Teachers and Sports Coaches Supporting Young People’s Mental Health

The roles of teachers and sports coaches in promotion, prevention and early intervention for young people’s mental health

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Abstract

This thesis by published works contributes to the knowledge of how adults in community-based roles influence and support young people’s mental health through promotion, prevention and early intervention. It makes an original contribution to this field by advancing the understanding of the specific actions that adults, such as teachers and coaches, perform to support young people’s mental health, and their role perceptions related to these activities. The goal of the research was to inform ways to improve the mental health and wellbeing of Australian young people by enhancing the conceptual and practical understanding of the positive contributions that adults in community-based settings can make to young people’s mental health. The research aimed to achieve this by investigating teachers’ and coaches’ perceptions of their role, influence, and involvement in young peoples’ mental health through promotion, prevention and early intervention.

This research used a mixed methods design that was comprised of three phases. These phases were developmental in nature, whereby the findings of each phase informed the next. Phase I used a qualitative approach and investigated how teachers and coaches perceive their role to be relevant and effective in promotion, prevention and/or early intervention for young people's mental health. Semi-structured interviews were conducted with 21 teachers and 13 sports coaches of young people aged 12 to 18 in Canberra, Australia. Thematic analysis was employed to identify main themes from the interview transcripts. Phase II addressed a significant gap in the literature by developing a measure of promotion, prevention and early intervention behaviour for mental health using a consensus technique involving 10 experts in the field. Phase III used this measure to examine the influence of role related perceptions on teachers’ and coaches’ involvement in supporting young people’s mental health. An online survey was completed by
117 teachers and 131 coaches from Canberra, Australia. Multiple group path analyses were conducted to determine common and unique behaviour and relationships for teachers and coaches.

Five research papers resulting from the three phases of research are presented. The main outcome of paper one was that teachers and coaches perceived having influential but slightly different roles in supporting mental health. Paper two reported teachers’ views of their role breadth and highlighted their perceived lack of knowledge and skills in mental health related areas. Paper three revealed that coaches held expectations of themselves to support youth mental health and were comfortable talking with young people about related concerns. Key findings from paper four indicated both teachers and coaches frequently performed activities to promote young people’s mental health, and that teachers more commonly engaged in behaviour that supports prevention and early intervention for mental health than coaches. Paper five revealed three types of role-related perceptions—role breadth, instrumentality, and efficacy—significantly influenced teachers’ and coaches’ involvement in supporting young people’s mental health.

This thesis has contributed significant new conceptual knowledge by defining specific activities that characterise promotion, prevention and early intervention for mental health and creating an instrument to measure these constructs. This investigation of teachers and sports coaches, whose opportunity to contribute to this area is less well recognised, should extend the awareness and knowledge of the variety of settings and people that are influential and have potential to benefit young people’s mental health. Encouraging and assisting adults in community-based settings to engage in promotion, prevention and early intervention behaviour will strengthen and diversify young people’s access to mental health support and help to reduce the burden of mental health problems.
Key words: Youth mental health; mental health promotion; prevention; early intervention; teachers; sports coaches; role breadth; self-efficacy; community
List of Papers for PhD by Published Works


Conference Presentations During PhD Candidature

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CHAPTER ONE: INTRODUCTION

1.1 Contribution of the Thesis as a Whole

This thesis by published works contributes to knowledge of how adults in community-based roles influence and support young people’s mental health through promotion, prevention and early intervention. It makes an original contribution to this field by advancing understanding of the specific actions that teachers and sports coaches perform to support young people’s mental health, and providing insight into the influence that perceptions related to their professional roles have on these adults’ engagement in such behaviours. Increasing this knowledge and encouraging adults in community-based roles to take early action to support young people’s mental health may assist in reducing the prevalence and burden of mental health problems experienced by Australian young people.

1.2 Rationale: Need for this Research

There is a high prevalence of mental health problems among Australian young people, aged 12 to 25. Adolescence is a critical period for the promotion of young people’s mental health and wellbeing as well as to prevent and intervene early to treat mental disorders. However, young people tend not to receive professional help for their mental health problems as they prefer to seek help from people they already know. Familiar and trusted adults working with young people in community-based roles, such as teachers and sports coaches, may therefore, be in positions to effectively support young people’s mental health through promotion, prevention and early intervention. However, better understanding of teachers’ and coaches’ views regarding their influence and involvement in young people’s mental health, and how well equipped they feel to fulfil this role, is required.
1.3 Aims of the Thesis

The overarching aim of this thesis was to explore the roles of adults in community-based roles, such as teachers and sports coaches, in supporting young people’s mental health. The intended outcome was to gain knowledge into whether and how teachers and coaches are actively involved in the promotion, prevention, and/or early intervention for young people’s mental health. Specifically, this research aimed to:

1. Investigate teachers’ and coaches’ awareness, acceptance, and involvement of their roles in promotion, prevention and early intervention for young people's mental health.
2. Identify specific types of promotion, prevention and early intervention activities that teachers and coaches may perform.
3. Develop a measure of promotion, prevention and early intervention behaviour for mental health relevant for teachers and coaches.
4. Investigate and compare teachers’ and coaches’ involvement in promotion, prevention and early intervention activities for young people’s mental health.
5. Identify and explore predictors of teachers’ and coaches’ involvement in supporting young people’s mental health in relation to role perceptions.
6. Investigate barriers or challenges to supporting young people’s mental health within the teacher and coach roles.

1.4 Structure of the Thesis

This thesis is submitted in the format of thesis by published works. The structure of the thesis is presented in Figure 1.1. This research used a sequential exploratory mixed methods design which consisted of three phases. Phase I was an exploratory qualitative study involving
semi-structured interviews with teachers and sports coaches of young people aged 12-18, exploring their perceived influence and involvement in promotion, prevention and early intervention for young peoples’ mental health. Phase II used an expert consensus technique to develop a measure of promotion, prevention and early intervention behaviour. Phase III incorporated this measure into an online quantitative survey that was completed by teachers and coaches. Five papers prepared during these three phases of research are reported. Individually, each paper makes an important and valuable contribution to the overall aims of this thesis. Collectively, these five papers provide a cohesive investigation and argument for the opportunity and value of adults in community based-settings to take action in promotion, prevention and early intervention to support young people’s mental health.

Following the introduction (chapter one), the thesis begins with a literature review (chapter two). This chapter summarises recent literature on young people’s mental health needs, promotion, prevention and early intervention, as well as the influence and role perceptions of adults in the community, focusing on teachers and coaches, to support mental health. Chapter three describes the research methodology. It provides a rationale for the research design and inclusion of both qualitative and quantitative methodologies. Three research papers report from Phase I of the research and are presented in chapters four through six. Paper one explores how teachers and coaches perceive their role to be relevant and effective in the promotion, prevention and/or early intervention in young people's mental health (chapter four). Paper two investigates teachers’ views of their perceived role breadth and perceived self-efficacy in supporting students’ mental health (chapter five). Paper three similarly explores coaches’ views of their role and ability to support young people’s mental health (chapter six). Chapter seven presents paper four which stemmed from phases II and III of the research. This paper describes the development
of a measure of promotion, prevention and early intervention behaviour and compares teachers’ and coaches’ involvement these behaviours. Paper five reports on phase III of the research and is presented in chapter eight. This paper investigates the relative effects of teachers’ and coaches’ role perceptions—including: role breadth, instrumentality, efficacy, and discretion—as predictors of involvement in supporting mental health through promotion, prevention and early intervention. Finally, chapter nine presents a synthesis of the thesis findings along with limitations, future directions for research, and overall conclusions.
**Phase I: Qualitative**

*Aim:* to investigate teachers’ and coaches’ awareness, acceptance, and involvement of their roles in promotion, prevention and early intervention for young people's mental health, as well as to investigate barriers or challenges to supporting young people’s mental health; and to identify (specific) types of promotion, prevention and early intervention activities that teachers and coaches may perform.

*Method:* Semi-structured interviews (*N* = 34)

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**Phase II: Measure Development**

*Aim:* to develop a measure of promotion, prevention and early intervention behaviour

*Method:* Delphi consensus technique using an activity categorisation checklist (*N* = 10)

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**Phase III: Online Survey**

*Aims:* to investigate and compare teachers’ and coaches’ involvement in promotion, prevention and early intervention activities for young people’s mental health; and to identify predictors of involvement in supporting young people’s mental health.

*Method:* Online survey (*N* = 248)

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**Figure 1.1 Phases and aims of the research and structure of the thesis**
CHAPTER TWO: LITERATURE REVIEW

2.1 Chapter Introduction

This chapter summarises recent literature on young people’s mental health and mental health needs. Promotion, prevention and early intervention are discussed as a framework for improving young people’s mental health and wellbeing. In addition, this review considers the role of the wider community and potential for adults within that community, particularly teachers and sports coaches, to support young people’s mental health. Finally, the chapter provides the rationale for the current research and states the aims of this research.

2.2 Mental Health, Wellbeing, and Mental Illness

*Mental health* is ‘a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’ (World Health Organisation [WHO], 2001, p. 1). *Wellbeing*, refers to health in its broadest sense—including physical, mental, social, cultural, and economic health—and is related to quality of life (Trewin, 2001). Within society, however, the term mental health has tended to take on a variety of incomplete meanings. For instance, mental health has been used to refer to mental illness or, alternatively, to indicate the absence of mental illness. A holistic view of mental health considers more than the occurrence of mental disorder; it describes the capacity of individuals to interact with one another and their environment in ways that promote mental wellbeing and positive functioning (Australian Health Ministers, 1991; Keyes, 2002). A key component of mental health, therefore, is *menta well being*, which is a positive dimension generally linked to qualities such as life satisfaction,
optimism, self-esteem, mastery and feeling in control, and having a sense of purpose, belonging, and support (NHS Health Scotland, 2012).

*Mental illness* or *mental disorder* describes a number of diagnosable disorders that significantly interfere with an individual’s cognitive, emotional or social abilities (Commonwealth Department of Health and Aged Care [CDHAC], 2000b). The diagnosis of mental illness is typically made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) or the International Classification of Diseases (WHO, 2007). Some of the major types of mental illness are affective disorders, anxiety disorders, and substance use disorders. The term *mental health problem* is used to describe alterations in cognition, emotion, or social behaviour that are associated with distress or impaired functioning, but not to the extent that criteria for mental disorder is met (Sawyer et al., 2000b). Mental health problems are less severe and of shorter duration than mental disorders, but can develop into mental disorders (CDHAC, 2000b). Mental health, mental illness, and mental health problems greatly impact and are of critical importance for a young person’s wellbeing.

### 2.3 Young People’s Mental Health and Wellbeing

#### 2.3.1 Developmental transitions and wellbeing

Adolescence and young adulthood is typically a period of good physical health, with 93% of young people considering themselves to be in good or excellent health (Australian Institute of Health and Welfare [AIHW], 2011). Attributes such as strength, speed, fitness, and many cognitive abilities are all at their peak during this stage of life. However, adolescence and young adulthood is also a time of significant change and transition. Young people experience rapid
physical, social, emotional, and intellectual growth as they make the transition from childhood to adolescence through to adulthood (AIHW, 2011). Many challenges arise throughout this time, including: increasing need for independence, development of self-identity, sexual changes, shifting peer and family relationships, and enhanced academic expectations (CDHAC, 2000a; Lerner, Boyd, & Du, 2010). Such transitional challenges have the potential to impact young people’s overall wellbeing. Young people who are unable to make the transition to adulthood smoothly can face significant short and long term difficulties such as reduced educational outcomes and vocational opportunity, trouble forming and maintaining relationships, and socially withdrawn behaviour (AIHW, 2011; Osgood, 2005). Vulnerability and risk of developing mental illness is also heightened at this time of major life change (Commonwealth of Australia [CoA], 2004).

2.3.2 Prevalence

A high proportion of young people, aged 12 - 25, suffer from mental health problems. One out of every four Australian young people aged 16-24 experiences a mental health problem in a 12 month period. This is the highest prevalence of any age group (Australian Bureau of Statistics [ABS], 2008; 2007; Slade et al., 2009). Anxiety disorders are the most common mental health problems among youth, experienced by 15% of young Australians aged 16-24 every year. Substance use disorders and mood disorders such as depression are also common, with 13% and 6% of Australian young people suffering from these problems, respectively. Comorbidity of these disorders, which is experiencing more than one disorder simultaneously, occurs in around one in three young people with a mental disorder (ABS, 2010). A critical gap in data exists on the recent prevalence of mental health problems among adolescents aged 12 - 15 (AIHW, 2011), but the Child and Adolescent component of the National Survey of Mental
Health and Wellbeing (NSMHWB) conducted in 2000 reported that 13% of young people aged 13-17 had a mental health problem (Sawyer et al., 2000b). Adolescence and young adulthood is a critical period for mental disorders as most have their peak period of incidence during this stage of life (De Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012). Indeed, half of all mental disorders have their first onset before the age of 14 and more than three quarters before age 25 (Kessler et al., 2009; Kessler et al., 2007).

2.3.3 Impact

The burden associated with mental illness is high and rising (Patel et al., 2007). For young people mental health problems and mental disorder are a leading cause of health-related disability and account for almost 50% of the burden of disease in this age group (Kieling et al., 2011; Patel et al., 2007). Around 17% of young people with a mental disorder suffer a severe level of impairment associated with their disorder (ABS, 2010). Mental illness is particularly disruptive during adolescence when the foundations for adult life are developing (CoA, 2004). Mental health problems can significantly impede young people’s social and emotional development, self-confidence, social and family relationships, and educational and vocational attainment during a stage of life when these foundations are crucially important (AIHW, 2011; CoA, 2004; Kessler et al., 2009). Consequently, young people with mental health problems tend to have a poorer quality of life than their peers (Sawyer et al., 2000a). Mental health problems in young people are also strongly related to other health and developmental concerns including increased alcohol and drug use, violence, and poor sexual health as well as greater risk of intentional self-harm, suicidal behaviour or suicide (Patel et al., 2007). Those that suffer from comorbid disorders typically experience greater impairment than those with a single mental disorder and are at even greater risk of suicidal behaviour (ABS, 2008). Often young people with
mental disorders also experience problems such as isolation, discrimination and stigma (WHO, 2003).

Experiencing mental disorder as a young person can also have long-term impact. Poor mental health in adolescence is associated with adverse life course outcomes, such as marital instability and low financial status, and is linked to a range of subsequent physical disorders including heart disease (Kessler et al., 2009; Ormel et al., 2007). Even relatively mild mental health problems can cause social, emotional, or cognitive changes and discomfort, which are often ongoing into later adult life (Rickwood, White, & Eckersley, 2007a). Adolescence is, therefore, a vital period in which to provide effective mental health care and treatment for mental health problems to prevent longer lasting burden in adulthood (Kieling et al., 2011).

2.4 Provision of Mental Health Care

In Australia, treatment for mental health problems can be obtained from a wide range of health care services. Depending on the level of individual need, mental health care can be received from professionals in a variety of settings including hospitals or other residential care, hospital-based outpatient services, community mental health services, private consulting rooms, in the home and over the phone (AIHW, 2012). The CoA (2004) conceptualises three tiers of support and service provision for young people with mental health problems. The tiers consider the complexity and severity of mental health problems, and illustrate the appropriate service response, and relevant care pathways. Tier three represents specialist mental health care, which can be provided by multidisciplinary services and professionals who are highly and specially trained in mental health and the treatment of mental illness such as psychiatrists, clinical psychologists, mental health nurses, and some allied health workers. Young people with complex
mental health problems or diagnosed disorder generally require tier three care. (Where required, hospital inpatient units may be available within tier three support which offer intensive acute care to stabilise and treat severe mental health issues until the difficulties can be successfully monitored and managed in a less intensive environment). Tier two support is generally suitable for young people who have identified mental health concerns that are developing into a mental health problem or disorder. This level of support is comprised of more generalist mental health care provided by professionals with some training or expertise in mental health, but who typically work alone rather than as part of a multidisciplinary team, such as general practitioners (GPs) with additional training, paediatricians, psychologists, counsellors and other allied health workers.

Tier one recognises support and services that operate outside of what are typically considered mental health services but often have a major role in dealing with the mental health of young people. This includes adults that work with and have direct relationships with young people but do not specialise in mental health, such as GPs, community health workers, hospital emergency department staff, teachers and other school staff, youth workers, sports coaches and club members, juvenile justice health employees and child welfare workers. Informal supports such as parents, family, and friends are also included in this category. Young people at risk of developing a mental health problem will most likely come to the attention of tier one support (CoA, 2004).

The inclusion of tier one support in this framework acknowledges the important influence that adults in a variety of community-based settings can have in supporting young people’s mental health. Stiffman, Pescosolido, and Cabassa (2004a) acknowledge the importance of tier one type support in their ‘gateway provider model’ which describes influences that affect young
people’s access to treatment in the US. The gateway provider model focuses on the influences of individuals not in the mental health system, such as parents, teachers and other adults, in facilitating young people’s help-seeking processes and access to treatment. In the context of help-seeking, tier one support people may be referred to as ‘gatekeepers’, defined as people in the community who are in a position to assist distressed people to access appropriate professional support services (Frederico & Davis, 1996), or ‘gateway providers’, defined as the individuals who first identify a problem and guide young people to treatment (Stiffman, Pescosolido, & Cabassa, 2004b). Tier one support people may provide significant support to young people who are at risk of developing mental health problems and disorders but who choose not to seek treatment or access any service until they come to the attention of others (CoA, 2004).

2.5 Help-Seeking

2.5.1 Professional help-seeking and service use

Despite young people having the highest prevalence of mental health problems, they tend not to seek professional help. Over 80% of males and close to 70% of females aged 16 to 24 years do not use any services for their mental health problems (ABS, 2008; Reavley, Cvetkovski, Jorm, & Lubman, 2010; Slade et al., 2009). Young people with substance use disorders are the least likely to seek professional help (ABS, 2010). The onset of mental disorders during childhood or adolescence is associated with longer duration of untreated illness, or treatment delay (De Girolamo et al., 2012). So even when young people do receive professional treatment, it typically does not occur until several years after the development of mental disorder (Kessler et al., 2007).
The latest Australian NSMHWB, conducted in 2007, showed that among the small proportion of Australian young people (aged 16-24) who do seek professional help for their mental health problems most consult a GP (ABS, 2010). Psychologists were the second most frequent professional group consulted by young people with mental health problems; fewer young people consulted psychiatrists. The Child and Adolescent component of the 2000 NSMHWB showed that younger, school-age adolescents (aged 13-17), with mental health problems most frequently access school-based counselling, followed by a GP or other community health service, then private psychologists (Sawyer et al., 2000a). As was the case for 16-24 year olds, psychiatrists were much less commonly consulted by younger adolescents with mental health problems. Consistently, the recent Australian National Mental Health Literacy survey, conducted in 2011, also identified GPs as the most likely professional source Australian young people would seek help from, with young people reporting considerably less intentions to seek help from psychologists and psychiatrists (Reavley & Jorm, 2012).

The overall use of specialised mental health services has increased by almost 20% since 2005 (AIHW, 2012). This positive trend is largely attributable to the introduction of the Better Access Initiative which has improved the affordability of treatment by providing medicare-subsidised access to psychologist and other allied health professionals. The 2011 Australian National Mental Health Literacy Survey showed a similar positive trend specific to young people with around 30% of young people who had an intention to seek help indicating they would consult professional services, compared to only 10% in 2006 (Reavley & Jorm, 2012). Despite this positive increase, young people’s low use of professional services and delay in accessing treatment remains concerning. This highlights a need for further action to be taken to encourage and assist young people to seek appropriate professional help for their mental health problems.
Many barriers to young people’s professional help seeking have been identified. These include: previous negative experience of services; (not liking) the environment and style of service or treatment offered; perceiving that services will be unable to help; stigma and concerns of what others may think; fears regarding confidentiality and trust; embarrassment or shyness about disclosing issues; and structural barriers such as transport and cost (Gulliver, Griffiths, & Christensen, 2010; Rickwood, Deane, & Wilson, 2007b; Yap, Reavley, & Jorm, 2013). Additionally, the lack of established or pre-existing relationships with mental health professionals is a major barrier to young people accessing services for their mental health problems. They are reluctant to seek professional help as it typically involves engaging with a person who is a stranger, and young people tend not to feel comfortable opening up to people they do not know (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

### 2.5.2 Preferred sources of help and help-seeking pathways

Not only do few young people access professional services for their mental health problems, many do not seek help from anyone at all (Rickwood et al., 2005; Wilson & Deane, 2011). Poor help-seeking behaviour is especially evident in young people with suicidal ideation, close to half of whom will not inform anyone of their distress (Arria et al., 2011). When young people do reach out, they prefer to seek help from someone they already know and trust (Rickwood et al., 2005). The trust, familiarity, and rapport developed within established relationships are vitally important for young people’s help-seeking (Rickwood et al., 2005). As a result, young people are most likely to seek help from family and friends with whom they have existing relationships, rather than seeking professional help for their mental health problems (Hampshire & Nicola, 2011; Reavley & Jorm, 2012; Rickwood et al., 2005; Yap et al., 2013). In fact, more than 85% of adolescents who seek help do so within their social network (Rickwood
& Braithwaite, 1994), and up to 90% will inform their peers of their problems (Kalafat & Elias, 1995).

Young people usually do not seek services or treatment on their own (Rothi & Leavey, 2006; Stiffman et al., 2004a). Many may not be aware of the signs and symptoms of mental disorder and may lack the skills to help themselves (Gulliver et al., 2010). Consequently, young people tend to need the encouragement and guidance of trusted adults in order to identify mental health problems and seek appropriate professional help (Rickwood et al., 2005). The influence of trusted and familiar adults, whose regular contact with young people enables them to identify emerging problems, is paramount during a young person’s help-seeking pathway (Gulliver et al., 2010). Help-seeking pathways refer to the sequence of contacts with individuals and organisations prompted by a young person or their significant others, to seek help. Help-seeking pathways further include the help that is supplied in response to such efforts, including attempted therapeutic and social interventions by lay persons and professionals, and referral to other help sources (Rogler & Cortes, 1993). Rogler and Cortes (1993) propose that help-seeking pathways provide the critical link between the onset of mental health problems and the provision of mental health care. Parents are especially important in the help-seeking pathways of younger adolescents, whilst the role of friends and partners becomes more prominent for older adolescents and young adults (Rickwood et al., 2007b).

