative refresher to compliment face-to-face. As Participant 18 and 11 express,

> '…I think that initial exposure should be face-to-face. And then I think you could, the follow up stuff there could, that could be online.' (18)

> ‘(erm) So I think I prefer face-to-face training, (erm) but then as a coach I feel a commitment to keep my kind of skills, knowledge up-to-date by doing a bit of an online refresher every now and again.’ (11)

Refreshers were viewed as a significant part of the MHT, providing an opportunity to recall and add to existing knowledge. In agreement with Scantlebury *et al*. (2018) who suggests refreshers courses could be utilised to keep skills and knowledge updated. To the extent of my knowledge, there are no refreshers currently in place to aid the development of MHT. As suggested, this would be an extremely beneficial avenue to explore once MHT is more established within society.

6.3 Impact

While it is important to recognise that MHT can be flexible in its approach, the main element is the impact that it has upon the learners. Throughout the interviews, several aspects of impact were identified by the participants. One of the leading impacts was increased confidence, as many participants stated this is something which would be gained from the training. The consistent result is identified within many research studies tailored towards sporting environments, inclusive of Bapat, Jorm and Lawrence (2009), Pierce *et al*. (2010) and Breslin *et al*. (2017) who all reported a growth in a coach’s confidence in providing support for individuals who are experiencing poor mental health. This study agreed with these findings, as the main focus of this increased confidence was the improved ability to initiate a conversation and support their sport participants surrounding mental health. Many participants identified this, Participant 18 hoped that the training would benefit the coach’s self-confidence as indicated, ‘…just make them feel a bit more comfortable that they can have that conversation’. Further, Participant 5 expressed,

> ‘So all of the training I guess has the common theme of helping coaches feel more comfortable, and have better conversations about mental health when they feel like they need to.’

A shared remark from the study’s participants understood that MHT is not to make the learners all round experts on mental health, but simply to start a conversation and support those who may be experiencing a difficult time. If and when needed, understand how and where to signpost them to professional services. As both Participant 3 and 10 identified,

> ‘… confidence that they know they don’t need to be an expert in this, they so just need to be able to initially have a conversation.’ (3)

> ‘It’s not about diagnosis or anything like that, or making a judgement and guessing what may be a condition that they might be (um) experiencing. But it is about checking in and asking, just feeling confident enough to go ‘are you okay, you don’t seem your usual self?’ or something.’ (10)

This identification is in agreement with Mazzer and Rickwood (2015a), who discuss the importance that a coach recognises their limits and capabilities in terms of their sport participant's mental health. When speaking with participants who are coaches or leaders, all of them identified a noticeable shift in their confidence after they had received the training. When asked about how the training impacted them, Participant 21 observed 'so it gives me more confidence to speak to someone…'. Furthermore Participant 11 commented '…through the training I feel like I have got that confidence in my knowledge to be able to give some good support'. This connection between confidence and knowledge can be explained through a knock-on effect, once knowledge is improved, their confidence of how to deal with disclosures is likely to increase. As explained by Participant 2,

> '…I think it gives the coaches and volunteers confidence, it gives them information so when they are talking it comes from an informed place.'

As inferred, an additional identified impact was the growth in knowledge, although this could be argued to be a given and assumed effect as that is the purpose of receiving the training. In concurrence with Sebbens *et al*. (2016) who understand that the training is effective in aiding MHL. Furthermore, Dimoff, Kelloway and Burnstein (2016) suggest that regardless of the training duration, MHL increases. An increase in knowledge was remarked by most of the participants, with particular focus upon how coaches can now actively look for signs and suggestions that their participants might be experiencing a mental health illness. This allows for coaches to become more 'holistic', which as highlighted above is now an encouraged and expected part of their role. Several participants cited this notion, Participant 11 expresses it from a coach's point of view,

> '…if it wasn't a young person making a disclosure to me, I was more actively looking out for things (erm) to be able to, to be able to offer that support quite quickly, and not actually have to wait for them to come to me (erm) with a problem.'

Through the training, the coaches can detect and recognise signs which indicate towards their participants experiencing poor mental ill health. Subsequently, through their increased knowledge and therefore, improved confidence it allows a coach to initiate a conversation with an individual. It was suggested that when partaking in the training, it was important that the learners identified and related with the information about mental health. This was deemed as a result of the training, that the learners understood their own mental health, and in turn it helped them to help others. As suggested by Participants 5 and 2,

> 'So the coaches will come in with their professional head on, and go I'm here for my young people and I want to be able to work with my young people better. And I think a lot of them take away stuff personally that maybe they weren't expecting to.' (5)

> 'But in that room, just because they were going through the training and how to work with young people (erm), they were opening up about themselves as well.' (2)

It is of note to recognise that not only will the training benefit the sport participants, but the coaches themselves. Similarly, this recognition within the learners themselves was also acknowledged in Kitchener and Jorm (2004), who stated that the mental health of the learners was improved as a result of the training, an unexpected find. Participant 12 extends this, appreciating the training to be 'two-fold',

> 'So it is always like to twofold you know. How does this affect me (erm) and how can I use it understand me better? And then how can I use it to understand perhaps what others might be going through or understand others better.'

Through the information resonating with the participants, it enables them to have a more informed perspective of what mental health is, and therefore how to best support their participants. Instructors of the MHT, as discussed earlier recognised a change in attitude upon completion of training, and this may be a contributing reason for it. This is in agreement with both MacDonald, Cosquer and Flockton (2008) and Davies, Beever and Glazebrook (2018). Davies, Beever and Glazebrook (2018) credit the training because it allows for the learners to apply the course content to themselves, helping to understand their own mental health.

Explored within several interviews was the sustainability of the training, and whether completing the training would be worthwhile for those who work in community roles. Participant 17 notes that it is the effect that the training has on the individual that makes it sustainable.

> 'There is sustainability I think above anything, probably the impact it has upon the individual them self. I think we are definitely seeing these changes in people's personalities in the way that they are talking about certain stuff.'

When asked whether they believe the training to be sustainable, Participant 2 argued that it is. They considered that through the knowledge and understanding gained, the way that a coach thinks, speaks and approaches mental health will be different.

> '… I think once you are doing it, and you change your dialogue around mental health and your thought process around mental health you (erm), you are far more aware and you pick up on things.'

As suggested, through this change in outlook, the coach will be regularly looking out for signs of individuals experiencing poor mental health. Therefore because of this repetition, it will keep the coach's knowledge of their training on the forefront of their coaching practice. This identification of sustainability was also discussed within several other studies, which were investigated from six months to two years post training (Jorm *et al*., 2010; Kelly *et al*., 2011; Svensson and Hansson, 2014). They all recognised that the impact of the training was prominent within the learners, and being applied within practice. However, Participant 18 claims '…I think again it is like safeguarding if you don't use it you lose it'. Implying that if a coach does not regularly utilise their training, then the

knowledge that they have gained will be lost. This argument disagrees with the other participants and studies, deeming the sustainability of the training to be short lived. This argument supports the notion of implementing refresher training for the coaches, since it cannot be guaranteed that coaches will utilise their training frequently. Nevertheless, as MHT is only a certified form of training, rather than accredited like physical first aid and safeguarding, it is not compulsory that MHT must be completed every three years to maintain the qualification. Therefore, if you apply Participant 18's argument, then a coach may carry the certification of being mentally health awareness trained, however does not have sustained and furthermore, updated knowledge about mental health.

Chapter Seven: Findings

Future Direction for Mental Health Training

This section investigates MHT alongside physical first aid and safeguarding, understanding where it lies in comparison. Furthermore, this section examines whether the training belongs in coaching qualifications, and the perceptions of whether it should be made a mandatory requirement for coaches to complete. While taking the above themes into account, this section additionally explores the expense of implementing the training. Regarding the themes within this section, there is a lack of academic literature and research available. This suggests that the data discussed below are newly researched topics, and therefore can be considered as the starting blocks for future research and evidence.

7.1 Mental Health Training, Physical First Aid and Safeguarding

To be able to explore this section further, it is of significance to understand where MHT currently lies within the sphere of training for coaches, and other community roles. The participants within this study perceived MHT to be within the same domain as physical first aid and safeguarding, both of which are mandatory training qualifications for coaches. Although viewed to be similar, MHT is not at the same level as the other two. As displayed by Participant 14 and 2,

> '…Sport B club that I am a part of, they insist that all the coaches go on the safeguarding for children course, they insist on them all going on the first aid course, they would like them all to do the coaching badges. And to me at the moment no one has mentioned anything about adding mental health first aid or awareness to that, I believe they should.' (14)

> '… you know if we look at physical first aid you know how many physical first aiders there are in the country and then we look at mental health first aid, we know how many mental health first aiders there are, I think it highlights the difference.' (2)

To evaluate this, MHT is a more recent occurrence in comparison to physical first aid and safeguarding, as safeguarding was first introduced into the physical activity and sport sector in 2001 (Sport and Dev, 2020). Therefore, it is more likely to be perceived as behind in contrast to the others. However, it was noted that several participants believe it should be treated as an equal, and brought up the same importance as physical first aid and safeguarding. Participants 15 and 17 voiced their opinions,

> 'I think that sort of core set of three (erm), if we are going to say physical first aid and safeguarding are basic requirements then mental health first aid or mental health awareness training should be in there as well, yeah.' (15)

> ‘(erm) I would see it as important as safeguarding and as important as your physical first aid. I don’t know why you wouldn’t, (erm) they have got to be, they have got to be the same.’ (17)

As indicated, the above participants felt strongly about making MHT a counterpart of physical first aid and safeguarding, advocating for it to be accepted and included within the same domain. As examined, coaches feel inadequate in their role as a coach due to their lack of MHL, resulting in an inability to fully support the needs of their sports participants. Therefore, it could be argued that MHT needs to be aligned with physical first aid and safeguarding to ensure that a coach is capable to provide all forms of care which is now expected as part of their holistic role. However, it was suggested that MHT could merge into either of the two mandatory trainings rather than be an individual one. As suggested by Participants 4 and 14 below, MHT belonged with physical first aid.

> ‘Well I think in many ways that’s the way society and well-being kind of is going, they are closely linked. Your physical, so I know physical first aid is slightly different from physical well-being but why not put it together. Why, why are you separating the two out completely?’ (4)

> ‘I think it should be there, (erm) and it is not at this moment in time. (erm) I think it sits nicely with you know physical first aid training, the two could become merged in terms of first aid and using physical and mental.’ (14)

This connection made by the participants between mental and physical first aid can be explained by Kitchener and Jorm (2008). They understand that individuals can easily relate and apply the concept of first aid due to the familiarity they already have with physical first aid. Therefore, it highlights the understanding that mental health problems should be responded to in a similar way, also emphasising the initial role that individuals can play (Kitchener and Jorm, 2008). Nevertheless, some participants perceived MHT to suit more with safeguarding. Participant 12 claims, ‘I think it’s hard isn’t it because it kind of does come under so many overlaps with safeguarding’. Moreover, Participant 7 also viewed MHT to coincide with safeguarding,

> ‘By having coaches required to go on three different things which actually overlap quite a lot as well, I think it’s unfair on coaches and volunteers to do that. I would rather see it come under the banner of safeguarding a little bit more.’

The opinions of whether MHT sits alone, with physical first aid or safeguarding is mixed. From the perceptions of those interviewed, there is no current decisive conclusion as to where the training belongs, although it is viewed of the same significance. To evaluate this, much of the literature examines physical first aid, safeguarding and MHT as separate entities, with academic publications based predominantly on one or the other. Therefore, the possibility for them to be combined has not been thoroughly researched, and explored by those in the field. At this point in time, it would be

unfounded to claim that the training fits in with physical first aid or safeguarding. Therefore, until MHT is considered to be on the same level as the other two, it would be best for it to be completed as its own individual course.