2.6 Community Adults

Family and friends are not the only sources of support available to young people that they know and trust. Young people can have regular contact and long-lasting relationships with a range of adults in their lives outside those in their family. Some of these people may be involved
with the young person through a professional role or community setting such as teachers, sport coaches, youth workers, social activity leaders as well as many other ‘tier one’ support people (CoA, 2004; Rickwood et al., 2005). While the primary professional role of such community-based adults is not concerned with mental health, or even general health care, as a result of their pre-established relationships young people are likely to feel more comfortable and willing to seek help from these adults than they are from professionals they have not previously met (Rickwood et al., 2005). Stiffman, Elze, Hadley-Ives, and Johnson (1999), in a US based study, found that a greater number of young people with mental health problems had been in contact with community-based adults or tier one support, including 25% with social workers and 12% teachers or coaches, compared to only 3% receiving care from psychologists or psychiatrists and only 7% from medical doctors.

Young people’s preference to seek help from people they know creates opportunities for many community-based adults to be highly beneficial in young people’s help-seeking pathways by encouraging early and appropriate mental health care (Mazzer & Rickwood, 2009; Rickwood et al., 2005). Most young people who engage in professional help-seeking have sought help from informal sources prior to accessing the professional service. An Australian study by Steel et al. (2006) reported that 15% of people making their first contact with one of 12 sampled Sydney mental health services had initially contacted a non-health professional such as a teacher or welfare worker, 12% had been through an emergency department, 11% through the police, 10% via allied health professionals, and 5% had been assisted by a traditional healer, alternative medicine practitioner or religious leader on their help-seeking pathway. Notably, GPs emerged as the most common contact on the pathway to mental health care, with 45% of participants presenting to a GP before accessing a mental health service. Only 13% sought help directly from
a mental health service, without the involvement of another source. These findings highlight the pivotal role that adults within the community who are in young people’s lives have in assisting them to access professional help. The CoA (2004) specifically acknowledges that these adults, as tier one support people, can play a major role in young people’s mental health by assisting in mental health promotion, prevention and early intervention.

2.7 Promotion, Prevention and Early Intervention (PPEI)

Traditionally, mental health care has been focused on treatment once a mental health problem or disorder has occurred. However, it is evident that in order to reduce the personal, social, and financial burdens associated with mental illness, such help and interventions are required earlier in the development of mental health problems and mental disorders (CDHAC, 2000a). Secondly, since young people tend not to seek out help and are reluctant to access professional treatment for their mental health problems, meeting the mental health needs of young people requires help and interventions to be actively taken to young people by utilising places and people they are already familiar and engaged with (Rickwood et al., 2005).

In response to these needs, mental health policy in Australia emphasise promotion of mental health, prevention of mental health problems, and early intervention for mental disorders, as depicted by the mental health intervention spectrum (CDHAC, 2000a; Parham, 2007). Originally developed by the Institute of Medicine (Mrazek & Haggerty, 1994), the spectrum portrays the continuum of mental health interventions within a population health framework. A revised version of the spectrum is presented in Figure 2.1. Promotion, prevention and early intervention approaches operate on a community level to influence the risk or likelihood of developing mental illness within populations (AIHW, 2011; CDHAC, 2000b). So, people outside
of traditional mental health services, including many adults within the community with whom young people have relationships, can assist.

Figure 2.1 Spectrum of interventions for mental health (revised; Rickwood, 2007)

2.7.1 Promotion

Mental health promotion is any action taken to maximise mental health and wellbeing among populations and individuals (Mrazek & Haggerty, 1994). It aims to optimise, protect, and sustain the mental health and wellbeing of individuals, families and communities as a whole by developing environments—including social, physical, economic, educational, and cultural environments—that are supportive of mental health (CDHAC, 2000a, 2000b). It focuses on promoting factors that enhance mental health, such as competence, resilience, and empowerment.
(headspace, 2011), and endorsing activities that build the community’s capacity to support mental health (CDHAC, 2000b).

Mental health promotion draws on the principles and practice of health promotion first outlined in the Ottawa Charter for Health Promotion (WHO, 1986). It is concerned with enhancing a sense of wellbeing and promoting positive mental health rather than illness prevention or treatment (WHO, 2005). This enables mental health promotion to improve the lives of all people, not just those experiencing illness; it focuses on the promotion of wellbeing for the entire population, including people who are currently well, at risk of developing a mental disorder, and those experiencing mental illness (CDHAC, 2000b). Some of the benefits of promoting mental health include improved psychosocial functioning and better physical health, as well as reduced mental health problems and associated burdens (CDHAC, 2000b; WHO, 2005).

One common method for promoting mental health is increasing mental health literacy within the community. Mental health literacy is comprised of ‘knowledge and beliefs about mental disorders which aid their recognition, management, or prevention’ (Jorm et al., 1997, p. 182). It includes the ability to recognise specific disorders, attitudes that promote recognition and appropriate help-seeking, and knowledge of risk factors and causes, of self-help interventions, of professional help available, and of how to seek mental health information (Jorm et al., 1997). Other methods of mental health promotion include interventions designed to increase the sense of belonging and connectedness within school communities, to support and strengthen family functioning, and to promote awareness and acceptance of cultural diversity (CDHAC, 2000b; Queensland Health, 2009).
Many people within the community can assist in mental health promotion. In fact, community members are in ideal positions to contribute, as community participation itself is associated with better mental health and wellbeing as well as increased life satisfaction (AIHW, 2011; Berry & Welsh, 2010). Community participation refers to activities that demonstrate people’s connectedness to their community, such as being involved in clubs, sporting teams, community groups, and other leisure activities with the community. Participation in social and community life is an important aspect of promoting mental health and wellbeing (AIHW, 2011). Young people develop many attributes and skills through such participation that contribute to mental health promotion, such as learning to set and achieve goals, develop initiative, time management, peer relationships, team work and social skills (Dworkin, Larson, & Hansen, 2003).

### 2.7.2 Prevention

*Prevention* refers to ‘interventions that occur before the initial onset of a disorder’ to prevent the development of disorder (Mrazek & Haggerty, 1994, p. 23). It aims to reduce the prevalence of mental health problems and mental disorders through enhancing protective factors and reducing risk factors (CDHAC, 2000a; Mrazek & Haggerty, 1994). Risk factors indicate vulnerability and increase the likelihood that a mental health problem or disorder will develop, and can exacerbate the burden of existing mental health problems. Protective factors, on the other hand, enhance resilience and decrease the likelihood of a mental health problem or disorder (CDHAC, 2000b). Both risk and protective factors occur in the everyday lives of individuals and communities. They can arise from perinatal and genetic influences, family relationships and living conditions, social and cultural influences, financial and economic conditions, education
and educational settings, sport and recreation activities, health behaviour and access to health services, demographic conditions, and personal coping skills (CDHAC, 2000a).

A wide range of risk factors may contribute to mental health problems and mental disorders in adolescence. Risk factors that arise from personal characteristics or biological factors may include: perinatal influences, conditions, or complications; chronic illness; low self-esteem or poor body image; and poor social skills. Families are important influences of young people’s mental health and many risk factors can arise from the family context, such as: being in single parent or step/blended families; family conflict, violence or breakdown; absence of warmth and affection; neglect or low parental involvement; unemployment, criminality, substance misuse, or mental disorder of parents; and being a young carer (AIHW, 2011; Hampshire & Nicola, 2011; Patel et al., 2007; Sawyer et al., 2000a). Other risk factors that can contribute to mental health disorders include stress associated with poverty and social disadvantage, homelessness, and racism (AIHW, 2011).

As with risk factors, there are many protective factors which help to prevent or moderate the negative impact of mental health problems and disorders. Many protective factors arise from personal and social contexts, such as: connectedness to community; having a positive role model or mentor; sense of self-worth; social connectedness; coping and social skills; internal locus of control; belonging to a positive peer group; participation in community groups; and leading an active lifestyle (CDHAC, 2000a; Slade et al., 2009). Families can also provide critical protective factors, including: having close family relationships; strong parenting skills; good communication and positive adult behaviours; security and stability (AIHW, 2011).

Prevention is essential in minimising the risk of individuals developing mental health problems and delaying the onset of disorder (CDHAC, 2000b). An individual’s risk of
developing a mental health problem or mental disorder is influenced by their exposure and vulnerability to risk factors as well as the presence of protective factors (CDHAC, 2000b). The ability to determine the risk of individuals and groups of individuals mental health problems has enabled a variety of prevention interventions to be developed which target different populations according to their level of risk. Prevention interventions that target the general population and are not identified by their level of risk are known as universal. Selective prevention programs are aimed at subgroups or individuals whose risk of developing mental disorder is significantly higher than average. Finally, indicated prevention programs target high-risk individuals, such as those showing early warning signs and symptoms of mental health problems or mental disorder (CDHAC, 2000b). Through modifying risk and protective factors, prevention interventions can have positive outcomes for mental health, and are associated with health and educational benefits generally (CDHAC, 2000b).

Communities and individuals need to be supported to develop the skills to understand and respond to their mental health needs (headspace, 2011). Most of the protective and risk factors for mental health problems occur in everyday life, outside the environment of mental health services. In order to influence these factors, knowledge about the prevention of mental health problems and mental disorders needs to be available to the wider community (CDHAC, 2000b). This highlights the importance and need for collaborative community partnerships to improve mental health and prevent mental health problems (CDHAC, 2000b).

2.7.3 Early intervention

Early intervention refers to interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder (CDHAC, 2000b). Early intervention endeavours to minimise
the distress and longevity of mental illness, as well as foster hope for future wellbeing, by taking
effective action in the early stages of its development (CDHAC, 2000a; Mrazek & Haggerty,
1994). This process requires early identification of mental health problems to allow timely,
effective, and appropriate treatment to occur (CDHAC, 2000b).

Early intervention is critical in reducing the impact and progression of mental health
problems over an individual’s life span (CoA, 2004). Intervening early in the development of
mental health problems minimises the negative impact on individuals, their families, and the
wider community (Mental Health Commission, 2011). Delay in the treatment of mental health
problems has been linked to poor symptomatic and functional outcomes, both short- and long-
term (Berk et al., 2007). Responding early in the course of a mental disorder leads to improved
treatment outcomes, and helps to reduce risk of escalation, minimises the duration of illness and
prevents future mental health problems (Colognori et al., 2012; De Girolamo et al., 2012;
Hampshire & Nicola, 2011; Mental Health Commission, 2011). Additionally, early intervention
can prevent many of the secondary psychosocial effects of mental disorder and assist in relapse
prevention (Commonwealth of Australia, 2004). Early intervention is also a cost-effective
approach that reduces the need for hospitalisation and inpatient facilities (Mental Health
Commission, 2011).

The reluctance of young people to seek professional help for mental health problems is a
challenge for early intervention approaches (Rickwood et al., 2007b). In response, Hampshire
and Nicola (2011) emphasise that any early intervention initiatives aimed at helping young
people need to support parents and other significant adults to assist young people with their
concerns. Early intervention is strengthened by partnerships with a diverse range of people in the
community who are in positions to identify, refer and/or treat individuals displaying early signs and symptoms of mental health problems (CDHAC, 2000a).

2.7.4 Challenges to operationalising the PPEI model

Importantly, while the goals of promotion, prevention and early intervention differ, there can be a great deal of overlap in actions and interventions that seek to achieve these goals. In practice, these interventions often apply similar methods and produce similar outcomes (CDHAC, 2000b). Furthermore, it can be difficult to classify an intervention as purely promotion, prevention, or early intervention as many combine or include elements from each (CDHAC, 2000b). For instance, a promotion initiative aimed at increasing wellbeing within a community may also contribute to prevention by reducing the incidence of mental health problems in that population (CDHAC, 2000a). Actions that distinctively characterise promotion, prevention and early intervention as separate constructs are, therefore, not presently well defined. This lack of clarity increases the difficulty of accurately measuring or examining promotion, prevention and early intervention behaviour. Consequently, there is currently no available instrument to measure such behaviours. This limits progress in the field because the level of activity across these intervention domains cannot be easily ascertained.

2.7.5 Benefits of PPEI

Improving mental health and wellbeing through mental health promotion, prevention and early intervention is a primary focus of government mental health strategies in Australia (CoA, 2009) and internationally, for example in the United Kingdom (HM Government, 2011) and Europe (European Commission, 2008). Promotion, prevention and early intervention activities can substantially improve mental health across the population as well as reduce the prevalence and burden of mental health problems and mental disorders (CDHAC, 2000b). Furthermore, it
will result in long-term benefits to the personal, social, emotional, and economic wellbeing of Australian individuals, families, and communities (CDHAC, 2000a; National Advisory Council on Mental Health, 2011).

Over the 10 to 15 years, the emphasis on mental health promotion, mental illness prevention, and early intervention has worked to complement and expand the traditional focus on treatment for mental health problems and mental disorders (CDHAC, 2000b). It is now evident that efforts across all of these areas are required to maximise mental health outcomes (Department of Health and Ageing [DHA], DHA, 2003; WHO, 2012). Accordingly, mental health reform and service provision in Australia is focused on building a more balanced approach to supporting mental health that provides a mix of services and supports across the spectrum of promotion, prevention and early intervention, as well as treatment and recovery interventions and supports (Mental Health Commission, 2011).

2.7.6 Adolescence critical period for PPEI

Adolescence is a critical period for the promotion of wellbeing, prevention of mental illness, and early intervention for mental health problems and disorders. The health and wellbeing of young people not only affects their immediate quality of life but also shapes the future health of the population (Kessler et al., 2009). Investment in promotion, prevention and early intervention during this stage of life is essential to address the high prevalence of mental health problems, reluctance to seek help, and likelihood of treatment delay when onset of mental disorder occurs within this age group (De Girolamo et al., 2012). Promotion, prevention and early intervention in adolescence has the capacity to generate greater benefits than intervention at any other time in the lifespan (McGorry, Purcell, Hickie, & Jorm, 2007). It provides unique opportunities to act toward preventing a range of problems in later life including obesity,
criminality, unemployment, homelessness and excessive financial strain (CDHAC, 2000a; Queensland Health, 2009). As a result, it is socially and economically more effective to address mental health problems as they occur in adolescence rather than treating enduring problems in adulthood (AIHW, 2011). Promotion, prevention and early intervention is a key strategy to enable optimal development of vulnerable adolescents and to reduce the burden of disease in both current and future generations (De Girolamo et al., 2012; Kieling et al., 2011; McGorry et al., 2007).

2.7.7 PPEI and the community

Mental health is an issue for the whole community (CDHAC, 2000a; Parham, 2007). Communities play a major role in shaping young people’s health and wellbeing. Many factors targeted by promotion, prevention and early intervention develop and exist through day to day life within the community (CDHAC, 2000a; DHA, 2008). Family, home, school, and community environments are essential in protecting young people from physical and emotional harm and providing opportunities for them to develop (AIHW, 2011). Promotion, prevention and early intervention activities need to be carried out across a wide range of contexts and many community-based adults can help (CoA, 2009). Effective action to enhance mental health requires cooperation and partnerships that extend well beyond mental health services, into the broader community—including schools, workplaces, and the sports, arts and recreation sectors (CDHAC, 2000a). Individuals, families, professionals, as well as other community members, all share roles in promotion, prevention and early intervention for mental health (CoA, 2009; Mazzer & Rickwood, 2009).

Young people’s mental health and access to treatment for mental health problems can be improved by reaching out to young people through the people and places they are already
familiar and engaged with (Rickwood et al., 2005). Promoting connections with community-based adults has, therefore, been proposed as a response to mental health problems among Australian young people, as two thirds of young Australians report participating in social community groups, such as sports or recreation groups (AIHW, 2011; Pierce, Liaw, Dobell, & Anderson, 2010). Furthermore, informal community support is frequently required to sustain good mental health and can be provided at a relatively low economic cost (Mental Health Commission, 2011). The value of community involvement in promotion, prevention and early intervention for young people’s mental health is recognised in a number of Australian government initiatives, including: Models of Collaborative Care for Children and Young People (0-25 Years): Final Report (National Advisory Council on Mental Health, 2011); National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (CDHAC, 2000a); Responding to the Mental Health Needs of Young People in Australia (CoA, 2004); Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009–2014 (CoA, 2009).

Community groups and organisations that regularly come into contact with young people need to be supported, educated and utilised in promotion, prevention and early intervention programs (Hampshire & Nicola, 2011). The Australian Government’s National Action Plan for Promotion, Prevention and Early Intervention (CDHAC, 2000a) represented landmark policy and has been an international leader in encouraging a holistic approach to improving mental health and wellbeing. It has highlighted a number of specific community settings in which to deliver programs aiming to improve mental health and wellbeing including: schools and tertiary education settings; primary health care; health and mental health services; sport and recreation settings; youth refuges; welfare settings; and juvenile justice and correctional settings. Of these,
most young people spend the greatest amount of time participating in school and sports, making these particularly valuable settings in which to access and support young people’s mental health. Adults within these settings, such as teachers and coaches, likely have the most frequent contact with young people of anyone outside of their family, and can make a major contribution to their mental health (Donovan et al., 2006).

2.8 Schools and Teachers

2.8.1 Schools as settings for PPEI

Most Australian young people attend and spend much of their time at school. In Australia, it is compulsory for young people to attend school until they complete Year 10 and to participate in full-time education, training or employment until age 17 (Council of Australian Governments [COAG], 2009). National apparent retention rates from 2012 show 80% of students who start secondary school remain in school and complete year 12. Moreover, almost two thirds of older adolescents, aged 15-24, continue to participate in education beyond compulsory schooling (ABS, 2013b). A significant proportion of these young people have high needs for mental health support and schools play a crucial role (headspace, 2011; Spratt, Shucksmith, Philip, & Watson, 2006).

School mental health is rapidly developing as an influential approach to better address the mental health needs of young people (Green et al., 2013; Kutcher & Wei, 2012). Schools are an ideal setting in which to reach out to young people and are key sites for mental health promotion (Graham, Phelps, Maddison, & Fitzgerald, 2011; Rickwood, 2005). Pastoral care systems within schools assist to promote the health and wellbeing of all young people through endorsing a holistic approach to education, addressing students’ social, psychological, developmental, and
educational needs (Hearn, Campbell-Pope, House, & Cross, 2006). Increasing interest in the emotional health and pastoral care of young people in schools has resulted in national and international commitment towards implementing ‘Health Promoting Schools’, which address how curriculum and pastoral practice can best enrich the social, emotional, physical and moral wellbeing of all members of their school community (CDHAC, 2000a; WHO, 1998). The role of schools in promoting young people’s mental health and wellbeing is also evident in the Australian government’s National Safe Schools Framework, the key vision of which is for ‘all Australian schools to be safe, supportive and respectful teaching and learning communities that promote student wellbeing’ (Ministerial Council for Education, Early Childhood Development and Youth Affairs [MCEECDYA], 2011). This framework also emphasises the importance of working with the community to extend support to students and families where needed. Significant long-term benefits for both health and education are anticipated through schools promoting health and mental health as they do learning (CDHAC, 2000a; headspace, 2011).

Schools are also valuable settings for prevention of mental disorders in young people (Lendrum, Humphrey, & Wigelsworth, 2013) as many risk and protective factors for mental illness occur within this environment. Experiencing victimisation or bullying at school is a major risk factor along with peer rejection, poor attachment to the school, deviant peer group, and school failure or drop out (AIHW, 2011; Arseneault, Bowes, & Shakoor, 2010; Bond, Carlin, Thomas, Rubin, & Patton, 2001). School connectedness serves as a protective factor for emotional distress, as do experiences of achievement and having positive connections with peers at school (AIHW, 2011; Wilkinson-Lee, Zhang, Nuno, & Wilhelm, 2011). Schools provide opportunities for young people at risk of developing mental health problems to be identified and supported (Finney, 2006). A school’s engagement in early identification and intervention of
mental health issues is associated with increased mental health service use by adolescents (Green et al., 2013). This highlights the important role of schools in assisting young people to receive appropriate treatment for mental health problems (Colognori et al., 2012). Strengthening the role of schools in promotion, prevention and early intervention is a priority and the development of school-based mental health programs has been a major focus in Australia (DHA, 2003; Lechtenberger, Mullins, & Greenwood, 2008).

Many school-based mental health programs addressing mental health promotion, prevention and early intervention have now been developed. These programs generally focus on addressing specific mental disorders, promoting general mental health, suicide prevention, stigma and/or mental health literacy (Katz et al., 2013; Kutcher & Wei, 2012). Kutcher and Wei (2012) from a Canadian-based review stress that while many school-based mental health programs have been developed, research has not generally been able to demonstrate the effectiveness, safety, or cost-effectiveness of these programs. Neil and Christensen (2007) had a more positive summary from their Australian-based systematic review, which identified 13 Australian school-based prevention and early intervention programs, many of which have reported positive outcomes.

In Australia, MindMatters is the national initiative in mental health promotion, prevention and early intervention for secondary schools. By providing education on mental health within the school setting, MindMatters aims to: improve students’ mental health literacy; develop social and emotional skills; help develop school environments where young people feel safe, valued, engaged, and purposeful; assist schools to support students with mental health needs; and better collaborate with families and services (DHA, 2009; MindMatters, 2009). All Australian secondary schools have received MindMatters resources kits and two thirds have used
it as a curriculum resource (MindMatters, 2009). This move towards a more explicit recognition of the role of schools in addressing young people’s mental health relies on teachers’ involvement and commitment to this purpose (Kidger, Gunnell, Biddle, Campbell, & Donovan, 2010).

### 2.8.2 Teachers’ role in PPEI

Teachers have received increasing attention as important sources of support and influence for young peoples’ mental health. They can have a profound impact on adolescent development and wellbeing and expectations for teachers’ involvement in student mental health are growing (Rothi, Leavey, & Best, 2008). For young people still attending school, teachers are an easily accessible source of support (Rickwood et al., 2005). Furthermore, their role as facilitators of learning suggests that young people listen to and accept advice on other topic areas, which may assist with young people taking their advice on issues surrounding mental health. Teachers have been identified as prominent adult role models in a young person’s life who are in a unique position to make a difference when it comes to promoting and addressing young people’s mental health (Meldrum, Venn, & Kutcher, 2009). It has been argued that promoting the mental health and wellbeing of young people is a vital part of the core role of teachers and that they need to be comfortable and confident in promoting and teaching for mental health (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000). Calear (2012) argues that preventing the development of mental health problems through classroom programs should be encouraged and supported within the school environment.