7.2 Mental Health Training in Coaching Qualifications

Currently, to be a coach in the United Kingdom it is compulsory within many sports to have completed physical first aid, and safeguarding if working with children and young adults. At the time of writing and to the extent of my knowledge, within the coaching syllabus MHT is not a course expected to be completed to ensure the right to coach. During the interviews, the notion of employing MHT within coaching qualifications was explored. It was also indicated from the participants as far as they were aware, coaching qualifications do not require or request MHT be completed. After exploring numerous NGBs coaching qualification requirements, there was no evidence of any NGBs employing MHT within their coaching syllabus. Participant 11 and 18 supposed,

> '(erm) Obviously coaches have got to have their minimum operating standards, it is your kind of physical first aid, your safeguarding and kind of mental health wasn't really discussed.' (11)

> 'I am certainly aware that a lot of sports coaches when they do their level two training, they get no mental health training whatsoever.' (18)

As conferred, the notion of completing MHT as a part of coaching qualifications is absent. Participant 19 who organises coach's training specified,

> '…so there is certain modules (erm) around health and well-being and role of a coach, and supporting you know the young person in front of you. But it is not specifically that training, so that is not a requirement of the Programme Z yet.'

This shows that although MHT is not employed on its own terms, there is reference and information given to those who participate within that organisations training, this however may not be the same for the rest. Hence, it was examined as to whether MHT should be considered and implemented within coaching qualifications, a large amount of the participants within the study proposed that it should. Although there is a lack of literature based upon this notion, Schinke *et al*. (2018) and Bissett, Kroshus, and Hebard (2020) both recommend for to be employed as part of a coach's education. As Bissett, Kroshus, and Hebard (2020) imply existing coaching educational resources do not address or tackle all of the ways in which a coach can be effectively used to promote mental health. This indicates that there is significantly more for coaches to learn and implement within their coaching practices to benefit the mental health of their participants in the coaching environment.

Further investigated was if MHT was to be implemented as a requirement for coaches, at what level would this be introduced at. Numerous participants within this study articulated that they would like

MHT to be employed at all level one coaching qualifications. Participant 16 declared 'I think (erm) mental health awareness should be included on every qualification from a level one'. Similarly, Participant 21 who is an ex athlete, asserted that starting from level one allows a coach to have informed knowledge of mental health all the way through their coaching career, 'I think from the bottom because you know get it all the way through'. One specific argument which justifies why the participants encouraged training from the beginning is due to the mass amount of people who partake within level one training in comparison to the higher levels. Participant 14 went into depth regarding this,

> '…ultimately the best people to be trained are the ones that are going to come into contact with the most people and they are the lower, the lower part of the training triangle.'

Participant 14 views the amount of people with coaching qualifications as a triangle. The bottom of the triangle consists of individuals who have gained their level one coaching qualification. As the triangle progresses upwards, the higher the coaching qualifications become, however there is decreasing number of individuals qualified. Hence, their argument offers that more coaches are going to receive level one training, and therefore positively impact more people within their sessions. If higher qualifications were to receive the training, they potentially work with less people, therefore reducing the amount of people they can impact. Participant 11 also conferred with this idea, stating that a lot of individuals that they work with have only completed a level one qualification.

> '…I think right from the start because (erm) a lot of organisations we work with, people will only have a level one or a youth work qualification.'

However, as explored, some NGBs do not require physical first aid or safeguarding for level one coaching. As earlier argued by Breslin and McCay (2012), mental health is not viewed to be as important as physical health by the public. Therefore, it could be argued that before MHT is even considered to be a required condition for level one coaching, physical first aid and safeguarding must be implemented across the board at all NGBs.

An alternative reason as to why MHT should be implemented at level one is due to the probability that sport participants are more likely to approach an assistance coach in comparison to a head or lead coach. Some participants discussed this notion, Participant 2 puts it most clearly,

> '…quite often, you know, sometimes the assistant coach in (erm) sport is far more approachable than the coach… you know there is sometimes barriers to approaching a coach who has got authority, whereas the assistant coach has got authority but they are probably viewed differently.'

As displayed within a dynamic of two coaches, the assistant coach is more approachable for the sport participants to disclose information to. More often than not, the assistant coach is a level one

coach who is working alongside a more qualified lead coach. Therefore, their argument portrays the suggestion that it would be beneficial if a level one coach had training to manage arising situations. Additionally, from a coach's perspective, it is of significance to mention that all the grassroots coaches interviewed within this study believed that MHT should be implemented at the beginning of the coaching qualifications. However, Participant 18 who works as a stakeholder within a large sporting organisation contends that coaches should not complete a standardised MHT at level one, but rather at level two once the coach is aged 18 or over. They reason that because the minimum age to complete a level one coaching qualification is 16, some coaches are still young adults and therefore are not ready to manage such disclosures.

> 'That is a big responsibility to put on a child, and I think mental health, I am not saying I wouldn't but there would have to be a different workshop for children (erm) attending mental health training than you would for adults.'
>
> '… whereas to be a level two for most NGBs you have to be 18 because you are then a lead coach. So you are then delivering to adults all who are supporting other adults and children.'

The views of Participant 18 are noteworthy, and they are the only participant to have brought up an opposing argument against implementing a standardised MHT at level one. Participant 18 suggests that if the coach is under the age of 18, they could complete a different workshop in comparison to their aged 18 or over counterparts. They further state 'I am not suggesting that you don't include it even within that level one curriculum syllabus…'. This implies that Participant 18 does not agree with the majority of the study's participants, and if MHT was to be implemented within coaching qualifications at level one, it can either be part of the coaching syllabus or on a separate course more tailored to younger coaches.