As well as having established relationships with young people, teachers are also in a valuable position to observe their behaviour and identify issues concerning young people’s mental health and wellbeing (Johnson, Eva, Johnson, & Walker, 2011). Furthermore, they are part of the pastoral care systems within schools and have links with other supports, including
school counsellors, and have knowledge of other community-based services and supports (Graham et al., 2011; Johnson et al., 2011; Rickwood, 2005). Their role in identifying young people with mental health concerns and encouraging appropriate help-seeking may be critical to improving young people’s access to and engagement in treatment (Colognori et al., 2012; Graham et al., 2011).

Teachers should be motivated to support young people’s mental health and wellbeing as it is fundamental to teaching and its aims, such as achieving learning outcomes, and, personal development of young people (Kidger et al., 2010). Another facet of a teachers role is to identify and remove obstacles to educational progression (Rothì et al., 2008). Mental health problems can be such an obstacle as they can inhibit the ability of students to learn and perform productively at school (International Union for Health Promotion and Education [IUHPE], 2000). Mental health concerns can cause students to not participate fully in their educational programs and result in disruptive behaviour, inability to concentrate, incomplete academic work, absenteeism and withdrawal from school activities (Anderson, 2005; Johnson et al., 2011). As a result, adolescent emotional wellbeing is a strong predictor of educational achievement (Sznitman, Reisel, & Romer, 2011). Mental disorders such as learning disorders or Attention Deficit Hyperactive Disorder (ADHD) impose further specific barriers to optimising learning outcomes. Given the high prevalence of mental health problems in young people, it is likely that a large number of students are not learning or achieving to their potential at school as a result of their mental health concerns (Anderson, 2005). By being aware of such concerns, teachers can better meet the specific needs of students and assist them learn most effectively (Meldrum et al., 2009).
2.9 Sports and Coaches

2.9.1 Sport as setting for PPEI

Sporting clubs often serve as social hubs within communities and have recently been proposed as effective environments to promote youth mental health and to identify and support young people experiencing mental health difficulties (Pierce et al., 2010). Sports or physical recreation groups are the most common type of community groups that young people participate in (AIHW, 2011). The Participation in Exercise, Recreation, and Sport Survey conducted in 2010 showed approximately 75% of Australian young people (aged 15 to 24) participate at least weekly in physical exercise. Football (soccer), netball, Australian rules football (AFL), and basketball are among the most popular organised physical activity or sports for young people (Australian Sports Commission [ASC], 2010).

Sport is important to many young people and regular participation has clear benefits across a number of domains. Most obviously, exercise leads to physical health benefits such as cardiovascular fitness, weight control, and disease prevention (Warburton, Nicol, & Bredin, 2006), but participation in exercise and sport also promotes good social and psychological health. It is associated with increased alertness and resilience, and better mental health (Street & James, 2010). It reduces anxiety, depression, negative mood, helplessness, and suicidality, while improving confidence, cognitive functioning and emotion regulation (Callaghan, 2004; Fox, 2000; Fullagar, 2008; Taliaferro, Rienzo, Miller, Pigg, & Dodd, 2008; Tang & Zhang, 2008). Involvement in activities, such as sport, that are regular, enduring, and increase in complexity over time also fosters positive and effective youth development (Fraser-Thomas, Côté, & Deakin, 2005). The reciprocal social support that occurs in sport is another important factor in promoting physical and mental wellbeing as well as for the management and recovery of mental
health problems (Carless & Douglas, 2008). Due to its multiple benefits, exercise is a valuable, but often neglected, factor in the prevention, management of, and recovery from mental illness (Carless & Douglas, 2008; Larun, Nordheim, Ekeland, Hagen, & Heian, 2006). The high proportion of young people who participate in sport along with the positive contributions that exercise has on mental health makes it a valuable setting to encourage promotion, prevention and early intervention.

Reaching young people through environments that they are familiar with and enjoy with their peers, such as sports, is a powerful and beneficial approach for promoting and learning about mental health (Danish & Nellen, 1997). The sporting environment has been identified as a particularly valuable setting for accessing and supporting vulnerable young people as many of those who may not access other supports or services do participate in sports. Physical activity programs have the potential to improve social and emotional wellbeing in at risk young people (Lubans, Plotnikoff, & Lubans, 2012). As a result, targeted sports programs have been designed and implemented in Australia to enhance both life and sport skills for at-risk young people (Danish & Nellen, 1997). Midnight basketball is a national social inclusion program which provides food, transport, life skills workshops and basketball games, to help young people identify and embrace positive opportunities (Midnight Basketball Australia, 2011). Sport-for-Development (S4D) programs have also been applied to contribute to social cohesion and community empowerment and to improve the everyday needs and social life of disadvantaged communities (Kidd, 2008; Schulenkorf, 2012). The Good Sports Mental Health Program works with sport clubs to raise mental health awareness and reduce stigma of mental illness, as well as to educate clubs on how and when to respond to individual mental health issues (Australian Drug Foundation, 2013). Additionally, the Mental Health Sports Network is a service of the
Schizophrenia Fellowship of NSW which promotes opportunity for people with mental illness to improve both their mental and physical wellbeing through increasing participation in sporting activities (Schizophrenia Fellowship of NSW, 2008).

2.9.2 Coaches’ role in PPEI

Coaches serve important roles in the lives of many young people. They assist young people to reap the natural benefits of sport and exercise, but the role of the youth sport coach carries great responsibility and extends far beyond winning games (Fraser-Thomas et al., 2005). Through their position of care and responsibility for young people within the sporting environments, coaches often serve as role models for young athletes and are able to develop trusting and enduring relationships with them (Mazzer & Rickwood, 2009). The coach-athlete relationship has an important role in young people’s development, both as athletes and as people (Jowett, O’Broin, & Palmer, 2010). These relationships are reciprocal, trusting and helping in nature, characterised by growing appreciation and respect for each other as individuals (Bloom, Durant-Bush, Schinke, & Salmela, 1998; Jowett, 2005). Most coaches aim to behave in a manner that will encourage the success and personal development of their young athletes (Williams et al., 2003).

Coaches are instructors or mentors who use sports as a setting in which to impart both sport-specific and life skills, contributing to physical, psychological and social development (Gould, Chung, Smith, & White, 2006). Coaches facilitate the development of many useful life skills and values—such as leadership, self-motivation, confidence, discipline, problem solving, decision making, effective communication and positive peer relationships, concentration, commitment, and personal growth (Bell, 1997; Danish, Forneris, & Wallace, 2005; Gould et al., 2006)—which allow young people to transfer and apply constructive principles and attitudes
learned through sport participation to other domains and into adulthood (Danish & Nellen, 1997). Skill development in this manner acts towards the promotion of wellbeing and prevention of mental health problems.

As assisting and improving performance in sport is a core aim of the coach’s role and poor mental health negatively impacts sporting performance (Jones, 2007), this should provide additional motivation for coaches to engage in promoting mental health and preventing mental health problems (Jones, 2007). Building psychological skills such as peaking under pressure, anxiety, coping with adversity, concentration and focus, goal setting, mental preparation, confidence and motivation, improves athletes’ performance (Danish & Nellen, 1997; Edwards, 2007). Accordingly, mental toughness, which has been defined as ‘an unshakeable perseverance and conviction towards some goal despite pressure or adversity’ (Middleton, Marsh, Martin, Richards, & Perry, 2004, p. 6) has long been valued in sport and is an important factor in determining sporting outcomes and success. Young people with greater mental toughness cope more effectively with adversity and pressure, possess increased resilience in the face of challenges, and deliver better, more consistent, cognitive and physical performance in sport (Crust, 2007; Kumar, 2012). These links provide motivation for coaches to play a role in the promotion and practice of psychological skills that are beneficial to young people’s mental wellbeing and help to prevent mental health problems (Edwards, 2007; Hancock, 2008).

In contrast to the significant focus on teachers, little research has examined the extent to which young people turn to their sporting coach for assistance with mental health problems. However, Pierce et al. (2010) argue that coaches are key individuals that are readily identifiable, respected, and easily accessed as a source of help for young people engaged in sport, who could be a valuable resource in facilitating more effective help-seeking and earlier intervention for
mental health issues. Furthermore, the position of leadership, trust and support that coaches fulfil, along with their regular contact with a large number of young people, suggests that coaches have the potential to be a helpful source of identification, assistance and recommendation for mental health problems amongst young people (Mazzer & Rickwood, 2009; Sherman, Thompson, Dehass, & Wilfert, 2005). For these reasons, coaches are in positions to make a major contribution to the mental health and wellbeing of young people (Donovan et al., 2006) and may be able assist in the promotion of mental health, prevention of mental health problems and early intervention for mental disorder amongst young people.

Coaches may be an especially vital link for preventing and intervening in mental health problems for which athletes are at higher risk. For instance, athletes are more at risk than non-athletes of developing disordered eating particularly in high-risk sports that emphasise a thin shape or small size, have an appearance aspect, use revealing sport attire or involve weight classes. Gymnastics, swimming, and running are among those sports that have been identified as high-risk sports for disordered eating (Sherman & Thompson, 2004). There is also increasing attention within sport on the problematic use of drugs and alcohol amongst young athletes. Coaches are in an ideal position to identify mental health problems such as these among young people.

2.10 Role Requirements

While teachers and coaches may be in valuable positions and have potential to support young people’s mental health through promotion, prevention and early intervention, such behaviour is not necessarily a formal part of their job description. Many professional positions require or benefit from performance of additional behaviours that may be considered above and
beyond the formal job description or requirements of the job. Such behaviour has been referred to as Organisational Citizenship Behaviour (OCB), defined as ‘individual behaviour that is discretionary, beyond the strict description of job requirements, not directly or explicitly recognised by the formal reward system, and that in the aggregate promotes the effective functioning of the organisation’ (Organ, 1988, p. 4). Such behaviour contributes ‘to the maintenance and enhancement of the social and psychological context that supports task performance’ (Organ, 1997, p. 91). Organisations rarely anticipate or specify the entire array of desired or required behaviours for a position in formally stated job descriptions (George & Brief, 1992). In view of this, OCBs are highly valued as they are often vital for achieving goals and are related to better job performance (Parker, 2007; Van Dyne & LePine, 1998).

Teaching and coaching are undoubtedly among the numerous professions that entail a great deal more than that stated in the formal job description. The roles of teachers and coaches are broad and encompass a variety of required skills and responsibilities (Donovan et al., 2006). While taking action to support young people’s mental health through promotion, prevention and early intervention, may not be in the formal job description of a teacher or coach; it is increasingly being encouraged and expected from these professionals. Consistent with this, one Australian study by Donovan et al. (2006) found both teachers and coaches to perform a number of activities which support young people’s mental health. The most frequent behaviours coaches identified performing were providing stimulation and positive reinforcement, not over criticising, having good communication, and setting realistic goals. For teachers, providing stimulating environments, positive reinforcement and good communication were salient behaviours for supporting the mental health of those in their care, along with recognising and dealing with problems promptly and sympathetically, and encouraging relationships with family and others.
Given the valuable positions teachers and coaches are in to positively influence young people’s mental health and the rising expectations for their involvement, further examination into the roles of teachers, coaches, and other community-based adults, and how they can best support young people’s mental health is required (Hampshire & Nicola, 2011; Mazzer & Rickwood, 2009). Additionally, the professional role identities of these adults, that is, the way they perceive their roles, need to be investigated to explore whether they view supporting mental health through promotion, prevention and early intervention as an appropriate part of their role (Mazzer & Rickwood, 2009).

2.11 Role-Related Perceptions

The way individuals perceive and define their professional roles has a powerful influence on behaviour and subsequent job performance (Parker, 2007). Teachers and coaches views of their positions are likely to impact their engagement in promotion, prevention and early intervention behaviour for mental health. It is less clear, however, which types of role related perceptions are most important for understanding behaviour (McAllister, Kamdar, Morrison, & Turban, 2007). Four main types of role perceptions have received interest in past research: perceived role breadth, perceived instrumentality, perceived role efficacy, and perceived role discretion. These role perceptions have been found to have a substantial impact on behaviour and have been specifically applied to examine interpersonal helping behaviour at work when such behaviour may be above and beyond the formal requirements of a job (McAllister et al., 2007), as may be the case for promotion, prevention and early intervention behaviour for teachers and coaches. McAllister et al. (2007) found these four role perceptions to account for more than 50% of the explained variance in professionals’ interpersonal helping behaviour.
2.11.1 Perceived role breadth

Role breadth is the most studied role-related perception (Bachrach & Jex, 2000; Morrison, 1994). It refers to whether an individual regards particular activities, or set of behaviours, as part of their job (McAllister et al., 2007). Role breadth is subject to an individual’s perception; so, two people holding the same formal position can differ in how broadly they each define that job. Perceived role breadth increases when individuals view more activities as expected within their role. Previous studies have shown perceived role breadth to directly predict behaviour, whereby, individuals are more likely to perform behaviour they perceive as within their role breadth (Coyle-Shapiro, Kessler, & Purcell, 2004; Morrison, 1994). Furthermore, McAllister et al. (2007) found role breadth to be the strongest predictor of professionals’ interpersonal helping behaviour when compared to perceived instrumentality, perceived role efficacy, and perceived role discretion.

The focus on promoting and supporting mental health within schools is relatively recent, and while the past decade has seen significant developments in Australian school-based mental health with the development of initiatives such as MindMatters advocating a whole-school approach to mental health (MindMatters, 2009), this is not necessarily perceived by all teachers as being a required part of their role (Finney, 2006). Although not being a formal requirement, teachers have generally been found to endorse the involvement of schools in addressing the mental health needs of students and recognise that as teachers they have a responsibility to care for and address the mental wellbeing and concerns of their students (Reinke, Stormont, Herman, Puri, & Goel, 2011; Rothi et al., 2008). Graham et al. (2011) in a study of over 500 teachers from NSW, Australia, reported that most teachers acknowledged they play a significant role in developing the social and emotional wellbeing of young people and viewed mental health
education as important. Only a minority voiced beliefs that supporting the social and emotional well-being of students was not part of their role and felt a sense of burden by students’ needs in this area.

The potential of coaches to support young people’s mental health is considerably less well recognised than that of teachers. Despite, national mental health policies—such as the Australian Government’s National Action Plan for Promotion, Prevention and Early Intervention (CDHAC, 2000a) and the Fourth National Mental Health Plan (CoA, 2009)—having emphasised the influence that adults within community settings, including the sports and recreation sectors, can have for promotion, prevention and early intervention, the role of coaches has received little attention in this area. Coaches’ views concerning the breadth of their role and whether or how it extends to supporting young people’s mental health has not previously been examined. However, given their potential to positively influence young people’s mental health and well-being it is important that coaches’ opinions regarding this opportunity are explored.

2.11.2 Perceived role efficacy

Role efficacy refers to a specific form of self-efficacy relating to an individual’s perception of their competence in performing a given type of behaviour (Bandura, 1977; McAllister et al., 2007). Self-efficacy is a well-established predictor of behaviour and performance (Bandura, 1986; Beauchamp, Bray, Eys, & Carron, 2002). Surprisingly, McAllister et al. (2007) did not find that self-efficacy influenced professionals’ interpersonal helping behaviour. They suggested that the unexpected result may have occurred due to the professionals having perceived consistently high efficacy for the particular helping behaviours that were assessed and that more difficult tasks may be more affected by efficacy beliefs.
Given that young people are most likely to seek help for their mental health problems from people they know and trust, there is a clear need to ensure teachers and coaches feel skilled and able to take on this role (Hampshire & Nicola, 2011). ResponseAbility is an Australian initiative that targets this need by providing pre-service teacher education and training on how to assist young people with particular mental health needs (Hunter Institute of Mental Health, 2012). Ross, Cousins, and Gadalla (1996) reported that a teachers’ sense of self-efficacy determines the level of effort they put into teaching, their degree of persistence when faced with challenges, and the selection of tasks they choose to complete in their job. Furthermore, teachers’ perceptions of their own capability to recognise and address mental health concerns influence their responses and the subsequent effectiveness of school-based mental programs (Graham et al., 2011; Weare & Nind, 2011).

Graham et al. (2011) in an Australian-based study, found teachers to have mainly positive self-efficacy, with the majority of teachers reporting they were moderately confident in their ability to deal with mental health issues. Of concern, however, are other reports that teachers may lack the skills and confidence to engage with mental health issues (Finney, 2006; Kidger et al., 2010). Studies of teachers’ perceptions reveal that many feel inadequately prepared to identify or implement appropriate mental health supports for students (Reinke et al., 2011). Rothì et al. (2008) described teachers perceiving a global lack of experience and training for supporting students’ mental health. Kratochwill and Shernoff (2004) suggest that, while teachers may be the professionals who are most likely to be able to impact the behaviour and mental health needs for young people on a regular basis, they may neither have the resources nor the knowledge to do so effectively.
It is important that teachers’, as well as students’, mental health literacy is supported. Mental Health First Aid (MHFA) is a program that targets mental health literacy and has been developed to assist adults to respond to mental health concerns and crises. MHFA has been defined as ‘the help provided to a person developing a mental health problem or in a mental health crisis. The first aid is given until appropriate professional help is received or the crisis resolves’ (Langlands, Jorm, Kelly, & Kitchener, 2008, p. 158). A specialised version of MHFA focusing on how to assist adolescents with mental health problems has been developed and delivered to teachers (Kitchener & Jorm, 2007). This training has been found to have positive effects on teachers’ mental health knowledge, attitudes, confidence in providing help to students (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010). Teachers’ confidence, capability, and concerns for responding to young people’s mental health needs have been identified as important areas for further investigation (Crawford & Caltabiano, 2009).

Coaches have only recently begun to gain recognition as a source of support for young people’s mental health (Mazzer & Rickwood, 2009). Consequently, there has been little research investigating their perceived ability in this area; so they are likely to lack the necessary skills and knowledge to effectively influence young people’s mental health and wellbeing (Bapat, Jorm, & Lawrence, 2009). Coaches may benefit from education and training in mental health to enable better support for young people and their mental health needs. Programs have now begun to be developed that target coaches and the sports setting as an avenue to benefit mental health. For instance, the headspace centre in Wollongong has offered a training package ‘mind your game’ to sports coaches and club leaders which aims to increase their ability to support to young people in their club by improving their understanding of mental health problems, developing confidence and skills in identifying and responding to problems, and promoting positive attitudes toward
help-seeking (headspace, 2013). Similarly, MHFA has recently been applied within the sports context. The ‘Coach the Coach’ (Pierce et al., 2010) project provided MHFA training to coaches of rural football teams in Victoria, Australia. Encouragingly, the training improved coaches’ knowledge of mental disorders and capacity to recognise mental illness as well as markedly increased their confidence in helping someone with a mental health problem. Online information and support for coaches and sports clubs regarding mental health in sport is also becoming more accessible through initiatives such as ‘Play by the rules’, which provides online information for clubs and coaches on how to help someone in crisis or whose mental health they are concerned for (Sporting Pulse, 2013).

2.11.3 Role instrumentality

The third role related perception, role instrumentality, can be defined as whether an individual perceives a relationship between performance of behaviour and outcomes such as rewards and punishment (McAllister et al., 2007). Anticipation of inducements or rewards contributes to and is an important factor in an individual’s willingness to engage in a behaviour (Coyle-Shapiro, 2002). Behaviour is often associated with positive or negative consequences from an organisation and can serve as a measure of job performance (Parker, 2007). Furthermore, behaviour that is linked to valued outcomes is more likely to be performed (Bandura & McClelland, 1977). McAllister et al. (2007) reported that role instrumentality was a significant predictor of professionals’ interpersonal helping behaviour.

Role instrumentality is likely to influence teachers’ and coaches’ engagement in promotion, prevention and early intervention behaviour as activities that are rewarded are likely to increase whereas those that are not rewarded, especially if they are associated with negative consequences, are less likely to occur. Though there is a growing range of high-quality mental
health resources available, particularly for school-based mental health, they are not routinely incorporated into ongoing professional development and performing promotion, prevention and early intervention activities may not currently be associated with valued outcomes for these professionals. Teachers’ and coaches’ role instrumentality for supporting young people’s mental health has not previously been investigated.

2.11.4 Role discretion

Finally, role discretion refers to the extent to which an individual perceives choice with respect to performing a particular behaviour (McAllister et al., 2007; Organ, 2006). Behaviour that is considered discretionary can vary from person to person and across different situations (Organ, 1997). Little research has investigated whether the extent that individuals have freedom to choose to perform interpersonal helping behaviour influences their actions, without confounding this discretion with role breadth. However, McAllister et al. (2007) emphasised the importance of role discretion as a construct separate to role breadth, highlighting that individuals can view particular behaviour as ‘not my job’ but still perceive little choice in whether to perform the behaviour due to social pressure or other factors. Such pressures may influence the extent to which teachers and coaches perform activities for the promotion, prevention and early intervention for young people’s mental health. Role discretion in relation to promotion, prevention and early intervention activities for teachers and coaches has not yet been examined.

2.12 Chapter Summary and Rationale for the Current Research

In summary, there is a high prevalence of mental health problems among Australian young people, which negatively impact their quality of life. Adolescence is therefore a critical period in which to provide mental health support and interventions to improve mental health
and wellbeing. Taking early and effective action facilitates better outcomes for young people with mental health problems. Promotion, prevention and early intervention is vital in improving the mental health and wellbeing of all young people, as well as reducing the prevalence and burden of mental health problems and mental disorders. But young people are reluctant to seek professional help, and often need the assistance of adults to identify a mental health problem, and guide them to appropriate supports and services.

Effective support and intervention for mental health can be carried out across a range of contexts. As young people prefer to seek help from people they already know, many adults in community-based roles are in positions able to support their mental health and assist them on their help-seeking pathway. Teachers and sports coaches are in particularly valuable positions to make major contributions to young people’s mental health, as they have the most contact with them. Such community-based professionals also occupy positions of care and responsibility for young people and are able to develop trusting and enduring relationships with them which provides a more comfortable setting for young people to discuss their mental health concerns. Additionally, through their roles as facilitators of learning and personal development, teachers and coaches may be able to effectively assist in the promotion of mental health and wellbeing and prevention of mental health problems amongst young people. Consequently, there has been a growing focus on the role of adults within the community, particularly teachers and more recently coaches, in supporting young people’s mental health.

Highlighting the potential for community-based adults to influence young people’s help-seeking pathways and the positive contribution they can make in enhancing the mental health of the young people they have working relationships with may achieve substantial population benefits (Donovan et al., 2006). Nevertheless, while many adults in community-based roles,
including teachers and coaches, have potential to support young people’s mental health, how they should or could be involved is not well defined. In addition, it is not well understood what actions teachers and coaches are currently performing to support young people’s mental health. Further exploration of the role of community-based adults and their influence on young people’s mental health is therefore required (Mazzer & Rickwood, 2009).

Investigation of teachers’ and coaches’ involvement in promotion, prevention and early intervention behaviour for young people’s mental health would raise awareness on how these community-based adults are currently supporting young people’s mental health and shed light on how to improve, expand, or enhance their influence. Through understanding what they can do within their roles to promote young people’s mental health, help prevent the development of mental health problems and facilitate early intervention, teachers and coaches have potential to assist in reducing the number of young people who develop mental health problems, as well as assisting to bridge the gap between the number of young people who need help and the currently low proportion of those who seek and receive professional mental health care. Notably, such an investigation would require developing a tool to assist in measuring promotion, prevention and early intervention behaviour, as there is no existing measure.

Furthermore, although the way individuals perceive their roles can be a powerful influence on behaviour little is known about teachers’ and coaches’ views regarding their role in supporting young people’s mental health. Only a small amount of research has been conducted in Australia on how teachers view and respond to mental health issues experienced by young people at school and whether they feel burdened by this apparent expansion of their role (Kidger et al., 2010). Previous research on the role of coaches in young people’s mental health, and the skills they have to promote mental health and encourage early response to mental health
concerns, is even more scarce (Pierce et al., 2010). A better understanding is required of teachers’ and coaches’ confidence and how well-equipped they feel to effectively support young people’s mental health and wellbeing (Graham et al., 2011). It is, therefore, important to investigate their perceptions and views towards supporting mental health within their role. Factors that may influence teachers’ and coaches’ support of mental health within their roles need to be considered. Potential challenges or limitations that impact teachers’ and coaches’ ability and/or willingness to support young people’s mental health within their professional roles need to be identified.

2.13 Aims

Given the high prevalence of mental health problems among young people and the potential for community-based adults to assist, this research sought to assist in improving the mental health and wellbeing of Australian young people by exploring the roles of teachers and sports coaches in supporting young people’s mental health. This research sought to address gaps in the literature by investigating teachers’ and coaches’ views of their roles and identifying whether and how they are actively involved in promotion, prevention, and/or early intervention for young people’s mental health.

Specifically, this research aimed to:

1. Investigate teachers’ and coaches’ awareness, acceptance, and involvement of their roles in promotion, prevention and early intervention for young people's mental health.

2. Identify specific types of promotion, prevention and early intervention activities that teachers and coaches may perform.
3. Develop a measure of promotion, prevention and early intervention behaviour for mental health relevant for teachers and coaches.

4. Investigate and compare teachers’ and coaches’ involvement in promotion, prevention and early intervention activities for young people’s mental health.

5. Identify and explore predictors of teachers’ and coaches’ involvement in supporting young people’s mental health in relation to role perceptions.

6. Investigate barriers or challenges to supporting young people’s mental health within the teacher and coach roles.
CHAPTER THREE: EXTENDED METHODOLOGY

3.1 Chapter Introduction

This chapter describes the overall design and mixed methodology of this research and provides a rationale for the qualitative and quantitative methods employed. The methods—participant characteristics, procedure and recruitment, techniques, and approach taken to data analysis—for three phases of research are discussed.

3.2 Research Design

The research used a sequential exploratory mixed methods design which consisted of three phases. The first phase addressed the first, second, and sixth research aims to generate a rich understanding of teachers’ and sports coaches’ views of their role in supporting young people’s mental health, barriers or challenges to this role, and the types of activities they may perform. Phase I used a qualitative design involving individual semi-structured interviews with teachers and coaches of young people aged 12-18. The second phase addressed the third research aim by using an expert consensus method to develop a quantitative measure of promotion, prevention and early intervention behaviour, as there was no existing measure. The third phase addressed the fourth research aim of providing quantitative description of teachers’ and coaches’ involvement in promotion, prevention and early intervention activities. Phase III incorporated the measure developed in phase II into an online quantitative survey, which was completed by teachers and coaches of young people. The online survey additionally addressed the fifth research aim of examining the influence that role perceptions have on these adults’ involvement in supporting young people’s mental health.
3.3 Rationale for Mixed Method Design

Given that little previous research had investigated teachers and coaches views and involvement in promotion, prevention and early intervention for young people’s mental health, the current research was exploratory in nature, primarily concerned with discovery and the building of hypotheses and theory throughout the research (Paul Vogt, 2005; Stebbins, 2008). A sequential exploratory mixed methods design—characterised by the inclusion of a qualitative phase followed by a quantitative phase with combined or integrated findings in an overall research program (Creswell, 2008; Johnson & Onwuegbuzie, 2004)—was utilised. This approach effectively accommodated the exploratory nature of this research and fully addressed the combination of research aims (Johnson & Onwuegbuzie, 2004). The sequential exploratory typology of mixed methods designs is particularly advantageous and has been indicated as the procedure of choice when developing a measure in the absence of adequate existing instruments (Plano Clark & Creswell, 2011). A developmental approach to survey development and data analysis occurred within this design, whereby findings from the initial qualitative investigation (phase I) were used to inform the development of a quantitative measure (phase II), that was subsequently administered to a larger sample (phase III; Creswell & Plano Clark, 2007).

3.4 Strengths and Limitations of Mixed Methods Research

Mixed methods research is a complementary form of research that encourages an eclectic approach to study design and implementation, rather than being limited to a single (qualitative or quantitative) research methodology paradigm (Johnson & Onwuegbuzie, 2004). While historically there has been debate about the use of mixed method designs—namely, the incompatibility thesis, which posits that qualitative and quantitative research paradigms and
associated methods cannot and should not be mixed (Howe, 1988)—it is now recognised as the third major research paradigm in the social and behavioural sciences (Johnson & Onwuegbuzie, 2004).

The fundamental goal of mixed methods research is to collect multiple data using different approaches within a single research program in such a way that the produced combination is likely to result in complementary strengths of research design (Johnson & Onwuegbuzie, 2004). By incorporating the strengths of both qualitative and quantitative methodologies, mixed method designs provide opportunity for greater insight and understanding of research problems than either approach in isolation (Creswell, 2008; Johnson & Onwuegbuzie, 2004; Plano Clark & Creswell, 2011).

A sequential exploratory mixed methods design offered a number of core advantages for the current research including:

- Expansion—The use of mixed methods allowed exploration of a greater array of research questions and elicited insights that may have been overlooked or missed by the inclusion of a single method, either the interviews or online survey, in isolation.

- Complementarity of findings—Findings from interviews in phase I were able to be elaborated, enhanced, and clarified in the subsequent phases II and III.

- Triangulation—The strength of results was increased through convergence and corroboration of findings across different methods, i.e., interviews and online survey, which studied the same phenomenon.

- Development—Findings from each phase helped to inform the development of the subsequent phases. For instance, phase III was influenced by the results of both phases I and II (Greene, Caracelli, & Graham, 1989).
Mixed methods research also has a number of challenges or limitations. The use of more than one method requires more extensive data collection. Additionally, the data analysis of both text and numeric data is time-intensive and requires knowledge of both quantitative and qualitative forms of research (Creswell, 2008). Such challenges were considered and were able to be accommodated within the scope of this PhD research.

3.5 Phase I Methodology

3.5.1 Aim and overview

Phase I aimed to investigate teachers’ and coaches’ awareness, acceptance, and involvement of their roles in promotion, prevention and early intervention for young people’s mental health. It also sought to identify types of PPEI activities they may perform as well as investigate barriers or challenges to supporting young people’s mental health within the teacher and coach roles. Phase I was an exploratory qualitative investigation consisting of interviews with 34 teachers and sports coaches of young people aged 12-18.

3.5.2 Rationale for phase I approach

A qualitative approach was employed in phase I as it best accommodated the exploratory and descriptive nature of the research aims in this phase. The main characteristics of qualitative research include induction, discovery, and exploration (Johnson & Onwuegbuzie, 2004). Qualitative methods are considered to offer greater breadth and deeper exploration and understanding of inquiries than quantitative approaches (Silverman, 2009). The qualitative design employed in phase I allowed greater depth and richer, more comprehensive exploration and understanding of teachers’ and coaches’ views of their roles in supporting young people’s mental health, through a small number of semi-structured interviews. Additionally, this
qualitative investigation provided information and insight into the types of PPEI activities that teachers and coaches may perform to support young people’s mental health, which helped to inform the development of a quantitative measure of PPEI activities in phase II.

3.5.3 Participants

Participants were 34 teachers and sports coaches of young people aged 12 to 18, who were employed or volunteer within Canberra, Australia. Twenty-one teachers (11 female and 10 male) and 13 coaches (five female and eight male) were included in the sample. The age of participants ranged from 23 to 65 years ($M = 36.3$, $SD = 11.5$). Years of experience in their role ranged from seven weeks to 49 years, with teachers’ mean experience 12.0 years ($SD = 10.7$) and coaches’ mean experience 14.8 years ($SD = 9.7$).

Teachers of grades seven to 12 from six schools within the ACT participated in the study. All 21 teachers were employed at co-educational schools; 16 taught at public high schools or colleges and five at private or independent schools. Seven teacher participants predominantly taught the core subject areas of mathematics, sciences, English, and SOSE; eight were primarily physical education (PE) teachers; and six taught other subjects such as wood, metal, and food technologies, religion, or psychology.

Coaches from a variety of community sports, including basketball, netball, football (soccer), Australian Football Rules (AFL), touch football, rugby union, rugby league, tennis, and cricket, participated in the study. Most coaches who participated were involved with coaching both adolescent males and females or mixed gender adolescent groups; four predominantly coached females; and two coached mainly male adolescents. All coach participants reported they had coached over a variety of levels of sport, and most had some experience of the full range of social, competitive, and elite sport.
3.5.4 Procedure

Teachers and sports coaches within Canberra, Australia, were invited to participate in the research through a snowballing circulation of an advertisement flyer (see Appendix A). The flyer was emailed to local contacts within the teaching and coaching communities (see Appendix B), who then further circulated the flyer to colleagues and other relevant individuals.

Participation involved taking part in an individual semi-structured interview. Commitment of time for research participation can be challenging for many teachers and coaches due to their demanding professional schedules, therefore, convenience and brevity were prioritised. Interviews were arranged at a time and location suitable to each interested participant and were limited to approximately 30 minutes in duration. Overall the interviews ranged from 11:43 minutes to 34:06 minutes ($M = 21:38$, $SD = 7:19$) in duration. All interviews were conducted by the research candidate and were audio recorded and fully transcribed. Information about the research (see Appendix C) was provided and informed consent (see Appendix D) was obtained prior to participation in the study. Participants were able to request a copy of the transcript of the interview for checking, but no participant made this request. A summary of findings was also provided to participants who elected to receive it ($n = 20$).

3.5.4.1 Rationale for semi-structured interviews

Semi-structured interviews are able to generate in-depth discussions of both targeted and opportunistic areas, with the interviewer being able to adjust and adapt to participants’ responses throughout and probe for further information where appropriate or interesting. Interviews were selected as the approach for phase I rather than focus groups as value was placed on obtaining each individual’s understanding and awareness of issues relating to young people’s mental health and promotion, prevention and early intervention. The group setting of focus groups would have
limited this exploration as individual responses may have been influenced by the responses and opinions of other group members. Semi-structured interviews were considered the best option and were used.

### 3.5.5 Interview schedule

Interview questions were designed by the candidate, in consultation with the candidate’s supervisors and were informed by literature. Demographic information was collected along with questions aiming to explore participants’ awareness, acceptance, and involvement, and skills in supporting young people’s mental health through promotion, prevention and early intervention behaviours. Additional questions addressed limits or challenges to participants providing such support.

The main questions discussed in the interviews were:

- Do you see young people’s mental health as relevant to or part of your role as a teacher or coach?
- What is your understanding of the terms: (a) Promotion; (b) Prevention; and (c) Early Intervention for young people’s mental health? And how do you think each of these areas influence your role?
- Do you believe your role allows capacity to support young people’s mental health?
- Do you feel you have the skills to support a young person with their mental health?
- Are you confident in your ability to support young people with their mental health?
- Have you had experience(s) of young people turning to you for support with their mental health concerns?
- What actions, if any, do you perform that you believe benefits young people’s mental health or wellbeing?
• What limits are there in supporting young people’s mental health within your role?
• What involvement with young people’s mental health do you intend to have in future?

Of special interest were participants’ understanding and perceptions of their role across the very broad area of young people’s mental health and whole PPEI spectrum of promoting positive mental health and wellbeing, preventing the development of mental health problems, and identifying and intervening early in mental disorder. So as not to pre-empt understanding of how participants defined mental health and the breadth of their role across promotion, prevention and early intervention activities, no definitions were initially provided to allow individual perceptions to emerge. Part way through the interview, however, once participants’ understanding of PPEI had been explored in question two, explanations of PPEI were provided to participants. This was required to ensure participants had an agreed understanding of these constructs for the remaining interview discussion as well as to prompt specific information relating to PPEI, which was not otherwise evident. The following definitions were provided (CDHAC, 2000a):

*Mental health promotion* is any action taken to maximise mental health and wellbeing among populations and individuals.

*Prevention* refers to interventions that occur before the initial onset of a disorder to prevent the development of disorder.

*Early intervention* comprises interventions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder.
3.5.6 Data analysis

Transcripts of the interviews were analysed using thematic analysis and a combination of inductive and deductive approaches (Fereday & Muir-Cochrane, 2006). Thematic analysis involves repeatedly examining interviews for patterns of emphasis across responses, and systematically coding responses into themes. This method exposes commonalities concerning dominant themes as well as differences between participants and attributes (Miles & Huberman, 1994).

Data were first coded using an inductive approach, whereby repeating ideas and patterns form ‘data driven’ themes which emerge from participants’ discussions (Boyatzis, 1998). A second layer of coding was then conducted using a deductive approach in which data are coded based on a priori themes derived from a philosophical or theoretical framework (Crabtree & Miller, 1999). In the current research four types of role perceptions—role breadth, role instrumentality, role efficacy, and discretion—as discussed in McAllister et al. (2007), were incorporated as theoretically based themes. Preliminary examination of the data was conducted by hand, followed by the use of NVivo qualitative data analysis software, version 9 (NVivo, 2010).

Tests of coding reliability were conducted, whereby after completion of initial coding of all transcripts, six transcripts were re-coded by the same coder to assess coding consistency over time (Richards, 2005). Inter-rater reliability was also tested by a fellow higher degree by research student coding six clean transcripts. Coding assignment was compared between coders with a calculated Kappa coefficient of .80, which is above the level of .75 generally considered excellent (Robson, 2002). Coding discrepancies were resolved by consultation with the
candidate’s research supervisor, providing further strength of reliability through researcher triangulation.

To determine the level of representativeness of responses, four levels of frequency labels were applied. As proposed by Hill, Knox, Thompson, Williams, and Hess (2005), a theme that applied to all or all but one of the cases was considered general. A typical theme applied to more than half of the cases. A theme considered variant included at least three cases and up to half of all cases. A theme that included two or three cases was considered rare. Findings that emerged from only one case were not reported as they were not considered to be descriptive of the sample.

Phase I is reported in paper one (see chapter four), paper two (see chapter five), and paper three (see chapter six).

3.6 Phase II Methodology

3.6.1 Aim and overview

The primary aim of phase II was to develop a measure of promotion, prevention and early intervention behaviour in order to investigate and compare teachers’ and coaches’ involvement in such behaviour to support young people’s mental health. Phase II provided an important link between the qualitative and quantitative components of this research program. It used an expert consensus method to create a 15-item measure of PPEI behaviour for mental health.

3.6.2 Rationale for phase II approach

No measure of promotion, prevention and early intervention behaviour was previously available. Therefore, phase II of this research sought to create a measure comprising a set of activities that characterise promotion, prevention and early intervention and capturing the range
and diversity of actions that lie within each of these categories for both teachers and coaches. Development of this measure addressed a significant gap in the literature and provided a critical link for the sequential exploratory mixed methods design of this research by enabling the qualitative findings of phase I to be quantitatively examined in phase III.

### 3.6.3 Participants

Ten experts in the field of promotion, prevention and early intervention for mental health took part in this phase. The experts were identified and selected by the candidate and research supervisor based on Australian publishing in the field, those demonstrating national prominence in policy concerning promotion, prevention and early intervention for mental health and those motivating advances in youth mental health. Seventy-seven percent (10 of 13) of invited experts participated and returned responses to the activity checklist.

### 3.6.4 Procedure

The first step in developing a measure of promotion, prevention and early intervention behaviour was to identify a pool of behaviours that teachers and coaches may engage in that could influence young people’s mental health through promotion, prevention and early intervention. To do this the qualitative analysis of interview transcripts from phase I was drawn upon and a pool of 70 activities were identified as potential items. Each item described an activity that may be performed by adults in community-based roles that can affect young people’s mental health. The activities were tentatively categorised into three groups by the candidate and research supervisor: activities that benefit the promotion of mental health (promotion), activities that support the prevention of mental health problems (prevention) and

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1 The overall design and methodology of phase II and III have been peer reviewed and published in paper four (see chapter seven).
activities that represent early intervention for mental health problems (early intervention). An additional category was formed for activities that fell outside the scope of these three areas.

To minimise researcher bias and to examine the validity of the proposed categorisation of activities, experts in the field of promotion, prevention and early intervention for mental health were consulted. Ten to 15 activities proposed by the candidate and supervisor as depicting the range and diversity of activities within each of the three categories—promotion, prevention and early intervention—were selected from the pool of 70 potential items for inclusion in a randomly ordered 40-item promotion, prevention and early intervention activity categorisation checklist.

The 40-item PPEI activity checklist (see Appendix E) was sent via email to invited experts in the field of promotion, prevention and early intervention for mental health (see Appendix F). Experts were asked to complete the checklist by indicating whether they thought each activity was best categorised as: the promotion of mental health, the prevention of mental health problems, early intervention in mental health, or unclear or not represented by any category (none/unclear). Selecting more than one category for a given activity was allowed if a single category was not able to be determined. To avoid the influence of one respondent on another, experts were recruited and responded independently via email.

3.6.4.1 Rationale for expert consensus method

Consensus methods are used to enable effective decision making in situations where there is contradictory or insufficient information (Hasson, Keeney, & McKenna, 2000). This was an appropriate approach for development of a measure of promotion, prevention and early intervention as activities that represent these categories are not well defined. While the conceptual framework is well articulated (CDHAC, 2000a), categorising specific activities and behaviours for promotion, prevention and early intervention is a challenge. Phase II used the
consensus method of the Delphi survey technique which aims to obtain expert opinion in a systematic manner generally through individual and (pseudo-) anonymous response to questionnaires (Hasson et al., 2000). The Delphi technique is a widely used method for gathering data, exploring topics and assessing consensus from selected specialised respondents within their domain of expertise (Hsu & Sandford, 2007). As was the case in the current research, Delphi respondents should be highly competent within the targeted area of knowledge as this assists the content validity of findings (Hasson et al., 2000).

### 3.6.5 Data analysis

Responses were analysed and compared over the 10 participants’ responses. Items were scored one point for each response in a category. This resulted in each item recording four scores, one for each category: (a) Promotion; (b) Prevention; (c) Early Intervention; (d) None/Unclear. A higher score in a category indicated greater expert consensus or agreement that the item was an activity representative of that category. For example the item ‘encourage inclusivity and participation of all young people in activities’ scored nine (out of a possible 10) in the promotion category, indicating it is an activity that promotes the mental health and wellbeing of young people. Items were then grouped into their highest scoring category and ranked from highest to lowest score within that category. Five activities with the greatest consensus were selected from each category to create a final 15-item set of activities that characterise promotion, prevention and early intervention behaviour.

Phase II is reported in paper four (see chapter seven).
3.7 Phase III Methodology

3.7.1 Aim and overview

Phase III of the research aimed to investigate and compare teachers’ and coaches’ involvement in promotion, prevention and early intervention activities for young people’s mental health. This phase additionally sought to explore predictors of teachers’ and coaches’ involvement in supporting young people’s mental health. In order to address these aims, an online survey that included the measure of PPEI behaviour developed in phase II along with measures of role perceptions proposed by McAllister et al. (2007) was used.

3.7.2 Rationale for phase III approach

Phase III used quantitative methodology in the form of an online survey to confirm, or disconfirm, and expand qualitative findings from phase I. Quantitative research brings with it the advantages of larger sample size and improved the generalisability of findings, standardised data collection, and statistical analysis (Creswell, 2008; Johnson & Onwuegbuzie, 2004).

3.7.3 Participants

Participants were 124 teachers (76 female, 45 male and three did not report) and 147 coaches (50 female, 96 male and one did not report) of 12 to 18-year-olds from Canberra, Australia, creating a total sample of 271. The age of teacher participants ranged from 22 to 69 years, with a mean age of 41.88 (SD = 12.07). The age range of coach participants was slightly greater from 18 to 73 years, with a similar mean age of 39.33 (SD = 12.21). Participants’ length of experience in their role ranged from less than one to 50 years, with teachers’ mean experience of 14.55 years (SD = 11.43) being slightly greater than coaches’ mean experience of 9.39 years (SD = 8.46).
Teachers from eight schools within Canberra participated in the study. Most (n = 80) teachers were employed at co-educational schools, rather than single sex schools (n = 36; eight not reported). Sixty-nine taught at government high schools or colleges and 55 at non-government (private or independent) schools. Teachers who participated in the study taught a range of subjects including mathematics (n = 21), science (n = 11), English and social studies (n = 34), physical education (PE; n = 15) and other (elective) subjects such as drama, information technology and religion (n = 40; three did not report).