While it could be argued that Participant 18 has a thorough justification, it does highlight the matter that if level one coaches within a certain age bracket are too young to deal with disclosures brought to them by their sport participants, are they too young to be coaching at all. Throughout this study it has become apparent that modern day coaching is more of a holistic role, and that a coach's responsibility is much more than technical and tactical advice. Therefore, it could be suggested that coaches who are too young to be able to provide this holistic role, are not fulling their job role and providing the correct service to their sport participants. Nevertheless, Kroshus *et al*. (2019) provides a counter argument against this, they discovered how a coach's age was significantly linked to supporting a participant with their mental health. As uncovered, Kroshus *et al*. (2019) claim that an older coach is less likely to offer help in comparison to younger coach counterpart. They understand that if coaching children and young adults, a younger coach finds it easier to develop a trusted relationship and build a rapport with the athletes, therefore having the potential to facilitate more disclosures. Furthermore, they suggest younger coaches also have the potential to have a larger

willingness to address issues concerning mental health with their sport participants (Kroshus *et al*., 2019).

Considering both perspectives, this study determines that MHT should be employed from level one coaching qualifications, with the awareness training being implemented due to the lower cost. However, as the coach moves up to level two or higher, and dependent on the age and ability of their sport participants, MHT can be tailored to the audience. Furthermore, allowing for MHFA to be introduced due to its more informative and intensive structure. For example, implement altered formats of MHFA for children and young adults, adults and/or disabled people. Therefore, depending on which category the coach teaches and at what qualification level they are, will depend on which MHT they complete.

7.3 Mental Health Training as a Mandatory Requirement

Throughout this chapter the relationship between mental health and various factors have been explored; exercise, physical first aid, safeguarding and coaching qualifications. As shown, mental health and MHT is intertwined between all of these different aspects within physical activity and sport. Therefore, it comes to the concluding enquiry of whether MHT should be mandated for coaches. Within this study, the majority of the research participants stated that the training should be compulsory, with Participant 19 claiming 'absolutely I think it should be compulsory…'. A concept further supported by Bissett, Kroshus, and Hebard (2020) who understand as interest within MHT grows, there is an opportunity at policy level to introduce MHT as a compulsory requirement for coaches. This is also noted as a consideration by Pierce *et al*. (2010) for a subject of future research. However, despite this recommendation, there seems to be a lack of research, and therefore literature examining and advancing this notion. In addition, Participant 11 understands that by making it compulsory, those who need the training will receive it.

> '… some of the people we need to get on the training (erm) are not attending. And by making that compulsory, actually the people who need it most will have to go on it.'

Participant 11 suggests that by mandating the training, it will target coaches who so far have not volunteered themselves forward, arguing that those who are reluctant to attend are in fact the ones who need to complete it. Kitchener and Jorm (2008) anticipated that MHT would likely be developed to be a prerequisite for individuals who work in occupations such as teaching and welfare work. However, at the time of writing 12 years after the release of that publication, it could be argued that the training is no further forward in the development of this. A reason for this may be due to MHT being much further forward and developed in Australia, the research location of both Kitchener and Jorm, as well as the birthplace of MHT. Whereas within the United Kingdom as discussed, MHT has only become a recent phenomenon over the last few years. Although there is growing literature and research based on it within the United Kingdom, the notion of MHT being implemented within educational practices is still in its infancy.

When discussing whether MHT should be compulsory, there were differing opinions on what form of training this would be; mental health awareness or MHFA. Some participants understood first aid to be the most beneficial form of training. Participant 13 debates that they favour first aid, although due to the complex role of a coach, and the amount of qualifications they already have to complete, they understand that the awareness training is more achievable.

> 'I think if you are a coach, you know you are being asked to do first aid training, you are asked to do safeguarding training (erm), you were asked to do lots of different top ups things for your qualification. I don't, I think it should be a minimum of three hours but ideally, I think the two days.' (13)

In agreement with Participants 9 and 2 who also stated their preference towards MHFA. However, Participant 2 implies they are doubtful that it would be implemented due to the expense that it involves,

> '…whether that is realistic or not, I don't know? Because it is a two-day qualification and there is an expense involved, and so I think practically, in an ideal world, absolutely, but I think if we were to look at baby steps to get there. Maybe it's like we just discussed you know, that every single coach and volunteer has mental health awareness.'

Participant 2, a MHT instructor understands the high expenditure that is required to run a MHFA training course, suggesting that the awareness course would be the best first step, since they are less expensive to carry out. However, as concluded face-to-face was the preference of MHT due to the interactive nature of the course, a similar environment to which coaches are familiar with. Therefore, if coaches are to provide '…specialised support and guidance…' as understood by Sport England (2016, p. 6), then face-to-face training must be made available for coaches to complete. Consequently, the cost of funding must be covered to be able to implement this for each individual coach, a notion examined further within this chapter.

Despite the above participants inferring that the first aid course would be the preferred compulsory form of training, more of the participants suggested that mental health awareness would be the most suitable form. Participant 20 argues '…I think face-to-face would be too much'. Moreover, Participant 12 claimed, 'I absolutely think the awareness, the three hour one should be, fundamental and compulsory'. Nevertheless, alongside the doubts of implementing first aid due to the expense, Participant 4 and 17 were also hesitant about the application of the awareness training.

> '… I would say yes, so in an ideal world yes it would be compulsory. (erm) However there is obviously money involved in that kind of thing.' (4)

> 'I think at the moment it is very very difficult to do, I think finances would play a role in there.' (17)

From evaluation, this implies that funding is not available for either forms of MHT. The awareness at cost price is cheaper than first aid, but still this is argued to be too much for individuals or organisations to afford. A reason for this may be due to the perceived view of MHT, and how it is currently not observed or implemented at the same level as physical first aid or safeguarding. Due to the current gap between the different trainings, MHT is not seen as a priority. Consequently, it lacks funding and therefore, is difficult to implement within coaching structures or for organisations to invoke this for their coaches and other community roles. Furthermore, although seeming expensive on the cover, if all coaches were to receive MHT as a mandatory requirement and as a result support their participants, this has the potential to reduce the numbers of individuals utilising professional services due to early recognition, and therefore reducing overall cost to the NHS. As Rothi and Leavey (2006), Mazzer and Rickwood (2013), Rickwood, Mazzer and Telford (2015) and Sebbens *et al*. (2016) all note, increased MHL through MHT provides the opportunity for early intervention. This suggests that through the ability to recognise and facilitate conversations with sport participants, coaches are able to spot early signs of poor mental health and consider immediate action. Consequently having the potential to prevent the participants from developing a serious mental health problem (Rothi and Leavey, 2006), and therefore preventing them having to receive long-term professional help at a cost to the government.

Although the majority of participants within this study championed for MHT to be compulsory, some argued against this notion. For the remaining participants who did not agree with mandating the training as compulsory, they argued that it would make MHT be perceived as a 'tick box' exercise. Participant 7 who is a stakeholder in a sporting organisation, understood that if you make the training compulsory, it becomes concerned and centred around numbers rather than impact. They state, 'I think sometimes we can put too much on getting people trained rather than creating the right environments'. They further suggest that if you focus upon the number of individuals trained, then the training become just another course for the coaches, and reduces the impact.

> 'It is a tick box exercise because they have done all of these training courses and the environment is exactly the same.'

This suggests that if the training was to become compulsory, it would automatically lose the volunteer aspect to it, subsequently having the potential to decrease the importance placed on the training and the quality of environment that the coach could produce. Pierce *et al*. (2010) understand that voluntary participation within the training results in beneficial learning, however they were unsure whether obligatory training would have the effect. Comparably, Paton (2020) identified a participant within their study who was apprehensive that MHT would just be considered as a tick box exercise for organisations who implement a mental health trained individual. Participant 12 expands on this, discussing the reluctance that some organisations who design and administer MHT have about making it mandatory.

> '…they want it to still be something that people choose to do, and at the minute you know people are really receptive because of that…. I don't know whether a part of that is because at the minute it is not a mandatory (erm) requirement.'

Participant 12 understands that individuals volunteer to sign up to the courses because they want to expand their knowledge, and because of this they are more receptive to learn. In support of Bapat, Jorm and Lawrence (2009) who discovered that self-selection on a MHT course is due the learner having reduced negative associations and perceptions towards mental health. On the other hand, if their choice was taken away, and the training becomes compulsory, individuals are perhaps less inclined to learn. Consequently, it would then be seen as a routine and required training, and therefore the impact that it has might not resonate as well with the individuals. This argument considers the volunteer element to be significant, acknowledging that individuals are more likely to understand and take more away from the course compared to if it were mandated. Furthermore, it is significant to note that all of the above participants who reason against making MHT compulsory have all completed some form of the training. Therefore, they understand and have experienced the impact that the training can have upon the individuals who partake. This is noteworthy because although of the understanding that they have gained, they do not agree with the notion of making it compulsory, and would rather individuals benefit through their own initiative.

7.4 Expense of the Training

As previously discussed, the expense of MHT can be a contributing factor as to why it may not be commonly employed within the physical activity and sport sector. The participants within this study observed the cost of the training as one of the main disadvantages, shadowing the benefit and in some cases outweighing it. Participant 14 depicts, 'the wanting to do it is there but the money and time availability is what is holding most people back'. Likewise, Participant 8 suggests '…those that can afford it are definitely doing it, so the only thing stopping maybe the others is maybe cost'. The cost of the training appears to be an ongoing issue for individuals or organisations who do not have the available funding to be able to partake or employ it. Highlighting that many organisations and individuals simply cannot afford to be put through the training, subsequently causing a lack of trained coaches.

Participant 4, a stakeholder within a sporting organisation which works predominantly with lower socio-economic areas identified the expense as a barrier for participation, in addition to the other barriers previously discussed, '…again it's the cost of doing it, putting an extra barrier up to someone getting involved'. As reviewed, individuals who have low socio-economic status are at an increased risk of developing and experiencing mental health illnesses (Mental Health Foundation, 2016). Additionally, it is also this group which are the most likely to be inactive within the United Kingdom (Sport England, 2020). This suggests that although they are the most probable to be inactive and develop a mental health illness, MHT training is unlikely to be completed within these areas because

the cost is too high for it be employed. Furthermore, it is indicated that low socio-economic individuals are the most likely in comparison to higher socio-economic groups to turn to a coach or grassroots community leader to disclose information regarding their mental health (Mansfield, 2019). However, if these coaches are unable to support their participants due to their low MHL as a result of lacking MHT, it could lead to the progression of the sport participants developing a serious mental health illness. As Mansfield (2019) comments, coaches play a fundamental role to enhancing the well-being of their participants within low socio-economic areas, and even more so when they complete MHT. This study agrees, however, as reiterated MHT is not being executed due to the lack of investment, therefore there is not enough funding to cover the cost.

The training was regulated promoted by the participants, however as shown above by Participant 8 and also by Participant 17 they refer to the training to be completed by 'those that can afford it' or 'anyone who can afford it'. This implies that due to the cost, only selected and limited individuals are able to attend the course. This restricted accessibility due to the expense, has a knock-on effect in reducing the amount of coaches who can receive the training. Which in turn, results in low levels of trained and well-informed individuals within the sector. Participant 14, who delivers MHT has first-hand experience of people questioning the cost before enquiring about the benefits, '…the first question they ask is 'oh how much is it going to cost? Because we haven't got any money'. This demonstrates how important the cost is to individuals and organisations, and that although there are valuable impacts, the first thought is the price. Participant 14's comment also leads to suggest there is a lack of funds available to be able to implement the training. Despite this, Participant 13 indicates that there is sufficient funding aimed towards mental health,

> 'I think mental health is, is on everybody's agenda at the minute or it seems to be. (erm) Even if that is just because a lot of the funding that is out there is geared towards it.'

When discussing the training in the sphere of the sector, Participant 13 considers there to be a considerable amount of available funding concerning mental health, and highlights the significance that it has within today's society. This is shown in the publication 'Sporting Future: second annual report' released by the DDCMS (2018), Sport England has already invested over nine million pounds into physical activity and sport projects which focus upon mental health outcomes. As this may be the case, this study demonstrates that there is not enough funding being funnelled towards the training of coaches and other community roles. That currently, the government is focusing upon outcomes in relation to mental health instead of aiding interventions and support systems such as MHT. Therefore, it could be argued that the money and effort going into mental health within the sector is counteracted by the lack of trained coaches. That even though the sector is now tailored towards the social benefits it can provide, the lack of completed training hinders this development and impedes the whole movement.