Coaches from four sports participated: soccer (football; n = 55), netball (n = 30), basketball (n = 39), AFL (n = 20; three did not report). Slightly more coaches worked with girls only (n = 64) than boys only (n = 54) or mixed gender groups (n = 31). The level of sport competition that participants coached included social (n = 55), competitive (n = 118) and elite (n = 20) sport, with many (n = 46) reporting they coach across a variety of levels.

3.7.4 Procedure

Principals and presidents of each selected school and sports club were initially contacted by phone and/or email. Those who gave permission for involvement in the research forwarded an email from the primary researcher with a link to the online survey inviting teachers and coaches of young people aged 12–18 to participate in the research (see Appendices G & H). Information about the research (see Appendix I) was provided and informed consent (see Appendices J & K) was obtained prior to participation in the study. Participants then completed the survey online (see Appendices J & K). Reminder emails were sent to principals and presidents to relay to teachers and coaches to increase participation rate. A summary of findings was provided to each participating school and sports club.
3.7.4.1 Participant incentives

Offering small incentives for participation in research has consistently been found to improve response rates and encourage greater participation in research with human subjects when using online surveys (Evans & Mathur, 2005). For this reason, all participants in the online survey were given the opportunity to enter a prize draw to win an Apple iPad (see Appendix L) (Cobanoglu & Cobanoglu, 2003; Evans & Mathur, 2005). To enter the draw to win the Apple iPad, participants were given the option at the completion of the online survey to be redirected to a separate entry form page, where they were required to enter their preferred contact details, including their first name and contact email or phone number. iPad entry form data was recorded and stored separately to survey responses to maintain anonymity of responses and participant privacy. At the completion of data collection in November 2012, a winner of the Apple iPad incentive was selected using random number generator technology. The winner was contacted by the researcher and collection of the prize was arranged.

3.7.4.2 Recruitment of teachers

Teachers were recruited through their schools. To ensure that a representative cross-section of schools and school characteristics was included in the research, a multi-stage sampling technique combining a number of sampling methods was used. This involved alphabetically sorting and stratifying a list of all schools within Canberra (obtained from Directorate of Education and Training website) into categories: government high schools, government colleges, non-government independent schools and non-government Catholic schools. Systematic random sampling was then used to select every second school for inclusion. Twenty-three schools were invited to participate in the study; eight of these schools agreed and were included in the final sample. Reasons for refusal were generally that the school had too many other commitments to
participate at this time. All teachers of 12 to 18-year-olds from the selected schools were then invited to participate in the study.

3.7.4.3 Recruitment of coaches

Multi-stage sampling was similarly used for the recruitment of coaches in the study. Coaches were accessed through sports clubs of the four most popular team sports in Australia: football (soccer), netball, basketball and AFL (ASC, 2010). These sports were chosen to increase the representativeness of findings by accessing a large pool of coaches in contact with a greater proportion of young people. Individual sports were not targeted as coaching individuals entail dynamics different from coaching teams, and team coaches are more similarly comparable with school teachers by having contact with a large number of young people in group situations. A list of eligible sports clubs was developed by accessing each sport’s state organisation website. All sports clubs based within Canberra that were listed on their respective sport’s state organisation website and involved young people aged between 12 and 18 years were selected. Thirty-one sports clubs fit these inclusion criteria and were invited to participate in the research, of which 21 clubs agreed to participate, including: six football (soccer), four netball, four basketball and seven AFL clubs. All coaches of 12 to 18-year-olds within the selected sports clubs were then invited to participate.

3.7.4.4 Rationale for online survey

The survey was administered in online format to maximise the number of participants, and minimise inconvenience to participants and costs. Online surveys have been shown to be equally reliable as traditional methods for collecting data (Carlbring et al., 2007). For the current research, advantages of the online survey format included: broader range of access to target population for recruitment (by not having to physical visit each site, organised via email); time-
efficient administration and data collection; increased convenience and flexibility for participants to respond; and instant data entry and collation (Evans & Mathur, 2005). The cross-sectional nature and use of fixed-choice response format in the online survey further reduced the commitment of both time and effort required for participation. Low response rates can be a weakness of online surveys, so additional processes—including regular contact with participating organisations (schools and sports clubs), electronic reminders for potential participants, and participant incentives—were built into the recruitment procedure to encourage greater participation.

The online survey was designed to investigate the research aims of comparing teachers’ and coaches’ involvement in promotion, prevention and early intervention behaviour as well as predictors of such involvement. Organisation Citizenship Behaviour (OCB) literature identifies that individuals’ perceptions of their role influence their behaviour within a given job. McAllister et al. (2007) propose four distinct type of role perceptions—role breadth, instrumentality, efficacy, and discretion—and apply these perceptions to interpersonal helping behaviour. Measurement of these role perceptions was, therefore, incorporated into the survey as they may influence or predict teachers’ and coaches’ involvement in PPEI behaviour. This framework also captured most of the qualitative themes that were derived in phase I.

3.7.5 Online survey

The survey (see Appendices J & K) was a brief quantitative cross-sectional survey predominantly using a fixed-choice likert scale response format. In order to address the research aims of phase III the online self-report survey measured the following constructs:
3.7.5.1 PPEI behaviour

The measure developed in phase II was used to assess teachers’ and coaches’ involvement in behaviour that supports the promotion of mental health; behaviour that acts for the prevention of mental health problems; and behaviour that assists early intervention. Participants were asked to indicate the extent to which they engage in each item within their role as a teacher or coach. Responses were given on a 5-point scale, from 1 ‘Never’ to 5 ‘Very Often’. The three subscales—Promotion, Prevention and Early Intervention—contained five items each, and were calculated by averaging the relevant item scores. Higher scores indicated greater engagement in that type of helping behaviour. The Promotion, Prevention and Early Intervention subscales demonstrated adequate to high internal consistency, reporting Cronbach’s alphas of 0.69, 0.82 and 0.88. The reduced reliability of promotion is likely due to the construct of promotion itself being more broadly defined and inclusive of a larger range of activities than either prevention or early intervention.

3.7.5.2 Role perceptions

Four types of role perceptions used by McAllister et al. (2007) were also measured in the questionnaire: Perceived Breadth, Instrumentality, Efficacy, Discretion. These role perceptions have reported high internal consistency when applied to interpersonal helping behaviour, with Cronbach’s alphas of .89 for role breadth, .88 for role instrumentality, .91 for role efficacy, and .90 for role discretion (McAllister et al., 2007). Role breadth was measured with the statement ‘This behaviour is an expected part of my job’. Instrumentality was measured by the statement ‘I see a direct connection between whether I engage in this behaviour and my outcomes at work’. Efficacy was measured with the statement ‘I am completely confident in my capabilities when engaging in this behaviour’. Role discretion was measured by the statement ‘I have complete
freedom to choose whether or not I engage in this behaviour’. Participants were asked to indicate their level of agreement with the four role perception statements for each of the 15 PPEI behaviour items. Responses were given on a 5-point scale, from 1 ‘Strongly Disagree’ to 5 ‘Strongly Agree’. Items were averaged to create 12 subscales—Promotion Role Breadth, Promotion Instrumentality, Promotion Efficacy, Promotion Discretion, Prevention Role Breadth, Prevention Instrumentality, Prevention Efficacy, Prevention Discretion, Early Intervention Role Breadth, Early Intervention Instrumentality, Early Intervention Efficacy, and Early Intervention Discretion—which all showed good internal reliability with Cronbach’s alpha statistics ranging from .67 to .88 (see Table 3.1).

Table 3.1

*Reliability estimates of teachers’ and coaches’ PPEI behaviour and role perceptions*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion</td>
<td>.68</td>
</tr>
<tr>
<td>Prevention</td>
<td>.83</td>
</tr>
<tr>
<td>Early Intervention</td>
<td>.88</td>
</tr>
<tr>
<td>Promotion Role Breadth</td>
<td>.67</td>
</tr>
<tr>
<td>Promotion Instrumentality</td>
<td>.74</td>
</tr>
<tr>
<td>Promotion Efficacy</td>
<td>.77</td>
</tr>
<tr>
<td>Promotion Discretion</td>
<td>.82</td>
</tr>
<tr>
<td>Prevention Role Breadth</td>
<td>.72</td>
</tr>
<tr>
<td>Prevention Instrumentality</td>
<td>.77</td>
</tr>
<tr>
<td>Prevention Efficacy</td>
<td>.77</td>
</tr>
<tr>
<td>Prevention Discretion</td>
<td>.86</td>
</tr>
<tr>
<td>Early Intervention Role Breadth</td>
<td>.81</td>
</tr>
<tr>
<td>Early Intervention Instrumentality</td>
<td>.85</td>
</tr>
<tr>
<td>Early Intervention Efficacy</td>
<td>.87</td>
</tr>
<tr>
<td>Early Intervention Discretion</td>
<td>.83</td>
</tr>
</tbody>
</table>
3.7.6 Data analysis

Data were screened and checked for normality. To explore differences between teachers’ and coaches’ role perceptions and helping behaviour descriptive analyses and t-tests were conducted using SPSS Version 21 (IBM, 2012b). To examine and compare for teachers and coaches the effect of role perceptions in predicting promotion, prevention and early intervention behaviour, three multiple group path analyses were conducted using AMOS Version 21 (IBM, 2012a)

Multiple group path analysis examines group differences by testing for the equality of structural parameters across distinct groups and determines whether group membership moderates the effects specified in the model (Kline, 2010). This analytic approach was employed in order to simultaneously estimate and compare regression weights for the teacher and coach groups (Kline, 2010). Assessing equivalence across groups involves testing sets of parameters in an increasingly restrictive manner through hierarchical ordering of nested models, where each model constrains more parameters than the preceding model (Arbuckle, 2012; Byrne, 2004). Four nested models, which tested three sets of structural parameters, were produced for each of the three path analyses in the current study (see table 3.2).

When testing for the invariance of a theoretical model across groups as in the current study, the regression paths and covariances, assessed in the structural weights and structural covariances models respectively, are of most interest. A non-significant Chi-square statistic when comparing the unconstrained model with the structural weights model indicates that the model in which the structural or regression weights were constrained does not fit the data.

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2 Saturated models were used for the three multiple group analyses as the current research hypotheses were concerned with assessing group invariance of regression weights predicting behaviour rather than specifying the model fit.
significantly worse than the unconstrained model, demonstrating that the predictor variables act similarly across groups. If the structural weights model is shown to be equivalent across groups, the structural covariances model can then be comparatively analysed to determine whether it fits the data significantly worse than the structural weights model\(^3\). This comparison demonstrates whether additional paths constrained in the structural covariances model, being the covariances of predictor variables, differ between groups. Generally, testing for the invariance of error parameters is considered an overly restrictive test of little importance (Byrne, 2004). The structural residuals models are, therefore, not reported.

Table 3.2

*Nested models and parameter constraints for multiple group path analyses*

<table>
<thead>
<tr>
<th>Model</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unconstrained</td>
<td>All parameters free to vary across groups</td>
</tr>
<tr>
<td>Structural Weights</td>
<td>The structural (regression) weights is constant across groups</td>
</tr>
<tr>
<td>Structural Covariances</td>
<td>The structural weights and structural covariances (the covariances of predictor variables) are constant across groups</td>
</tr>
<tr>
<td>Structural Residuals</td>
<td>The structural weights, structural covariances, and the structural residual (the variance of e1) are constant across groups</td>
</tr>
</tbody>
</table>

A confirmatory factor analysis was not performed to confirm categorisation of the activities within the subscales of promotion, prevention and early intervention as determined in phase II. The reason for this was that when designing the PPEI behaviour measure in phase II the candidate sought to allow for exploration of the boundaries of activities within teachers’ and

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\(^3\) When the structural weights model is not accepted as equivalent across groups, subsequent models cannot be interpreted (Arbuckle, 2012)
coaches’ roles. Care was taken when selecting items for both the activity checklist and final 15-item set, to ensure inclusion of items that were likely to capture a range of endorsements from teachers and coaches, that is, including activities that were likely to be performed frequently as well as activities that were less frequent. For instance ‘Encourage inclusivity and participation of all young people in activities’ was included as a promotion behaviour that was expected to be performed frequently by teachers and coaches, whereas the promotion behaviour of ‘Actively advocate for young people’s voice in policies’ was anticipated to occur less often. As items were purposefully selected to reflect a range of frequency of involvement, activities within categories would not be expected to load similarly but rather would load according to frequency of endorsement.

Phase III is reported in paper four (see chapter seven), and paper five (see chapter eight).

3.8 Ethical Considerations

The project was approved by the Committee for Human Research Ethics at the University of Canberra (project no. 12-05; see Appendix M), the ACT Government Education and Training Directorate (project no. 2012/00545-5; see Appendix N), and the Archdiocese of Canberra and Goulburn Catholic Education Office (project no. R115773 2012/00039; see Appendix O). Final permission was sought and obtained from the principal of each school prior to the research proceeding at their site. The club president or club contact of each sporting club was also consulted prior to involvement in the research.

This project was conducted in accordance with the NHMRC National Statement on the Ethical Conduct of Research Involving Humans (The National Health and Medical Research Council, the Australian Research Council, & the Vice-Chancellors' Committee, 2007) and data
from all phases of the research were stored in accordance with the University of Canberra’s University Retention and Storage of Data Policy. All electronic data files and recordings were stored on a password protected computer accessible only to the candidate. Any personal information collected from participants in phases I, II, or III, including consent forms and details provided for the incentive prize draw, were recorded and/or stored separately to their responses to ensure participants privacy.

3.9 Chapter Summary

This chapter described the three phase mixed method approach used in this research. To address the first aim of exploring teachers’ and sports coaches’ views of their role in supporting young people’s mental health and the types of activities they may perform, phase I employed a qualitative design to allow greater depth and richer, more comprehensive exploration and understanding of the research questions, through a small number of semi-structured interviews. To address the second aim and gap in literature with no existing measure, phase II developed a measure of promotion, prevention and early intervention behaviours through expert consensus. This provided a critical link in the sequential exploratory mixed methods design of this research by enabling the qualitative findings from phase I to be examined through quantitative analysis in phase III using a larger sample size and statistical significance. The final aims of investigating teachers’ and coaches’ involvement, and predictors of involvement, in promotion, prevention and early intervention activities for young people’s mental health, were addressed in phase III through a quantitative survey. The survey was administered online which created a convenient and time limited methodology.
CHAPTER FOUR

Paper one: Teachers and Sports Coaches Supporting Young People’s Mental Health
Promotion, Prevention and Early Intervention

4.1 Chapter Introduction

This chapter presents the first of five research articles prepared during the course of
candidature. The paper explores teachers’ and coaches’ awareness, acceptance, and involvement
of their roles in promotion, prevention and/or early intervention for young people's mental
health. This paper was presented at the International Conference of Applied Psychology and
Behavioral Science in Paris, France during June 2012, and has since been published in the World
Academy of Science, Engineering and Technology, International Science Index 66, 6(6), 462-
468. The format of the paper is in accordance with the publication guidelines for this journal.
Teachers and Sports Coaches Supporting Young People’s Mental Health: Promotion, Prevention and Early Intervention

Kelly R. Mazzer, Debra J. Rickwood, Thea Vanags

4.2 Abstract—Young people have a high prevalence of mental health problems, yet tend not to seek help. Trusted adults in young people’s lives, such as teachers and sports coaches, can make a major positive contribution to the mental health of young people. Teachers and sports coaches may be in a position to be effective in supporting young people’s mental health through promotion, prevention and early intervention. This study reports findings from interviews with 21 teachers and 13 sports coaches of young people aged 12 to 18 in Canberra, Australia, regarding their perceptions of the relevance and effectiveness of their role in supporting young people’s mental health. Both teachers and coaches perceived having influential but slightly different roles to play in supporting mental health. There may be potential to elevate the influence of teachers and coaches as sources of support for young people and their mental health care.

4.3 Keywords Early intervention, mental health promotion, coaches, teachers, young people

4.4 INTRODUCTION

Young people have the highest prevalence of mental health problems of any age group. Despite the negative and long-lasting impact that mental disorders can have on a young person’s life, most young people do not seek help from professionals for mental health problems [1]. In fact, less than one of every four Australian young people with mental health problems receive professional help [2]. Furthermore, it is often only when symptoms reach a crisis point that young people seek this help [3], and they usually do not seek services or treatment on their own [4]. Young people prefer to seek help from someone they already know and trust. It is evident that young people tend to need the advice, encouragement and guidance of adults in order to seek appropriate professional help for their mental health problems [5]. Promoting the mental health and wellbeing of young people, preventing the development of mental health problems, and intervening early to detect and effectively treat mental health problems is essential [6]. Delay in the treatment of mental health problems has been linked to poor symptomatic and functional outcomes, both short and long term [7]. Early intervention is critical in minimising the impact of mental health problems over an individual’s life span [8]. Focusing mental health promotion interventions on young people, also acts towards preventing a range of problems in later life including obesity, criminality, unemployment, homelessness and excessive financial strain [9].

Mental health is an issue for the whole community. Many of the socio-economic and psychological protective and risk factors relating to mental health and well-being develop outside the scope of mental health services [10-11]. Promotion, prevention and early intervention activities need to be carried out across a wide range of contexts. This requires cooperation and partnerships that extend well beyond mental health services, into the broader community [12]. Schools, workplaces and communities have been targeted as settings to deliver programs aiming to improve mental health literacy and enhance resilience [8]. Given the elevated prevalence and impact of mental health problems amongst young people, as well as their low rate of help-seeking, it is vital that adults who have contact with young people promote positive mental health and well-being, advocate for the prevention of mental health problems, and facilitate early intervention. Adults who occupy positions of care or responsibility over young people, such as teachers and coaches, can make a major contribution to the mental health of those young people [13]. Teachers and coaches are often in regular contact with young people and are able to develop and maintain trusting and enduring relationships with them. Young people are likely to feel more comfortable and willing to seek help and receive support from these adults than they are from professionals they have not previously met [5]. Recently, teachers have received increasing attention and have been highlighted as important sources of support and influence for young peoples’ mental health. Teachers have been identified as prominent adult role models in a young person’s life who are in a unique position to make a difference when it comes to promoting and addressing young people’s mental health concerns [14]. It has been argued that promoting the mental health and wellbeing of young people is a vital part of the core role of teachers and that they need to be comfortable and confident in promoting and teaching for mental health [15]. Furthermore it has been suggested that it is part of a teacher’s role to be supportive and aware of student difficulties and to direct them to the appropriate resources for help where needed [14]. The recognition of the role of teachers in young peoples’ mental health care has lead to the development and implementation of school-based initiatives becoming a primary focus for mental health promotion in Australia [16]. There has been strong evidence supporting these programs’ effectiveness in improving functioning and reducing risks for mental health problems [10]. In contrast to the significant focus on teachers, and other school staff, little research has examined the role of sports coaches in supporting young peoples’ mental health. However, the position of leadership, trust, and support that coaches fulfill, along with their regular contact with young people, suggests that coaches have the potential to be a helpful source of early identification, assistance, and recommendation for mental health problems amongst young people [17-18].

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Additionally, sports psychology literature shows that psychological skills — such as peaking under pressure, anxiety, coping with adversity, concentration and focus, goal setting, mental preparation, confidence and motivation — influence athletes’ performance, further indicating that coaches have a role in the promotion and practice of psychological skills, beneficial to their young athletes’ mental well-being [19-20].

An Australian study by Donovan et al. [13] investigated behaviours performed by both teachers and coaches that support the mental health of those in their care. The most frequent behaviours coaches identified performing were providing stimulation and positive reinforcement, having good communication, and setting realistic goals. For teachers, providing stimulating environments, positive reinforcement and good communication were also salient behaviours for supporting the mental health of those in their care, along with recognizing and dealing with problems promptly and sympathetically, and encouraging relationships with family and others.

There has been a recent movement to increase the focus of the role of adults within the community, such as coaches and particularly teachers, in supporting young people’s mental health [21]. It is therefore important to investigate these sources’ perceptions and views towards supporting mental health within their role. Potential challenges or limitations that increase the difficulty of teachers and coaches ability or willingness to support young people’s mental health within their professional role also need to be identified. The current study aimed to investigate how teachers and coaches perceive their role to be relevant and effective in the promotion, prevention and/or early intervention in young people's mental health.

4.5 METHOD

4.5.1 Participants

Participants were 34 teachers and sports coaches of young people aged 12 to 18, who were employed or volunteer within Canberra, Australia. Twenty-one teachers, 11 female and 10 male; and 13 coaches, 5 female and 8 male, were included in the sample. The age of participants ranged from 23 to 65 (M = 36.3, SD = 11.5). Years of experience in their role ranged from seven weeks to 49 years, with teachers’ mean experience 12.0 years (SD = 10.7) and coaches’ mean experience 14.8 years (SD = 9.7).

4.5.2 Procedure

Approval for the project was obtained from the University of Canberra Committee for Ethics in Human Research. Teachers and sports coaches within Canberra, Australia, were invited to participate in the research through circulation of an advertisement flyer. The researcher then arranged individual interviews for interested participants at a time and location suitable to each participant. Interviews took approximately 20 to 30 minutes to complete and were audio recorded and fully transcribed. All interviews were conducted by the primary researcher. Informed consent was obtained prior to participation in the study.

4.5.3 Measures

A semi-structured interview was designed to explore teachers’ and coaches’ perceptions of their role in supporting young peoples’ mental health. Demographic information was collected along with questions aiming to explore participants’ awareness, acceptance, and involvement in supporting young peoples’ mental health through promotion, prevention and early intervention behaviours. Additional questions addressed limits or challenges to participants providing such support.

4.5.4 Data Analysis

Transcripts of the interviews were analysed using thematic analysis, a method for identifying, analyzing, and reporting patterns and themes in qualitative data [22]. Thematic analysis involves repeatedly examining interviews for patterns of emphasis across responses, and systematically coding responses into themes. This method exposes commonalities concerning dominant themes as well as differences between participants and attributes [23]. Data were initially analysed by hand, followed by the use of NVivo qualitative data analysis software, version 8 [24].