A repeated suggested reason as to why MHT is not implemented commonly within the sector, is due to the lack of funding within NGBs. Participant 7 proposed that the cost of the training is not covered by the NGBs because they do not have the available capital to spend on it.

> 'So if it is about the two day course, and if that is the preferred option of training than that is a good few hundred pound per person. So governing bodies are going to turn around and say well we haven't got that money.'

This reinforces the expense of the training and because of this NGBs are not able to implement the training widely. This could be a defensible argument as to why MHT is not employed within coaching qualifications, and even more reason to argue against making it compulsory. Although when speaking with the participants who work within NGBs, they explained that if the money was available, they would invest within MHT much more. Participant 20, throughout the interview described how they would like to engage their coaches with the training although at current, there was no available funding to cover the cost, '…yeah if we had the funding and if we could deliver it then we would go for it'. However, they further go on to clarify,

> '…there is always that will to do the right thing but there is sometimes not the budget or the sign off at the highest levels.'

This suggests that it is not for an absence of attention placed on the training, but rather the inability to be able to fully financially support and roll it out. The reality of the NGBs as described by Participant 20 is '…almost entirely reliant on government funding'. Therefore, despite their joined up want with the rest of the sector, they can only do as much as their budget allows. Despite the DDCMS (2015) announcing their change in remit to award funding to NGBs to make sport a 'meaning and measurable impact on improving people's lives'. Moreover, with Sport England (2016) publishing a 'clear line of investment' towards the five outcomes, inclusive of mental health, in addition to their 9.89-million-pound investment in mental health projects. This study suggests that five years later, there is an absence of this within grassroots MHT.

Participant 13, also an employee of an NGB understands that unless their budget specifically states that they must engage with MHT, then it is unlikely that it will happen.

> 'So (erm) you know unless we specifically go get a pot of funding to increase mental resilience for example then it is not something that we are going to necessarily (erm) measure at the minute.'

This suggests that for NGBs to really immerse themselves with implementing the training, their budget must have a detailed specific amount set-aside to be able to do this. This also implies that if they do not have specific targets surrounding MHT, then it would be difficult to sway part of the budget to be able to accommodate for this. MHT is only a small segment of what NGBs have to fund,

and as described by Participant 13, if it is not designated as a target then they are unlikely to pay much attention to it.

This study was only able to collect data from a small sample of NGBs, therefore it would be unjust to state that this is the given picture across all of them. Although, this study hints towards the big role that funding plays within NGBs for the future of MHT. At the time of writing, it seems apparent that they lack funding even though they wish to progress. This wish to progress was in fact evident within the participants who work across the different levels within the sector: coaches, sport charities, sport organisations and NGBs. Therefore, this leaves to conclude that there is a major push, want and need for the training. Which in turn leads to ask why is there such a limited amount of funding, and therefore training being conducted.

Chapter Eight

Grounded Theory

This chapter brings together and concludes the preceding chapters by presenting and examining the constructed GT. This theory has been developed throughout the study, and is specific to the data collected by the researcher. Below is the detailed GT, purposefully left until the last chapter so the reader is able to apply and understand the theory to their newly learnt knowledge and evaluations considered throughout this study.

More than ever, the topic and discussion of mental health is becoming increasingly more prevalent within society. This is shown within the physical activity and sport sector by the attention placed on mental health by the government (DDCMS, 2015; Sport England, 2016a). However, despite this there is a lack of informed and well-educated individuals regarding mental health within vital grassroot positions. It is an interesting notion that as mental health disclosures to coaches increase in frequency, the level of coaches trained in mental health does not correspond. This was shown with the requests for training from the grassroots workforce, stating that they did not know how to correctly manage their sport participants when they approached them regarding a disclosure. This determines that there is a need for MHT to aid knowledge and confidence within coaches, who can then subsequently support their sport participants.

As demonstrated the cost of the training can be the judgement call as to whether individuals and organisations partake within it. Due to this, it is not consistently implemented throughout the sector. Therefore, this study theorises that funding is the underlying factor which influences the implementation of MHT. Although not part of the interview guide at the beginning, participants within this study repeatedly referred back to funding, demonstrating the impact that it has. Due to theoretical sampling being employed, funding was identified as a common factor through the continual analysis. Therefore, once identified and developed into a working hypothesis, funding was further explored as a contributing factor to MHT. It became apparent within the study that the lack of funding available for MHT was a large obstacle for its implementation. Although all levels within the sector are calling out for MHT, the funding is simply not there to match it. Funding which comes from the higher echelons of the physical activity and sport sector highly influence how the rest of the sector prioritises their targets. In this case, sport organisations felt restricted within their budgets, and therefore do not prioritise the training amongst their other targets. Which in turn, reduces the amount of completed training, lessening the quantity of better informed and equipped coaches. Unless a large amount of funding is directed towards MHT, the cost will remain too high for individuals and organisations. Therefore, if nothing changes, it will continue to be the one big factor that is stopping the sector from progressing forward.

If the higher branches of the sector concentrated some funding into MHT, the knock-on effect would be far reaching. The dual relationship between cost and funding would be a positive one. Currently,

the cost of the training is perceived to be too much due to the lack of subsidy directed into funding the training. However, if there was an increase in the funding channel, and sufficient backing was available, then the expense of the training would not carry as much weight as it does now. Therefore, the cost would not have the current swaying influence of whether individuals or organisations implement the training. Consequently, this would result in more completed training within the sector. This would allow for an increase in equipped coaches, who feel comfortable and knowledgeable within their holistic role as someone who could support their sport participants.