Tests of coding reliability were conducted. Following completion of initial coding of all transcripts, six transcripts were re-coded by the same coder to assess coding consistency over time [25]. Inter-rater reliability was also tested through a second independent researcher coding six clean transcripts. Coding assignment was compared between coders with a calculated Kappa coefficient of .80, above the level of .75 generally considered excellent [26]. Coding discrepancies were also resolved by consultation with a third researcher, providing further strength of reliability through researcher triangulation.

To determine the level of representativeness of responses, four levels of frequency labels were applied. As proposed by Hill et al. [27], a theme that applied to all or all but one of the cases was considered general. A typical theme applied to more than half of the cases (up to the cutoff for general). A theme considered variant included at least two cases up to half of all cases. A theme that included two or three cases was considered rare. Findings that emerged from only one case were not reported as they were not considered to be descriptive of the sample.

4.6 RESULTS

All participants identified young people’s mental health as relevant to and part of their role as a teacher or sports coach of 12-18 year olds. Participants highlighted both the importance of their involvement as well as their acceptance of supporting young people’s mental health within their roles. All participants were able to identify behaviours they perform within their professional role which they perceive to support young people’s mental health. Limits of teachers’ and coaches’
professional roles and the impact they have on their involvement in supporting young people’s mental health were also noted.

4.6.1 Importance

The first major finding was that all participants identified young people’s mental health as relevant to or part of their role as a teacher or coach. Furthermore, participants recognised the importance and need for their role in supporting mental health, and the opportunity they have to positively impact young people’s mental health.

Both teachers and coaches (57% teachers, 54% coaches) typically reported knowledge of a high prevalence of mental health concerns being experienced by young people, particularly depression, suicidal ideation, and body image concerns. Most coaches (77%) additionally recognised the negative impact that mental health has on participation and performance in sport and related activities. Participants also highlighted that it was increasingly common for teachers and coaches to become aware of such concerns within the school or sporting environments.

‘I’ve noticed it’s [young people’s mental health] become more and more so [relevant to the role of a teacher], through the years from when I started... It’s become more relevant as I’ve been involved longer, because there is just more and more kids who have issues.’ – Teacher.

One of the most common areas participants reported on (88% of total participants) regarded the established relationships and positions of support teachers and coaches hold with young people. The ability to establish such relationships was perceived to be a major factor contributing to teachers’ and coaches’ opportunity to positively influence young people’s mental health. Both teachers and coaches typically (71% teachers, 62% coaches) reported that being approachable and having open communication with young people were important aspects to develop trust and enable them to support young people’s mental health. Participants also noted their relationships with young people enable them to act as a trusted outlet or support person, as well as being in a position to monitor behaviour change, and approach the young person regarding their concerns if deemed appropriate.

‘Quite often kids look to you as a role model and listen to what you say, particularly if there’s a common respect going both ways.’ – Coach.

4.6.2 Acceptance

Participants’ acceptance of supporting mental health within their role, as well as other people’s expectations of the roles of teachers and coaches, were reported as factors that affect participants’ involvement in supporting young people’s mental health. Typically participants (76% teachers, 85% coaches) reported an overall acceptance of supporting young people’s mental health within their role, with many participants viewing supporting mental health as ‘just part of the job’. Both teachers and coaches reported holding personal values and expectations of themselves to take action to support young people’s wellbeing. Participants also perceived a level of responsibility incumbent in their role, and typically reported a willingness to care for and communicate with young people regarding any concerns they observe or become aware of.

‘It is a major role and I think that we do have quite a responsibility as far as I suppose noting any issues that we either hear about or see.’ – Teacher.

Notably, a variant number of participants (24% teacher, 15% coach) emphasised that they were accepting of supporting mental health within their role only to a certain extent and reported taking caution to avoid too much responsibility for the care of a young person’s mental health as they reported other professionals were more equipped to assist with mental health concerns. Teachers perceived greater expectations or pressure from others for their involvement in young people’s mental health than did coaches.

Participants also identified on a variant level (14% teachers, 38% coaches), that the roles of both teachers and coaches are evolving and expectations for their roles have changed over time. They reported an increase in expectations, in recent years, for them to be involved and supportive of young people’s mental health.

‘A coach and a teacher are asked to do a lot more than they were in years past.’ – Coach.

4.6.3 Behaviours

All participants were able to identify activities and behaviours they perform within their role which they perceive to support young people’s mental health. Each of these behaviours were functions of promotion, prevention, or early intervention for young people’s mental health.

4.6.3.1 Promotion

Participants reported a number of behaviours that they perform within their role for the promotion of young people’s mental health. Reported by over half of both teacher and coach participants (52% teachers, 54% coaches), providing a positive, friendly, and safe environment was the most common action identified as being conducted within participants’ roles to promote positive mental health amongst young people.

‘Providing a safe, happy environment for those students to be in through the course of the day, an environment that keeps them busy, keeps them engaged and challenged, most times that’s of value.’ – Teacher.

Close to half of all coach participants (46% coaches,) reported facilitating and encouraging participation within groups and activities as a focus of their role which positively
influences young people’s mental health. Participation was rarely identified by teachers. A variant number of participants discussed promoting mental health in their professional role by assisting young people to develop life skills, through sport or education. Participants also identified influencing mental health indirectly through skill development or coping mechanisms.

‘I may not have tackled it intentionally or deliberately, but I think through the things we do, involved with sport, helps these kids immensely. It gives them self-belief, it gives them... improves their self-esteem, it does all those things that can help.’ – Coach.

Over one third (38%) of teachers also reported raising awareness and reducing stigma of mental health problems were acts they performed within their professional role to promote mental health amongst young people. Coaches rarely recognised educating young people on awareness of mental health and stigma reduction as a part of their role. Approximately half (48%) of all teacher participants also identified that certain areas of the curriculum they are required to teach target the promotion of mental health.

‘I guess we’re also looking at trying to break down that sort of mental illness stigma with the kids, and we are trying to do that through our curriculum.’ – Teacher.

4.6.3.2 Prevention
Participants less frequently reported behaviours they undertake within their professional role to support the prevention of mental health problems in young people, in comparison to actions towards both promotion and early intervention for mental health. Participants, on a variant level (33% teachers, 15% coaches), reported an overall care for young people and their wellbeing as a value they hold which leads them to support young people within their role and act towards preventing mental health problems.

‘I guess at the end of a day as a teacher the most important thing for me is that the kids see that I care about them.’ – Teacher.

Approximately one third of participants (38% teachers, 31% coaches) also recognised certain predisposing factors — such as family and peer pressures, bullying, personality, family structure and conflict, biological disposition — to be aware of that can affect a young person’s mental health.

‘It may not be particularly the kids fault, it could be a hereditary thing, a number of factors.’ – Coach.

4.6.3.3 Early Intervention
Behaviours for early intervention were the most commonly reported by participants, greater than both promotion and prevention activities. Teachers, in particular, reported being frequently involved in early intervention for young people’s mental health. Typically participants (52% teachers, 77% coaches) recognised the identification of mental health problems in young people as an action for early intervention performed as part of their role. Furthermore, most felt that they were able to identify or notice when a young person was experiencing a mental health problem, through indicators such as noticing a change in the young person’s behaviour or in their level of, or attitude to, participation.

‘You can recognise when there’s a problem... because you have the kids once each week or more sometimes, and you have them for an ongoing basis... so you recognise when there is a change.’ – Coach.

Participants typically also reported being previously involved in early intervention for young people’s mental health through providing supportive guidance and direction to further sources of help, for young people with mental health concerns. All participants discussed guidelines, and referral pathways of involving other people in supporting young people’s mental health. Coaches tended to report communicating only to the young person themselves and often their parents. Teachers commonly reported they would additionally communicate with other personnel within the school setting, such as school counsellors or pastoral care advisors, when concerned for a young person’s mental health. Notably, both teachers and coaches, identified young people’s parents as an important party to consider communicating with when taking action to support their mental health.

4.6.4 Limits
Participants highlighted a number of limitations to their involvement in supporting young people’s mental health. Participants typically identified capacity as a limitation. Teachers (76%) in particular recognised restrictions to supporting young people’s mental health due to high demands and workload of their core professional role, the volume of young people they support, and lack of available time. Much fewer coaches (23%) identified capacity as a limitation to their ability to support young people’s mental health.

‘You always say you’d like to get more involved, but the reality is you never have enough time.’ – Coach.

Participants also typically discussed a lack of knowledge, skills, and training in mental health, as a boundary to supporting young people’s mental health. Nearly all coaches (77%), and most teachers (62%), reported skill and training deficits in mental health related areas. Many participants, particularly coaches (29% teachers, 62% coaches), expressed that more training and resources in these areas would be valuable.

‘It becomes difficult because you do want to help, but then you don’t always know how, you don’t want to say the wrong thing. I’m not trained enough to know.’ – Teacher.
Thirdly, typically participants (66% teachers, 46% coaches) noted that the professional boundaries and obligations of their role, as well as the associated risks of acting beyond such boundaries, can also limit their ability to support young people’s mental health. Teachers more commonly reported professional boundaries as a consideration in supporting young people’s mental health than did coaches.

‘It’s important to recognise when it’s too much for a teacher and to pass that on then.’ – Teacher.

4.7 DISCUSSION

Interviews revealed that teachers and sports coaches do perceive themselves to be influential in young people’s mental health. The ability to develop relationships with young people through their roles was considered a major factor contributing to their opportunity to positively influence young people’s mental health. This is consistent with research emphasising the importance of an established relationship with young people given their preference to seek help from sources that they know and trust [5]. Teachers and coaches felt that their positions can allow them to act as an external and trusted outlet or support person, to which young people can communicate, and may also respond to. These findings provide support to Meldrum et al.’s [14] argument that teachers are in an opportune position to promote and support young people’s mental health concerns, and Mazzer and Rickwood’s [17] view that coaches have the potential to be a helpful source of early identification and support for young people’s mental health.

Teachers and coaches were accepting of supporting mental health within their role, many describing it as ‘just part of the job’. They expressed a willingness, to care for and communicate with young people regarding their concerns. This supports previous research which has argued that being supportive of young people’s mental health and wellbeing is an important part of a teacher’s role [6,14-15]. Teachers perceived greater expectations for involvement in supporting young people’s mental health than did coaches.

Both teachers and coaches identified behaviours they perform within their role for the promotion, prevention and early intervention of young people’s mental health. Providing a positive, friendly, and safe environment was identified by both teachers and coaches as one of the most prevalent actions they encourage in supporting mental health. This was consistent with Donovan et al.’s [13] findings in which providing a stimulating environment, and using positive language, were amongst the most frequent behaviours identified by teachers and coaches to sustain young people’s mental health.

In the current study, teachers perceived their role to have more involvement with early intervention than promotion or prevention and viewed identifying mental health problems and increasing awareness of mental health as actions they perform within their role.

Similarly, recognising problems, having good communication, and encouraging relationships, were among the most common behaviours acknowledged by teachers as supportive of mental health in Donovan et al. [13]. Despite coaches reporting a smaller variety of actions to promote mental health than teachers, coaches viewed their role as being more frequently involved in promotion, than prevention or early intervention, for young people’s mental health. Coaches recognised the impact that mental health can have on a young person’s participation and performance in sport, and the supportive role they can play to assist them, through good communication and guidance. This result again supported by Donovan et al.’s [13] findings that using positive language, and goal setting, were salient behaviours performed by coaches in supporting mental health.

Consistent with Meldrum et al. [14], who argued that an important part of a teacher’s role is to be aware of young people’s difficulties or concerns and to direct them to the appropriate resources for help where needed, teachers in the present study regularly reported they would communicate with other personnel within the school setting when concerned for a young person’s mental health. Teachers reported more awareness of structured pathways and procedures to assist them in supporting young people’s mental health and involving others in their care. Coaches were not guided by the same level of structure, and reported that they would primarily communicate with the young person themselves.

A number of challenges to teachers and coaches supporting young people’s mental health were identified, including limited capacity, lack of training, and professional boundaries. Many participants, particularly coaches, felt that they had skill and training deficits in mental health related areas, and expressed interest in, and need for, further training and resources. Making mental health training more available to sports coaches may be valuable in reducing boundaries to supporting mental health. These findings support the approach of Pierce et al. [28] who offered brief training in mental health to a group of sports coaches to encourage facilitation of early help-seeking behaviour, and had positive outcomes improving both coaches’ ability to recognize, and confidence in assisting, someone with a mental health problem.

Qualitative research contains some general limitations which may have impacted this study and should be noted. The researcher’s presence through data collection, which was necessary for conducting interviews, could have affected participants’ responses. Also interpretation of the meaning of qualitative data is required in the development of themes within thematic analysis [22], and can be influenced by researcher biases. However, this was addressed in the current study through the use of inter-rater reliability and researcher triangulation. Further research investigating the roles of teachers and coaches in supporting young people’s mental health, across a larger sample would be useful to determine the representativeness and generalisability of the current study’s findings.
In conclusion, this study has explored the role of teachers and coaches in supporting young people’s mental health. Both teachers and coaches were found to recognise supporting young people’s mental health as relevant to and part of their roles. Teachers viewed that their involvement in supporting young people’s mental health occurs predominantly through identifying mental health problems, and coaches through promoting positive mental health.

There may be potential to elevate the influence of teachers and coaches as sources of support and initial help for young people, as well as to facilitate their help-seeking and pathway to mental health care. However, challenges and boundaries to these sources involvement in supporting young people’s mental health, particularly their reported lack of knowledge in mental health and pathways to care need to be addressed. It may be beneficial for teachers and particularly coaches to receive more training in mental health and education on how they can effectively support young people with their mental health.

4.8 REFERENCES


CHAPTER FIVE

Paper two: Teachers' Role Breadth and Perceived Efficacy in Supporting
Student Mental Health

5.1 Chapter Introduction

This chapter comprises the second research article prepared during the course of

candidature, which has been submitted for publication in Advances in School Mental Health

Promotion. The paper explores teachers’ views of their role and perceived efficacy in supporting
young people’s mental health and wellbeing, and identifies additional support needs. The format
of the paper is in accordance with the manuscript submission guidelines for this journal.
Teachers' role breadth and perceived efficacy in supporting student mental health

5.2 Abstract: Teachers are considered well placed to identify issues concerning students’ mental health and wellbeing and can play a critical role in the helping process for their concerns. However, little is known about the views of teachers regarding their role in supporting student mental health and how well equipped they feel to fulfil it. The aim of this study was to investigate teachers’ perceived role breadth and perceived self-efficacy in supporting students’ mental health. Interviews were conducted with 21 teachers from Canberra, Australia. Teachers viewed supporting student mental health as part of their role, though perceived a lack of knowledge and skills in mental health related areas. They clearly emphasised the need to work within a well-coordinated pastoral care system. Additional training in mental health and clear role delineation within the school may assist teachers to feel better prepared to effectively and appropriately support student mental health.

5.3 Keywords: teachers; role breadth; self-efficacy; student mental health

5.4 Introduction

Young people spend a significant amount of time at school, and the school setting is critical for youth mental health and wellbeing. Mental health problems often have their first onset during the high school years and are common for teenagers. Data from a number of countries reveal that almost a quarter of young people will experience a mental disorder in any given year (Patel, Flisher, Hetrick and McGorry, 2007). Mental disorder is particularly disruptive at this stage of the lifespan as young people are developing the foundations for adult life. Notably, such problems can impact on learning and achieving at school (Anderson, 2005). Not only do young people need to achieve at school, but this is also an environment where problems can be identified and needs met. Teachers and other school staff, therefore, have an essential role in supporting youth mental health. This paper explores teachers’ views of their role in supporting young people’s mental health and wellbeing, focusing on how they define and accept their
responsibilities in this area, as well as identifying any additional support needs they have to
better fulfil this role.

5.4.1 Mental Health, Mental Illness and the Role of Schools

Mental health and mental illness are factors that impact strongly on the transition from
childhood to adulthood. During this lifestage most mental disorders first emerge. The large
national US co-morbidity survey revealed that half of all mental disorders have their first onset
before the age of 14 and three-quarters before 25 years (Kessler et al., 2009). The teenage years
are critical for the promotion of wellbeing, prevention of the development of mental illness,
and early identification and intervention for mental health problems and disorders (CDHAC,
2000).

Mental health is defined as a ‘state of wellbeing in which the individual realises his or
her own abilities, can cope with the normal stresses of life, can work productively and
fruitfully, and is able to make a contribution to his or her community’ (WHO, 2001, p.1).
Within society, however, the term mental health has tended to take on a variety of incomplete
meanings. For instance, mental health has been used to refer to mental illness or, alternatively,
to indicate the absence of mental illness. A holistic view of mental health considers more than
the occurrence of mental disorder; it describes the capacity of individuals to interact with one
another and their environment in ways that promote mental wellbeing and positive functioning
(Australian Health Ministers, 1991; Keyes, 2002)

A mental illness or mental disorder is a health problem that significantly interferes with
a person’s thoughts, feelings or behaviour, and is diagnosed according to standardised criteria,
usually the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) or the
International Classification of Diseases (WHO, 2007). A mental health problem also interferes
with a person’s thoughts, feelings and behaviour, but to a lesser extent than a mental illness,
and does not meet diagnostic criteria. Each of these facets of mental wellbeing are of critical importance for adolescents transitioning to adulthood.

Young people spend a significant proportion of their time and learn essential lifeskills at school. Consequently, schools can play a major role in young people’s mental health and wellbeing and are increasingly being recognised as effective and key settings for the promotion of mental health (Graham, Phelps, Maddison, & Fitzgerald, 2011; Rickwood, 2005; WHO, 1998). Pastoral care systems within schools assist to promote the health and wellbeing of all students through endorsing a holistic approach to education, addressing students’ social, psychological, developmental, and educational needs (Hearn, Campbell-Pope, House, & Cross, 2006). Pastoral care is integrated into the curriculum and structural organisation of the school to encourage the best opportunity for learning and to support the development of students as individuals and as members of the community (Hearn, et al., 2006; Lang, 2000).

Increasing interest in the emotional health and pastoral care of young people in schools has resulted in international commitment towards implementing ‘Health Promoting Schools’, which address how curriculum and pastoral practice can best enrich the social, emotional, physical and moral wellbeing of all members of their school community (WHO, 1998). Within Australia, recognition of the role of schools in young people’s mental health has led to the development and implementation of school-based initiatives becoming a primary focus for mental health promotion (DHA, 2003). The key vision of the National Safe Schools Framework is for ‘all Australian schools to be safe, supportive and respectful teaching and learning communities that promote student wellbeing’ (MCEEDYA, 2011, p.3). This framework also emphasises the importance of working with the community to extend support to students and families where needed. Spratt, Shucksmith, Philip, and Watson (2006) reason that schools should view pastoral care as a fundamental aspect of a teacher’s role, and the
promotion and support of mental wellbeing of students should be reflected in all aspects of the school’s life.

Teachers are in a critical position to identify and support students with mental health concerns (Johnson, Eva, Johnson, & Walker, 2011). They are well-placed to recognise issues concerning students’ social and emotional wellbeing and can play a valued role in the help-seeking process (Graham, et al., 2011; Johnson, et al., 2011). It has been argued that promoting the mental health and wellbeing of students is a vital part of the role of teachers who need to be comfortable and confident in promoting and teaching for mental health (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000).

5.4.2 Teachers’ Role Breadth

A focus on promoting mental health as part of a teacher’s role is relatively recent, however, and is not necessarily perceived by all teachers as being a requisite part of their role. Teachers’ perceived role breadth refers to whether a teacher regards particular behaviours as part of their job (McAllister, Kamdar, Morrison, & Turban, 2007; Morrison, 1994). Role breadth is subject to an individual’s perception; so, two teachers holding the same formal position can differ in how broadly they each define that job (Morrison, 1994). The way individuals construct and define their role can be a powerful influence on their behaviour and resulting job performance (Parker, 2007). Teachers, in particular, have sizable role breadth that requires them to perform a wide variety of activities involving a range of skills (Finney, 2006; Kidger, Gunnell, Biddle, Campbell, & Donovan, 2010). Specific role requirements for teachers in supporting student mental health tend to be vaguely defined and poorly articulated and expectations lack consistency (Finney, 2006).

Generally, teachers have been found to endorse the involvement of schools in addressing the mental health needs of students and recognise that as teachers they have a
responsibility to care for and address the mental wellbeing and concerns of their students (Reinke, Stormont, Herman, Puri, & Goel, 2011; Rothi, Leavey, & Best, 2008). Kidger et al. (2010) reported that teachers were happy with the role they were required to play in identifying vulnerable students and providing support where needed. Similarly, Graham et al. (2011) in a study of over 500 teachers from NSW, Australia, reported that most teachers acknowledged they play a significant role in developing the social and emotional wellbeing of young people. The majority indicated that they viewed mental health education as important and were very committed and willing to participate in extra-curricular mental health education programmes if allowed more time and resources to do so. Only a minority, of less than two percent, voiced beliefs that supporting the social and emotional wellbeing of students was not part of their role and felt a sense of burden by students’ needs in this area. A small number of teachers also expressed conflict around balancing the complexities and expectations of their roles in teaching and providing mental health support to students.

5.4.3 Teachers’ Self-Efficacy

Although teachers may perceive the need to promote mental health and agree that schools should be involved in addressing the mental health needs of students, responses to mental health issues are also influenced by teachers’ perceived efficacy in dealing with such issues (Graham, et al., 2011). Perceived self-efficacy refers to an individual’s perception of his or her competence in performing a given type of behaviour (Bandura, 1977; McAllister, et al., 2007). Graham et al. (2011) found teachers to have mainly positive self-efficacy, with the majority of teachers reporting they were moderately confident in their ability to deal with mental health issues.

Of concern, however, are reports that teachers may lack the skills and confidence to engage with mental health issues (Finney, 2006; Kidger, et al., 2010). Rothi et al. (2008)
described teachers perceiving a global lack of experience and training for supporting students’ mental health. Kratochwill and Shernoff (2004) summarise that while teachers may be the professionals who are most likely to be able to impact the behaviour and mental health needs for young people on a regular basis, they may neither have the resources nor the knowledge to do so effectively.