As displayed throughout the study, MHT was highly regarded by the participants. Especially noticeable through the majority of the participants who wanted the training to become a standardised element of the coaching qualifications, and further making it mandatory for coaches to complete. Again, being able to implement this within both aspects, an increase in funds would be necessary. Although the cost to complete mandatory forms of training is mainly paid by the coach themselves, the cost price of the training would have to be covered, subsidised, or reduced for all coaches to be able to afford this. Understandably, this is a big ask and would happen at a large cost and/or redirection of existing funds within the sector. Nevertheless, it is argued within this study that there are beneficial impacts of the training. Therefore, it is suggested that this redirection of funding would be worthwhile for those involved.

Chapter Nine

Conclusion

This aim of this study was to investigate MHT within grassroot community roles. A GT approach was adopted to allow and develop a theory to emerge from the data. This methodology allowed for simultaneous interaction between data collection and analysis. As outlined above, this resulted in a GT which concluded that funding was the underlying factor which influences the implementation of MHT.

Within this study, the strong connection between physical and mental health was identified. Further displayed by the participants was the recognition of the beneficial impact that physical activity and sport can have on their own mental health, a finding supported by Sport England (2019a). However, it was noted that despite this relationship between the two, they were viewed as unbalanced, a conclusion in line with Breslin and McKay (2012). It was expressed by some participants that they wanted this to change, and have parity between the two. The physical activity and sport sector is increasingly utilised as an environment which can achieve multiple social outcomes, as introduced by the DDCMS (2015) in Sporting Future. Understood by many of the study's participants, this included the social cohesion to which various sport settings can induce. The environment allows for a natural development of a social community, and through the connections made, an opportunity for mental health support, similarly concluded by Hurley *et al*. (2017). Furthermore, the evolvement of a coach's role appeared to also be a contributing factor to support mental health within sport participants. Progression from technical and tactical advice encouraged a holistic role, incorporating many responsibilities under the umbrella of a coach. This all encompassed role emphasised the trusted relationship that the coaches can have with their sport participants, allowing for a developed rapport. Cited by several participants and in agreement with Vella, Gardner and Liddle (2016) was how this trusted relationship was unique due to a coach not being part of family, peers or school.

As examined, there is an increasing attention placed on MHT, with a specific focus of the beneficial impact that the participants believed it can make within the physical activity and sport sector. However, it was noted that there is a lack of available and/or completed MHT within the sector, suggested by the frequent requests for MHT from the grassroots workforce. This could be explained by the GT, the lack of available funding directed towards the training significantly reduces the likelihood of coaches having completed a form of MHT. Although, it is argued to be of great importance, the requests as explained by coaches within this study is due to them witnessing individuals within their sessions regularly experiencing poor mental health. Due to the lack of training, the coaches have insufficient knowledge and confidence to assist and support their participants, therefore it could be argued that they not fulfil their role as a coach. This outcome is in line with a similar conclusion suggested by Ferguson *et al*. (2019).

The delivery of MHT focuses on two forms; online and face-to-face. It was argued that online training had a strong emphasis placed upon it due to its accessibility in the current COVID-19 circumstances. The two forms of training were both identified to have pros and cons which worked in conjunction with one another. As discovered, the online training lacked personal touch, whereas it was identified that the face-to-face training utilised this personal interaction to aid learning. The study concluded that the preference of training was face-to-face, however this was noted to be the most expensive form of training, and therefore potentially unrealistic for many to complete. To apply an aspect of the GT, if the funding streams were redirected towards MHT and therefore an increase in investment was made. This form of training would not be unrealistic, and instead achievable for many to complete.

The impact of the training as displayed by many of the participants showed an increase in knowledge and confidence, resulting in increased MHL. The ability to initiate a conversation and recognise signs of participants experiencing poor mental health was a key result of the MHT. No negative effects were identified as a result of receiving the training. Furthermore, there was an identification of the training impacting the learner themselves, viewing the training as 'two-fold', a conclusion in agreement with Kitchener and Jorm (2004) and Davies, Beever and Glazebook (2018). Not only is the training aimed towards understanding and supporting the participants, but the coach as well. This double impact could be argued as a strong reason to increase the funding directed towards MHT. WHO (2020) agree by stating that there needs to be increased investment on all fronts of mental health, inclusive of raising mental health awareness to further understanding and decrease stigma. However, as the GT suggests, this potential impact is limited and reduced by the lack of current investment available.

It was noted MHT was viewed in the same sphere as physical first aid and safeguarding. However, as the participants understood, MHT is not at the same level of importance. Again, to apply the GT, a potential disproportionate amount of funding is the reason. The training of physical first aid and safeguarding receive more attention than mental health, although this may be due to the long and popular implementation of them within the sector. This may contribute to MHT not currently being included within coaching qualifications. Many of the participants believed that MHT should be implemented from level one coaching qualifications. As suggested by Participant 14, this would affect a large proportion of coaches. This was furthered by the majority of the participants concluding that MHT should be compulsory for coaches, and other vital grassroot community roles. On the other hand, this would result in a large amount of coaches having to complete the required MHT. A mass amount of investment would have to be directed towards coaching qualifications, therefore to sustain this, a significantly increased amount of investment would have to be given to NBGs to support this notion. As we understand, MHT comes at a cost, this large-scale implementation with the current budget is simply unrealistic and unachievable.

As the GT explains, the expense of the training acts as a barrier, limiting the number of individuals who are able to complete it. This is of further significance within low socio-economic areas where mental health illnesses are at a higher risk of developing (Mental Health Foundation, 2016). However, the cost of MHT is too high for coaches to complete, therefore, the likelihood of early intervention through sport clubs and coaches is low. Therefore, the funding given to the mental health objective by DDCMS needs to be redirected towards to educating and informing coaches, where it can be especially significant within low socio-economic areas.

9.1 Limitations and Future Recommendations

Taking this study into consideration, there are a few possible limitations to be discussed. Firstly and most prominently, the COVID-19 pandemic affected the selection of participants. As explained theoretical sampling was employed within the study, however this may not have been fully achieved due to the lack of participants available as a significant number were partaking in the furlough scheme. Although, this was unavoidable and not a fault of the researcher. Therefore, should a similar future study be conducted when all potential research participants are available, their results may differ. Secondly, there is a lack of literature and therefore analysis within chapter seven. Consequently, this demonstrates there is a need for more research to be conducted within these areas, looking predominantly at implementing MHT in coaching qualifications and investigating whether MHT should be made a mandatory requirement for coaches. To lay an initial foundation, this study recommends that both MHT should be implemented in coaching qualifications and made mandatory for coaches to complete. There is a need for future studies to either support or disagree with this notion, resulting in a guide for evidence-based practice for the sector.

Lastly, the GT produced within this study was developed by the researcher through their interpretation. As discussed, constructivist GT with a reflective stance was adopted within this study. Therefore, this acknowledges that the researcher has an active role within the data analysis, and therefore the development of the theory. Should another researcher conduct a variation or development on this study, there is potential that they may produce an additional or altered theory.

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Appendix A

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 Sarah,

Title of study: Mental health awareness in sports coaching: an investigation of the #21by21 initiative.
Ethics reference: STHEC0004
Date of submission: 06/12/19

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 schedule).	31/01/20

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 B

Participant Information Sheet and Consent Form

Name of school: School of Sport, York St John University
Title of study: Mental health awareness in sports coaching: an investigation of the #21by21 initiative.

Introduction
You have been invited to take part in a research project examining the perceptions and experiences of the 21by21 mental health awareness campaign. 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 Sarah Ward, postgraduate research student 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 adults' opinions, insights and experiences of the 21by21 initiative. In conducting this investigation, I am trying to develop a greater understanding of the campaign itself, but further to understand how the campaign affect those involved.

What will you do in the project?
This study will involve a one-to-one interview between me and you that will last between 15-60 minutes. During this interview, you will be asked a series of set questions regarding your perceptions and experiences of the 21by21 mental health awareness training campaign. The interview will take place at a time, date and public place (i.e. café or work place) 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 campaign.

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:

Sarah Ward
School of Sport,
York St John University,
Lord Mayor's Walk,
York,
YO31 7EX.

Email: sarah.ward@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:

Daniel Madigan
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

Participant Informed Consent Form

Name of school: School of Sport, York St John University
Name of researcher: Sarah Ward
Title of study: Mental health awareness in sports coaching: an investigation of the #21by21 initiative

Please read and complete this form carefully. If you are willing to participate in this study, please circle the appropriate responses and sign and date the declaration at the end. If there is anything that you do not understand and you would like more information, please ask.

- I have had the research satisfactorily explained to me in verbal and / or written form by the researcher. **YES / NO**
- I understand that the research will involve an one-to-one interview which will last between 15-60 minutes and recorded for transcription purposes **YES / NO**
- I understand that I may withdraw from this study at any time without having to give an explanation and this will not affect my future care or treatment. I understand that I should contact you via email if I wish to withdraw from the study and that I can request for the information that I have provided to be removed from your investigation for a period of four weeks (28 days) after the date that I took part in your study. **YES / NO**
- I understand that all information about me will be treated in strict confidence and that I will not be named in any written work arising from this study. **YES / NO**
- I understand that any audiotape material of me will be used solely for research purposes and will be destroyed on completion of your research. **YES / NO**
- I understand that you will be discussing the progress of your research with your dissertation supervisor at York St John University. **YES / NO**
- I consent to being a participant in the project. **YES / NO**

Print Name:	Date:
Signature of Participant:	

Appendix C

Stakeholder Interview Guide

Theme 1: Mental health within physical activity and sport

1. What role do you believe physical activity and sport plays within mental health?
    a. How?
    b. Can you expand on that?

2. What role do you believe you or your organisation play within facilitating and improving grassroots physical activity and sport?
    a. Aiding and improving mental health within society?
    b. Can you expand on that?

3. Does your organisation have policies, workshops or opportunities for qualifications in place to help tackle mental health issues within physical activity and sport?
    a. Can you tell me more about that?

4. What are your opinions of mental health first aid within physical activity and sport?
    a. Can you tell me more about that?

Theme 2: Pre-perceptions of the 21by21 campaign

1. Why do you think the 21by21 project was established?
    a. Can you expand on that?

2. What did you think when you first heard about the 21by21 campaign
    a. Why is that?

3. Why did your organisation choose to be involved within the campaign?
    a. Can you tell me more about that?

4. What would you like the campaign to achieve?
    a. Can you tell me more about that?

5. The training focuses primarily on coaches/volunteers, why do you believe the campaign chose to target them?
    a. Role model?
    b. Friend?

Theme 3: Current perceptions of the 21by21 campaign and own experiences with MHFA

1. How do you think the project is currently running?
    a. Meeting its targets
    b. Successful/ not successful

2. Have you completed the training?
    a. Why/ Why not?
    b. If so, has your mental health literacy improved?

3. In what way do you think the training will affect the coaches/ volunteers?
    a. Long-term?

   b. Confidence?
   c. Ability?
   d. Knowledge?

4. If you could change the project, what would you do differently?
   a. Number of hours?
   b. Refresher courses?

Theme 4: Future perceptions of the 21by21 campaign and MHFA within physical activity and sport

1. What do you think is the next step is for the campaign?
   a. Can you expand on that?

2. Should mental health awareness training already be a recognised and a compulsory qualification for coaches?
   a. Learnt alongside physical first aid?
   b. Starting at Level 1

3. Do you believe there will be a change in culture amongst sports clubs and other social groups towards mental health with the help of this training?
   a. Why/ Why not?
   b. Are you already seeing a change?

4. Currently the campaign focuses its training on sport coaches/volunteers, however, do you think that the participants within the sport sessions would benefit from similar training? Like an interactive workshop?
   a. Can you expand on that?
   b. Why/Why not?

Appendix D

Participant Debrief Sheet

Debrief Sheet

Title of study: Mental health awareness in sports coaching: an investigation of the #21by21 initiative.

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