Graham et al. (2011) encourage further research into perspectives on the role of teachers and schools in supporting student mental wellbeing, as only a small number of studies have investigated this area and little is known about how well equipped teachers feel to fulfil this role (Kidger, et al., 2010; Reinke, et al., 2011). Teachers’ confidence and concerns for responding to students’ mental health needs have been identified as important areas for further investigation (Crawford & Caltabiano, 2009). Specifically, the rich description and deep understanding of individual experience that qualitative research methods can provide has been deemed to be valuable (Silverman, 2009; Silverstein, Auerbach, & Levant, 2006). In response, the current study uses qualitative methods to investigate teachers’ role breadth and perceived self-efficacy, examining whether teachers perceive themselves as being expected to (role breadth) and able to (self-efficacy) effectively support student mental health.

5.5 Method

5.5.1 Participants

Twenty-one teachers (11 female and 10 male) from six different schools within Canberra, the capital city of Australia, participated in the study. All participants were employed at co-educational schools with average class sizes of 21-22 students (ACT Government Education and Training Directorate, 2010) and taught students aged between 12 and 18. The majority of participants taught at public secondary schools (n = 16), with the remaining five participants teaching at private or independent schools. Seven participants predominantly taught core
subjects (i.e. mathematics, science, English, and studies of society and environment [SOSE]), eight taught physical education (PE), four taught other specialised technology subjects (e.g. food, wood, and metal work), and two taught psychology. The age of participants ranged from 23 to 65 years ($M = 37.9$, $SD = 12.3$). Years of experience in their role ranged from seven weeks to 49 years, with mean length of experience being 12.0 years ($SD = 10.7$).

### 5.5.2 Procedure

Approval for the project was obtained from the University of Canberra Committee for Ethics in Human Research. Teachers within Canberra were invited to participate in the research through circulation of an advertisement flyer. Individual interviews were arranged for interested participants at a time and location suitable to each participant. Interviews were approximately 30 minutes in duration and were audio recorded and fully transcribed. All interviews were conducted by the primary researcher. Informed consent was obtained prior to participation in the study.

### 5.5.3 Measures

A semi-structured interview was designed to explore teachers’ perceptions of their role in supporting student mental health. Demographic information was collected along with questions aiming to explore participants’ awareness, acceptance, and involvement in supporting students’ mental health. Additional questions addressed limits or challenges to providing such support.

Of special interest were teachers’ understanding and perceptions of their role across the very broad area of student mental health, including promoting positive mental health and wellbeing, preventing the development of mental health problems, and identifying and intervening early in mental disorder. To determine how teachers defined mental health and the breadth of their role across promotion, prevention and early intervention activities, no definitions were initially provided to allow for individual perceptions to emerge (see Mazzer,
Rickwood, & Vanags, 2012 for a full investigation of this issue). Midway through the interviews, following the interviewer’s inquiries into understanding of these areas, participants were provided the following definitions (CDHAC, 2000, p.6) to ensure that responses to a common understanding were being captured:

**Mental health promotion** is any action taken to maximise mental health and wellbeing among populations and individuals.

**Prevention** refers to interventions that occur before the initial onset of a disorder to prevent the development of disorder.

**Early intervention** comprises interventions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder.

### 5.5.4 Data Analysis

Transcripts of the interviews were analysed using a combination of inductive and deductive approaches (Fereday & Muir-Cochrane, 2006). Text relevant to the research questions was identified and organised into repeating ideas, then general themes. These themes were organised into theoretical constructs that link the data to broader psychological theory (Silverstein, et al., 2006). Data were initially analysed by hand, followed by the use of NVivo qualitative data analysis software, version 9 (NVivo, 2010).

Tests of coding reliability were conducted, whereby after completion of initial coding of all transcripts, six transcripts were re-coded by the same coder to assess coding consistency over time (Richards, 2005). Inter-rater reliability was also tested through a second independent researcher coding six clean transcripts. Coding assignment was compared between coders with a calculated Kappa coefficient of .80, which is above the level of .75 generally considered excellent (Robson, 2002). Coding discrepancies were resolved by consultation with a third researcher, providing further strength of reliability through researcher triangulation.
To determine the level of representativeness of responses, four levels of frequency labels were applied. As proposed by Hill, Knox, Thompson, Williams, and Hess (2005), a theme that applied to all or all but one of the cases was considered general. A typical theme applied to more than half of the cases. A theme considered variant included at least three cases and up to half of all cases. A theme that included two or three cases was considered rare. Findings that emerged from only one case were not reported.

5.6 Results

5.6.1 Role Breadth

5.6.1.1 Mental health as part of the job

All participants viewed student mental health as part of their role as a teacher. Generally, participants reported having previously been involved in specific cases of supporting a student’s mental health. Typically, teachers viewed supporting mental health as ‘just part of the job’.

‘I think teachers can and do play a pretty important role [in students’ mental health]… definitely.’— Male teacher, core subjects.

Teachers identified some specific actions performed within their role breadth that support student mental health. The most frequently reported actions, identified by approximately half of teachers, included: providing a positive, safe, and friendly environment; teaching for mental health education through specified curriculum; and identifying students’ mental health concerns.

Additionally, all teachers reported that part of their role was to communicate with other personnel within the school setting regarding student mental health. Typically, participants discussed guidelines or procedures for involving further supports for student mental health.
Figure 5.1 illustrates typical pathways reported by teachers for involving other staff. All Australian schools have embedded pastoral care systems (though these systems can vary) and access to school counselling services. Teachers typically stated that when concerned for a student’s mental health they would utilise these systems to inform or involve other school personnel including school counsellors, pastoral care advisors, and/or year coordinators, as these staff were perceived to be better able to assist students with mental health concerns. Teachers described they would rely on school counsellors and other specialised pastoral care workers to make any necessary referrals to mental health or psychiatric services, rather than having direct involvement in external referral processes. With the exception of parents, it was rare for teachers to report directly to parties external to the school setting.

‘If we see a problem… I will then have a chat to the child, obviously the parents would be involved, and they would be referred on to the school nurse or the school counsellor, and they are obviously more equipped to handle the problems than somebody like myself. So we do refer them on… We help them any way we can, but they are referred onto people with more expertise in that area than us.’ — Female teacher, specialised technologies.

5.6.1.2 Boundaries of role breadth

Participants also typically noted perceived boundaries to the breadth of their role. Elements viewed as outside the bounds of their role predominantly focused on limiting the amount of responsibility they hold for the care of a student’s mental health. Participants recognised that while they are involved in supporting student mental health, it is not a teacher’s area of expertise or a core focus of their role. They emphasised that other professionals are better equipped to assist with mental health concerns.

‘It's not necessarily a key part of what we do but there’s no doubt that at times it becomes a key part of the way we operate.’ — Male teacher, physical education.
Notably, while all participants agreed that supporting student mental health was within their role boundaries, a variant number also expressed some reluctance in this regard. A clear role boundary was that providing any form of treatment, or counselling, is outside the scope of their role. Participants were definitive that ‘dealing with’ or treating mental health issues, is not their responsibility. Teachers discussed having scope to support mental health and wellbeing, but that they would refer students onto more specialised staff or supports rather than becoming involved in the treatment of mental health problems.

‘We can support the kids through the problem, but it needs to go higher to be dealt with.’ — Female teacher, specialised technologies.

‘We are there to support, we’re not there to actually do any counselling or actually have any major interventions.’ — Female teacher, psychology.
Teachers identified a number of challenges to supporting student mental health, both in terms of broadly improving wellbeing as well as more specifically related to young people with mental health problems. They typically perceived significant challenges and restrictions in their capacity to support mental health due to the demanding workload of their core professional role, the volume of students they support, and lack of available time. Teachers also expressed concerns and challenges in decisions around confidentiality and the difficulty of balancing privacy of information versus communicating necessary information between other parties such as parents, colleagues, and mental health professionals. Teachers highlighted mandatory reporting of information that pertains to risk of a student’s safety as an additional complication in this area.

‘I think it’s hard. Especially if it’s a lot of kids, with a lot of problems. Because you've still got all that stuff you need to get through within a day, and then you are supposed to fit in other things that are for their wellbeing.’ — Female teacher, specialised technologies.

‘There is also the confidentiality issue, where if a student really doesn't want me to pass that information on, unless it’s something to do with mandatory reporting, I won't. I'll respect those wishes. And that’s where it does get a little bit tricky sometimes to make sure they get help.’ — Female teacher, physical education.

5.6.1.3 Expectations of role breadth

Teachers typically reported holding personal values and expectations of themselves to take action to support students’ wellbeing. They perceived a level of responsibility inherent in their role and reported a willingness to care for and communicate with students regarding any concerns.

‘I'm here to try and help develop anyone who is in my charge. And so if I've got somebody who has some sort of issue that needs a bit of extra support then I'm willing to do it.’ — Male teacher, core subjects.
A variant level of participants identified expectations for their role that they perceived others placed on them. They reported that external expectations can create pressure for teachers and the way in which they function, although there was variation on whether they felt such expectations were reasonable or overly demanding. Some teachers sensed that in their involvement with student mental health they were adequately supported by the school and its staff, particularly by school counsellors, principals, and specific pastoral care staff. However, a variant number of teachers reported having been in situations relating to students’ mental health where they had been expected to take on more responsibility than they were comfortable with.

‘I think teachers are getting pushed to do more and teachers say ‘oh do we have to do everything?’, but often it’s the teacher that the kids will open up to, so you can’t walk away from it.’ — Male teacher, core subjects.

‘We get stuck in the middle a lot. Expected to do more than what we're actually trained to do.’ — Female teacher, psychology.

Participants also highlighted, on a variant level, that the role of a teacher is evolving and expectations for their roles have changed over time. Teachers frequently commented on the high prevalence of mental health concerns among students and noted it was increasingly common for teachers to become aware of such concerns. They perceived this to have led to increased expectations in recent years for teachers to be more involved and supportive of students’ mental health.

‘You come across it all the time, more and more so now… I wouldn't have said that I would have when I first started teaching.’ — Female teacher, physical education.

‘I guess the change in... students, from when I was at school, they are dealing with a lot more than they used to... so I think they need... a lot more support.’ — Male teacher, physical education.
5.6.2 Self-Efficacy

5.6.2.1 Confidence

When asked if they felt comfortable or confident in supporting student mental health, participants typically reported they felt confident, particularly in providing a baseline level of support for mental health via talking with students about their concerns and providing guidance in connecting students with appropriate supports within the school setting. They were also comfortable to continue liaising with these support personnel in addressing students’ mental health needs.

‘I am comfortable in it. But I also know my limits of expertise, and my limits of duty of care.’ — Male teacher, core subjects.

5.6.2.2 Fear of saying the ‘wrong’ thing

While comfortable liaising with other staff who had more expertise to support students with mental health problems, teachers were not typically confident being responsible for these students themselves. In particular, a fear of saying or doing the wrong thing in supporting students’ mental health emerged. Participants reported worrying that what they say or do may negatively impact the student, and that this could have severe consequences at this vulnerable time of life.

‘I don't always feel like I have all the information that I need. And you just don't want to say the wrong thing, because you just really feel like, a 14 year old if you say the wrong thing you can stuff up their whole life. That’s just what it can sometimes feel like.’ — Female teacher, physical education.

5.6.2.3 Knowledge and skills

Teachers recognised on a general level having some knowledge and skills related to supporting student mental health, and were typically aware of or had participated in training through
professional development workshops or supportive programs. Nevertheless, a variant number of teachers identified using or relying on basic common sense knowledge in their involvement with supporting students’ mental health.

‘I'm just using my instinct I suppose, like just a normal human being.’— Female teacher, core subjects.

Importantly, participants typically reported that their skills were not sufficient to meet the mental health needs of their students, perceiving a deficit in their level of knowledge, skills, and training in mental health. A variant number of teachers further expressed that additional training and resources in mental health related areas would be valuable.

‘I think we need more [skills]… It is a necessity that all teachers have some sort of training in mental health.’— Female teacher, physical education.

5.7 Discussion

This in-depth qualitative study of Australian teachers reveals their views regarding their role breadth and self-efficacy in relation to supporting the mental health and wellbeing of young people at school. Overall, teachers saw this as a fundamental part of their role as a teacher, but expressed concerns that they lacked the knowledge and skills required to fully address their students’ mental health needs. In particular, they feared saying the ‘wrong’ thing to vulnerable young people, as well as problems juggling the many demands involved in their expanding role.

Supporting students’ mental health and wellbeing has been argued to be an important part of a teacher’s role for some time (Wyn, et al., 2000), and the current study shows that teachers now view this as ‘just part of the job’. The role of a teacher has evolved and broadened over time and teachers have been increasingly expected to address students’ mental health and wellbeing (Finney, 2006). Notably, promoting young people’s mental health within
schools is now recognised as having educational benefits (Hearn, et al., 2006; IUHPE, 2000; Weare & Nind, 2011). Teachers are motivated to support students’ mental health as doing so assists in reducing obstacles to learning and educational progression, which is a core part of their role (Rothi et al., 2008), as well as from a sense of concern for the general wellbeing of their pupils.

Evidence suggests that schools need to use positive models of mental health which emphasise wellbeing, not just illness, and that this needs to be a ‘whole school’ approach in which teachers are key contributors (Weare & Markham, 2005; Weare & Nind, 2011). This shift toward mental health promotion and prevention has seen an increased focus on young people’s social and emotional learning (SEL) at school and a great number of universal and targeted school-based SEL or mental health promotion and prevention programs now exist. MindMatters is a widely dispersed program in Australian secondary schools that aims to improve mental health wellbeing, reduce mental health problems, and increase support assistance to students experiencing mental health issues through whole school change (MindMatters, 2009).

Helping teachers to integrate the important roles they play in teaching social and emotional skills, identifying and monitoring mental health problems, and working with other school-based supports, into their everyday teaching practice should facilitate students’ access to mental health care and reduce barriers to service use (Reinke, et al., 2011). Due to the high prevalence of mental health problems among young people teachers themselves need support to enable them to promote students’ mental wellbeing within the boundaries of their role (Gott, 2003; Reinke, et al., 2011). Many teachers in this study noted a marked increase in the prevalence of mental health problems among students, confirming trends reported by youth mental health researchers (Rickwood, White, & Eckersley, 2007). This significantly impacts on the capacity of teachers to aid the growing number of students in need of additional support.
Teachers reported similar role boundaries and challenges to those revealed by Graham et al. (2011) in their survey of Australian teachers, including limited capacity, lack of training, and professional boundaries.

It has been argued that teachers should be comfortable and confident in promoting and teaching for mental health (Wyn, et al., 2000). Encouragingly, most teachers in the current study initially reported that they were comfortable or confident in supporting student mental health, particularly through talking with students and connecting them with appropriate supports in the school setting. Importantly, however, qualitative methods enabled deeper elaboration of this issue revealing that teachers clearly felt less efficacious than first indicated. Teachers disclosed fears that their skills were not adequate to address the increasing mental health needs of their students, concerns regarding the risk of their behaviour or advice negatively impacting on vulnerable students’ wellbeing, and that they were not comfortable being responsible for anything related to the actual treatment of students’ mental health problems and needed support from other school staff with appropriate expertise when students have complex mental health needs.

The importance of the broader pastoral care system to support teachers’ roles was very evident in the current study. Teachers only feel comfortable being involved in student mental health up to a certain point. When students’ mental health needs exceed the teachers’ scope, teachers want and need involvement from specialist trained colleagues to support the students. The capacity of teachers to support students’ mental health is predicated on the implementation of well-articulated networks of care and effective referral pathways, both within and beyond the school (Rickwood, 2005). Teachers need to be aware of where their role begins and ends within this system of care.

These school-based mental health approaches require teachers and other school personnel to possess a wide range of skills in the broad arena of mental health promotion,
prevention and early intervention. Consistent with previous research (Reinke, et al., 2011; Rothi, et al., 2008), a large proportion of teachers felt that they had skill and training deficits in mental health, and expressed interest in and need for further training and access to more resources. Such findings endorse the routine provision of training to assist teachers in appropriately addressing student mental health (Johnson, et al., 2011; Kidger, et al., 2010). Most teachers in the current study reported awareness and/or involvement in mental health related training provided to teachers through initiatives such as MindMatters (MindMatters, 2009) and Mental Health First Aid (MHFA; Kitchener & Jorm, 2007). These types of training typically aim to improve teachers’ mental health literacy. Providing effective training in mental health has been shown to build teachers’ knowledge and increase their confidence in providing support for students’ mental health concerns. However a number of challenges exist to effectively providing and implementing training to increase teacher confidence and competence in supporting student mental health (Rowling, 2008). At present, training that is generally available or received by teachers in mental health related areas is provided on an ad-hoc basis and tend to require a significant time commitment (e.g. MindMatters and MHFA require a minimum 14-hour commitment over two days) adding to teachers’ already demanding workloads and crowded curriculum. In order to improve the effectiveness of school-based mental health practices, the resourcing of initial teacher training and on-going professional development in the area of mental health and mental health literacy must remain a priority (Graham, et al., 2011). Additionally, further efforts must be made to integrate both teacher training and practices of supporting student mental health more tightly into the schools’ systems as routine components of teaching and learning.

While the current study supported previous findings regarding teachers’ expanding role breadth and need for greater self-efficacy, a number of limitations should be kept in mind. Typical of qualitative designs, the current study had a small sample of 21 participants, from a
single city in Australia. This small sample size and volunteer recruitment procedure may have attracted teachers who are more interested and committed to mental health which may limit the generalisability and representativeness of the current findings — there may be teachers who feel quite differently about their role in supporting student mental health. Notably, the representativeness of findings was somewhat improved through the recruitment and inclusion of a diverse range of teachers, varying in age and experience, and producing consistent results across this sample — as was shown by the majority of themes being reported on a ‘typical’ or ‘general’ level, representing the views of most or all participants respectively. Responses did not vary by age and experience, and a consistent message regarding the teacher role emerged. Furthermore, qualitative research aims to develop transferable theories by providing in depth information about the research participants and their contexts, as was achieved by the current study, rather than generalizable theories generated through less detailed information from a large sample. Still, further research is required to determine whether the current study’s findings reflect the views of teachers more widely across different localities and cultural contexts.

Future research needs to identify specific actions that can be considered a routine part of a teacher’s role which support young people’s mental health. The extent to which teachers are well-equipped to undertake these actions can then be determined and training as well as professional development can be informed to ensure teachers are competent and confident in these essential areas. Incorporating student perspectives on how they believe teachers can best support their mental health and wellbeing would also be valuable for future research.

5.8 Conclusion

Teachers acknowledge that supporting mental health is an important element of their teaching role and recognise the positive impact they can have on young people’s mental health.
However, they perceive a skill deficit and feel inadequately prepared to effectively address all the mental health needs of their students. Expectations of a teacher’s role have expanded over time and teachers need support to balance the demands of their complex role. Teachers must now accommodate student social and emotional wellbeing in conjunction with the more traditional goals of learning and academic performance. Clear role boundaries need to be set so that teachers are aware of their place in the pastoral care system for young people with mental health needs and relevant skills must be incorporated routinely into training and professional development. Aiding teachers to support student social, emotional and mental wellbeing is essential for students to learn productively at school and to prepare them for adulthood.
5.9 References


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CHAPTER SIX

Paper three: Mental Health in Sport: Coaches’ views of their role and efficacy in supporting young people’s mental health

6.1 Chapter Introduction

This chapter contains the third research article prepared during the course of candidature, which has been submitted for publication in the International Journal of Health Promotion and Education. Paper three explores coaches’ views of their role and ability to support young people’s mental health. The format of the paper is in accordance with the publication guidelines for this journal.
Mental health in sport: Coaches’ views of their role and efficacy in supporting young people's mental health

6.2 Abstract—

This study aimed to investigate coaches' awareness of mental health in youth sport, as well as their perceived role breadth and ability to support young people's mental health. Interviews were conducted with 13 sports coaches of young people aged 12 to 18 from Canberra, Australia. Interview transcripts were analysed using a combination of inductive and deductive qualitative content analysis. Coaches recognized their role breadth allows them to be a useful source of support for young people’s mental health by way of identifying concerns, facilitating help-seeking behaviour, and promoting engagement in sports. Further training in mental health would boost coaches’ ability to assist confidently and effectively, leading to benefits for young people’s mental wellbeing and sporting experience. Coaches are in a position to positively impact young people’s mental health, and set expectations for themselves to actively support young people in this way. Supporting mental health may be an area of future growth for the role of a youth sports coach.

6.3 Keywords: Youth mental health; sports coaches; mental health promotion; role breadth; self-efficacy

6.4.1 Sport, exercise, and mental health

Sport is important to many young people and regular participation has clear benefits across a number of domains, including physical, psychological, intellectual, and social health (Danish, Forneris, and Wallace 2005, Fraser-Thomas, Cote, and Deakin 2005). Of growing interest are the many psychological and social health benefits participation in sport and exercise provide. The sports environment fosters positive youth development (Fraser-Thomas, Cote, and Deakin 2005) by facilitating the self-esteem, identity formation, and feelings of competence,
and encouraging positive peer relationships, leadership skills, teamwork, commitment, and discipline (Danish, Forneris, and Wallace 2005). Furthermore, exercise reduces anxiety, depression, and negative mood while improving confidence, cognitive functioning and emotion regulation (Callaghan 2004, Fox 2000), and the reciprocal social support that occurs in sport is an important factor in promoting physical and mental wellbeing (Carless and Douglas 2008). Due to its multiple benefits, exercise is a valuable, but often neglected, factor in the management of and recovery from mental illness (Callaghan 2004, Carless and Douglas 2008).

Young people’s mental state and psychological skills also influence their physical performance in sport (Edwards 2007, Danish and Nellen 1997). Accordingly, mental toughness — “an unshakeable perseverance and conviction towards some goal despite pressure or adversity” (Middleton et al. 2004) — has long been valued in sport and is an important factor in determining sporting outcomes and success. Young people with greater mental toughness cope more effectively with adversity and pressure, possess increased resilience in the face of challenges, and deliver better, more consistent, cognitive and physical performance in sport (Crust 2007). This link provides motivation for coaches to play a role in the promotion and practice of psychological skills that are beneficial to young people’s mental wellbeing.

6.4.2 Young people’s mental health

An alarming proportion of young people suffer from mental health problems. One out of every four to five Australian young people will experience a mental health problem in any given year and most young people do not seek professional help (Barney et al. 2006, Patel et al. 2007). Importantly, when young people do reach out they prefer to seek help from
someone they already know and trust. Young people tend to need the encouragement and guidance of trusted adults in order to seek appropriate professional help for their mental health problems (Rickwood et al. 2005).

6.4.3 Young people’s relationship with community based adults

Promoting connections with community-based adults has been proposed as a response to mental health problems among Australian youth (Pierce et al. 2010). These are adults who have regular contact with young people and who are thereby in a position to support young people’s mental health and encourage early and appropriate help-seeking (Rickwood et al. 2005). Sporting clubs often serve as social hubs within communities and have recently been proposed as effective environments to promote youth mental health and to identify and support young people experiencing mental health difficulties (Pierce et al. 2010). Coaches occupy a position of care and responsibility for young people within the sporting environment and are able to develop trusting and enduring relationships with them (Mazzer and Rickwood 2009). For these reasons, coaches are in a position to make a major contribution to the mental health and wellbeing of young people in their care (Donovan et al. 2006).

6.4.4 Coaches’ role in mental health

Coaches serve important roles in the lives of many young people. Approximately 75% of Australian young people, aged 15 to 24, participate at least weekly in physical exercise, many specifically through organized sport involving coaches (Australian Sports Commission 2010). Coaches assist young people to reap the natural rewards of sport and exercise. But the coach’s role extends far beyond winning games (Bloom et al. 1998, Fraser-Thomas, Cote, and Deakin 2005). Most coaches aim to behave in a manner that will encourage the success
and personal development of their young athletes (Williams et al. 2003). They are able to use
sport as a setting in which to facilitate the development of useful lifeskills and values — such
as leadership, self-motivation, confidence, discipline, problem solving, decision making,
effective communication, concentration, and personal growth (Bell 1997, Danish, Forneris,
and Wallace 2005).

6.4.5 Challenges within the coaching role

There is great potential for coaches to assist young people’s mental health. However, there
are also inherent risks to such involvement and influence. The coach contributes heavily to
the quality and outcomes, both positive and negative, of young people’s sporting experiences
(Williams et al. 2003). Sadly, there have been cases of coaches exploiting their position and
relationship with young people in sport, resulting in child abuse and sexual exploitation
(Bringer, Brackenridge, and Johnston 2006). Bringer, Brackenridge, and Johnston (2006)
suggested that in light of increased public awareness and concern of sexual exploitation in
sport, coaches have reevaluated what is required of them to be an effective coach and may be
hesitant to offer support to young people due to their perceived risk of being accused of child
abuse. Consistent with this caution, Bapat, Jorm, and Lawrence (2009) found coaches raised
concerns in managing potential conflicts between developing a trusting and confidential
relationship with a young person versus informing family members about any issues. It is
important that coaches are aware of how to, and are able to, appropriately and effectively
assist young people with their mental health.

6.4.6 Coaches’ self-efficacy

While coaches may be in a position to support young people’s mental health and influence
help-seeking, they may not have the skills and knowledge required to do so effectively
There has been little research investigating this aspect of their role as coaches have only recently begun to gain recognition as a source that may benefit from education and training in mental health to enable better support for young people and their mental health needs. Mental Health First Aid (MHFA), a training program aiming to increase mental health literacy (Kitchener and Jorm 2002), has recently been applied within the sporting environment (Bapat, Jorm, and Lawrence 2009, Pierce et al. 2010). Pierce et al. (2010) offered the training to a group of rural football coaches. Encouragingly, the training improved coaches’ knowledge of mental disorders and capacity to recognize mental illness as well as markedly increased their confidence in helping someone with a mental health problem. Educating sports coaches was intended to encourage earlier help-seeking and capacity to respond to peer mental health issues by providing an easily accessed source of support (Pierce et al. 2010).

6.4.7 Aims

Previous research on the role of coaches in young people’s mental health, and the skills coaches have to promote mental health and encourage early response to mental health concerns, is limited (Pierce et al. 2010). Given the high prevalence of mental health problems among Australian youth and the potential for coaches to intervene, this study investigated what coaches perceive their role to be in supporting young people’s mental health. The study firstly aimed to investigate coaches' awareness of mental health in youth sport. Secondly, coaches’ perceived role breadth, or what they believe they are expected to do within their role, was explored. Thirdly, coaches’ perceived efficacy, or what they think they are able to do to support young people’s mental health, was investigated.
6.5 Method

6.5.1 Participants

Participants were 13 sports coaches (5 female and 8 male) of young people aged 12 to 18 years, living in Canberra, Australia. The age of participants ranged from 23 to 59 ($M = 36.1$, $SD = 11.9$). Years of experience in their role ranged from 7 to 37 years, with mean length of experience being 14.8 years ($SD = 9.7$). Participants coached across range of sports including: basketball, netball, football (soccer), AFL, touch football, rugby union, rugby league, tennis, and cricket.

6.5.2 Procedure

Approval for the project was obtained from the University of Canberra Committee for Ethics in Human Research. Sports coaches within Canberra, Australia, were invited to participate in the research through a snowballing circulation of an advertisement flyer among local sports coaches. Individual interviews were arranged for participants who contacted the researcher to indicate interest in participation at a suitable time and location. Interviews were approximately 30 minutes in duration and were audio recorded and fully transcribed. All interviews were conducted by the first author. Informed consent was obtained prior to participation in the study.

6.5.3 Measures

A semi-structured interview was designed to explore coaches’ perceptions of their role in supporting young peoples’ mental health. Demographic information was collected along with questions aiming to explore participants’ awareness, acceptance, involvement, and skills in supporting young peoples’ mental health. Additional questions addressed limits or challenges
to providing such support. Initially, no definitions of “mental health”, “promotion”, “prevention” or “early intervention” were provided so that participants could convey their own personal views on these issues. Then, when the questioning required an agreed understanding of these constructs, the following definitions were provided (Commonwealth Department of Health and Aged Care 2000):

**Mental health promotion** is any action taken to maximise mental health and wellbeing among populations and individuals.

**Prevention** refers to “interventions that occur before the initial onset of a disorder” to prevent the development of disorder.

**Early intervention** comprises interventions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder.

### 6.5.4 Data analysis

Transcripts of the interviews were analysed using a combination of inductive and deductive approaches (Fereday and Muir-Cochrane 2006). Text relevant to the research questions was identified and organised into repeating ideas, then general themes. These themes were organised into theoretical constructs that link the data to broader psychological theory (Silverstein, Auerbach, and Levant 2006). Data were initially analysed by hand, followed by the use of NVivo qualitative data analysis software, version 9 (NVivo 2010).

Tests of coding reliability were conducted. Following completion of initial coding of all transcripts, six transcripts were re-coded by the same coder to assess coding consistency over time (Richards 2005). Inter-rater reliability was also tested through a second independent researcher coding six clean transcripts. Coding assignment was compared between coders with a calculated Kappa coefficient of .80, which is above the level of .75
generally considered excellent (Robson 2002). Coding discrepancies were resolved by consultation with a third researcher, providing further strength of reliability through researcher triangulation.

To determine the level of representativeness of responses, four levels of frequency labels were applied. As proposed by Hill, Knox, Thompson, Williams and Hess (2005), a theme that applied to all or all but one of the cases was considered general. A typical theme applied to more than half of the cases. A theme considered variant included at least three cases and up to half of all cases. A theme that included two or three cases was considered rare. Findings that emerged from only one case were not reported. Figure 6.1 illustrates the strength and hierarchical structure of the identified themes.

![Diagram of identified themes](image)

**Figure 6.1**: Strength and hierarchical structure of identified themes.

*Note: The size of the shape indicates the strength of the theme, where larger shapes represent stronger themes.*
6.6 Results

6.6.1 Awareness of mental health in youth sport

6.6.1.1 Prevalence

Coaches typically reported awareness mental health problems being prevalent among young people. They also described that it was increasingly common for coaches to become aware of such concerns within the sporting environments. Depression, suicidal ideation and suicide, and body image issues were perceived (by a variant level of participants) as the most prevalent mental health concerns among young people.

“Usually there would be about 8 in a team, 8 to 10, and every team that I have coached I have had at least one maybe two girls that are having like high levels of stress, and not related to school stress or normal teenager stuff, but higher levels of experiencing suicide of friends or panic attacks, anxiety and depression. So there is always one in a group of that many, that I have come across, every time I have coached a team, and that is kind of concerning.”

6.6.1.2 Impact on performance

Participants discussed that the core focus of their role as coaches is to develop young people’s sporting performance. They further identified that mental health concerns can often complicate this process. Typically, coaches highlighted the impact that mental health has on participation and performance in sport and related activities. They recognised that mental health concerns often decrease a young person’s interest and participation in sporting activities, particularly within group settings such as practice or training sessions, and that the young person's ability to perform in their sport is weakened and often inconsistent.
“Things like self-esteem, confidence play a big part, as well as probably their... attitude towards learning at training. So if they’ve had a bad day or had an argument at home, when they're coming to training their attitude towards learning and participation is different than it is on a good day.”

6.6.2 Coaches’ role breadth

6.6.2.1 Self-expectations of the coach’s role

All participants identified young people’s mental health as part of their role as a coach, and recognised the opportunity they have to positively impact young people’s mental health. Coaches typically reported previous involvement in specific cases of supporting a young person’s mental health. Participants perceived a level of responsibility within their role, and typically reported willingness and expectation of themselves to care for and communicate with young people regarding concerns they become aware of.

“I think if you don't [support mental health] then you're not a very good coach. I mean if you can't... if you can't tap into the boys’ way of thinking or their headspace, and even read them before they walk on the field, then you're not really doing the boys justice.”

6.6.2.1.1 Supportive activities. Coaches identified a number of specific activities within the breadth of their role that they can perform to support young people’s mental health. Providing a positive, safe and friendly environment; encouraging participation within groups and activities; and identifying when a young person was experiencing a mental health problem, through indicators such as behaviour change or decreased participation, were among the most common activities, typically reported by coaches.
6.6.2.1.2 Established relationships. Another of the most common areas participants discussed concerned the position of leadership and support coaches occupy and the relationships they build with young people. Participants typically discussed that within their coaching role they have regular contact with many young people, often over an extended period of time, which enables them to develop strong relationships with many young people. In addition, coaches typically reported that they are often viewed with respect and seen as a role model or mentor by young people. They acknowledged that such a position can allow them to act as an external, trusted outlet or support person, for young people to communicate with. Coaches also described they are well placed to monitor behaviour change, and act accordingly (such as, approach the young person if needed). They discussed that sometimes young people do not feel comfortable disclosing to their parents, family members, or peers, and may feel more comfortable communicating concerns with an external source such as their coach. The ability to establish these relationships was perceived to be a major factor contributing to coaches’ opportunity to positively influence young people’s mental health. Being approachable and having open communication within their relationships with young people were typically reported as important aspects in developing trust and supporting young people’s mental health.

“I think a coach is in a unique position, that's different to maybe a teacher or a parent or some other sort of authority figure in their life, that they [coach] can see some things occurring in a social setting but as well as in a sort of semi structured setting and other people might not see. Whether it’s because they're with their friends they're more likely to talk about issues that they are having or you can pick up some activity or behaviour that's abnormal.”

6.6.2.2 External expectations of the coach’s role

In addition to self-expectations for effectively performing their role, coaches also discussed
expectations that other external sources place on coaches. A variant number of coaches reported they do not feel that there is a large focus or expectation for coaches to be involved supporting young people’s mental health, unless it is influencing the young person’s performance in sport, in which case coaches felt they were more likely to be expected to become involved. A variant number of coaches indicated that the greatest expectation or pressure for coaches to become involved in young people’s mental health would most likely come from the young people’s parents. Accordingly, coaches identified parents as an important party to consider communicating with when taking action to support their child’s mental health.

“I don't think there is too much expectation when it is non-performance related. But I would say that there might be an expectation say from a child's parent who you are coaching, if anything was to happen or change, that you would... that you would probably recognise it and take it further...that you would speak to them about it at least.”

“I think yeah generally we hear about it as coaches and unless it affects performance then we don't address it as much, or we don't have to deal with it as much.” – Coach.

6.6.2.2.1 The changing role. Participants on a variant level also identified that the role of the coach is evolving and expectations for their role have changed over time. Importantly, coaches noted that although they do not perceive much external pressure, they do feel that expectations for coaches to be involved and supportive of young people’s emotional and mental wellbeing have increased in recent years.

“A coach … [is] asked to do a lot more than they were in years past.”

“It's a changing role. From the days where I started, you didn't have to worry about that stuff. You just coached, [and] went home... the kids weren't our problem. Whereas now I really feel when I'm coaching juniors that I'm another role model for them... and I've got to be positive and... so I try and set a good example."
6.6.2.3  **Boundaries of role breadth**

While reporting willingness to support young people’s mental health through their coaching role, participants typically noted that this role does have limits. Elements viewed as outside the bounds of their role predominantly focused on limiting the amount of responsibility they assume for the care of young people’s mental health. Participants recognised that while they are involved in supporting young people’s mental health, it is not a core focus of their role. Participants definitively viewed “dealing with”, or treating, mental health issues in any way, as beyond the scope of their role and responsibilities. They emphasised that other professionals are better equipped to assist with mental health concerns.

> “I think as a coach you need to be involved in each of your players sort of headspace, up to a certain point... and then obviously you need to draw back or ask for further help.”

> “To a certain extent I don't feel I should have to be the one who that copes with it. There are plenty of services... well I would imagine there's plenty of services available to them.”

> “There’s only a limited window where we're involved. We're like basically the first point of contact and then it's out of our hands.”

6.6.2.3.1  **Coaching style.** Most coaches also recognised that coaching style would impact the extent to which coaches support mental health. Participants typically highlighted that individual coaches employ differing styles and approaches to their coaching role, some of which would be more congruent with supporting young people’s mental health than others. They noted that there is variation in coaches’ attitude toward supporting mental health within their role rather than a consistent approach. Participants additionally noted that the majority of coaches are community coaches and volunteer workers, with other jobs/careers, dedicating their personal time to coaching. They are not necessarily all experts in the field of coaching or related areas.
“Everyone's got a different style and the way they like to interact with the players. So some are obviously going to be more accommodating to any [mental health] issues like that and others just won’t be able to deal with it at all.”

“You’re only a volunteer and it’s not a paid job and you are doing what you think is best at the time.”

6.6.2.3.2 Reluctance and concerns of involvement. Participants rarely expressed reluctance for supporting mental health within their roles. A variant number of participants did, however, describe a need to act with caution and consideration when engaging in varying tasks to support young people’s mental health within the coaching role. They highlighted the importance of recognising the limits of their expertise and role breadth, and described associated risks and consequences of acting beyond them, such as losing their position. Self-protection when supporting young people was specifically identified as a concern by a variant number of participants. A small number of coaches reported concerns and challenges in decisions around confidentiality and the difficulty of balancing privacy of information versus communicating necessary information between other parties such as parents, colleagues, and mental health professionals.

“I think with the child protection they have to be careful. I think you have to be careful that you don't over cross the line of being a coach and then maybe get too involved. I think that maybe they should try and keep it at arms distance if they can. Giving advice but maybe not being too overbearing, or maybe if they think there is a problem recommending that that person goes and talks to someone, who’s a professional, about it, instead of letting it keep going.”
6.6.3 Self-efficacy

6.6.3.1 Confidence

Coaches, on a general level, reported that they were confident to support young people’s mental health by talking with young people about concerns relating to their mental health. Participants further agreed that they were comfortable for concerns to be raised through either being approached by a young person or parent or other party, or when they identify a change or cause for concern in the young person.

“If I could see that someone was having issues, whether maybe it was problems at home, they were coming, they weren't talking, they were down... I would feel quite comfortable in asking if they're okay and if there's anything we can do to help.”

6.6.3.1.1 Fear of negative impact. Although, participants generally reported confidence in supporting mental health through talking with young people, a variant number of coaches also described concern that this could lead to them saying or doing the “wrong” thing in supporting young people with their mental health. They reported worrying that their actions or advice may negatively impact young people, and that this could have severe consequences at such a vulnerable time of life.

“You don't want to be saying the wrong thing and then something really drastic happens.”

6.6.3.2 Knowledge and skills

A concerning finding was that only half of the coaches reported having any mental health related knowledge or skills and nearly all coaches reported knowledge, skill and training deficits in mental health related areas. A variant number of coaches discussed relying on basic common sense knowledge in their involvement with young people’s mental health.

Notably, many expressed that more training and resources in mental health related areas would be valuable.

“I think just using common sense and some skills that I have learnt I would be able to do something... but I would really need to know a lot more.”

“I think a bit of training in mental health and wellbeing for coaches would be great. Often it’s hard to recognise what’s a serious problem and what’s something that’s just going to go away. So a bit of training with that, and sort of recognising when there’s a problem, and then how to deal with it, what sort of steps you should be taking, whether you should be involving the parent... that's sort of all a bit unsure... so if coaches had that sort of training they'd be a bit more proactive I think in acting on it.”

6.7 Discussion

There is a range of adults in young people’s lives who can support their mental health. Coaches who have regular contact with young people through their social sport engagement are in a position to promote mental health and facilitate early help-seeking. It is important that these adults are able to effectively assist young people. This study sought to explore the ways coaches expect to support young people’s mental health and whether they feel competent and confident to carry out this role.

Coaches were aware of the negative impact mental health problems can have on a young person’s participation and performance in sport and general wellbeing. Despite not feeling strong external expectations or pressure to support youth mental health, coaches recognise the opportunity they have and held expectations of themselves to promote mental health and respond to mental health concerns. Consistent with help-seeking research (Rickwood et al. 2005), coaches identified the relationship they build with young people as a
vital component of their ability to influence young people’s mental health and help-seeking behaviour.

The role of a coach has evolved over time and the expanding breadth of activities and responsibilities within a coach’s role now provides increasing opportunity to be an accessible source of support for young people’s mental health. Coaches in the current study acknowledged they are in a position to observe behaviour change and identify when a young person is experiencing a mental health problem. Pierce et al. (2010) in Australian based study identified coaches as a helpful source for identifying mental health concerns and encouraging early help-seeking. Coaches in the current study agreed they are in a position to do so via monitoring behavior changes. Coaches additionally identified a number of other activities they perform within their role breadth to support mental health. One such activity, encouraging participation in groups and activities, is particularly important for vulnerable young people. Given the positive effects of exercise on mental health, including reducing anxiety, depression and improving emotion regulation, exercise is considered an effective component of the treatment and management of mental illness (Carless and Douglas 2008, Fox 2000). The ability of coaches to encourage ongoing engagement and participation within sports is uniquely valuable, particularly during adolescence, when many young people drop out of sport and exercise.

Notably, coaches raised some concerns regarding involvement in supporting mental health. The qualitative findings of Bringer, Brackenridge, and Johnston (2006) suggested coaches are concerned by risk of being viewed as too close to their athletes and accused of abuse or exploitation. Coaches in the current study similarly acknowledged that concern for self-protection (of their position and reputation) can create apprehension towards supporting young people. Congruent with previous findings, coaches also identified the challenges
involved and conflicts between respecting privacy of information versus informing parents and other professionals of concerns (Bapat, Jorm, and Lawrence 2009). Fear of negatively impacting young people by saying or doing the “wrong” thing emerged as a further concern of coaches supporting young people’s mental health. Training programs, such as MHFA, delivered to coaches and other leaders within the sports environment can target specific issues such as what to say to a young person experiencing a mental health problem, specifically addressing this fear as well as coaches own reported need for more mental health knowledge, have been shown to be effective in improving coaches confidence and capacity to respond to mental health concerns (Pierce et al. 2010).

Given the prominence of sport for Australian youth, coaches are an important target group for the provision of training to better equip them to assist young people (Bapat, Jorm, and Lawrence 2009). Increasing easily accessible adults’ knowledge of mental health can be a valuable community resource, by educating the wider community through a snowball effect of sharing information with others, and encouraging better care for their own and others’ mental health (Pierce et al. 2010). Current findings suggest coaches would welcome and value such training in mental health.

Findings from this study were encouraging showing coaches’ willingness and involvement in supporting young people’s mental health, but some limitations should also be acknowledged. Historically, sports psychology research has found coaches to be imprecise predicting their athletes’ mental states and tend to perceive their behaviour as more encouraging and supportive than their actual behaviour demonstrates (Salminen, Luikkonen, and Telama 1992). As the current study used self-report measures (interviews) responses may reflect an overestimation in the extent to which coaches’ actual behaviour is supportive of mental health. To gain a more accurate representation of their behaviour, future research
should look to measure coaches’ actual behaviour or seek the views of young people participating in sport as to the extent their coaches’ behaviour and coaching style is supportive of their mental health. This study involved only 13 participants, due to the intensive nature of qualitative interviewing and analysis, although a wide range of relevant sports was canvassed. As noted by participants, the extent to which coaches support mental health is likely influenced by individuals' personality and coaching style, and there can be large variation in the approach coaches adopt in their role. Future research would benefit from targeting a larger sample to determine the representativeness of the current findings.

6.8 Conclusion

Coaches are emerging as a valuable source of support for mental health, that are more compatible with young people’s lives and help-seeking preferences than traditional supports. This study explored the views of coaches across a wide range of sports and consistently found coaches were aware and accepting of actively supporting young people’s mental health within their role. The wide-ranging breadth of a coach’s role allows them to be a helpful source in identifying concerns and encouraging help-seeking for young people as well as being vitally important in promoting participation within sports for mental health benefits. Encouragingly, even though they perceived little pressure from others, coaches held expectations for themselves to support youth mental health. This is a promising finding as coaches are increasingly being recognized for their contribution to mental health and it may be an area of future growth for the role of a youth sports coach. Further training in mental health would boost coaches’ ability to assist confidently and effectively, leading to improved outcomes for young people’s mental wellbeing and sporting experience.
6.9 References


NVivo Qualitative Data Analysis Software 9. QSR International Pty Ltd.


CHAPTER SEVEN

Paper four: Community-Based Roles Promoting Youth Mental Health: Comparing the Roles of Teachers and Coaches in Promotion, Prevention and Early Intervention

7.1 Chapter Introduction

This chapter presents the fourth research article prepared during the course of candidature. It describes the development of a measure of PPEI behaviour and compares teachers’ and coaches’ involvement in PPEI activities for young people’s mental health. This paper has been published in the *International Journal of Mental Health Promotion* (online pre-print). The format of the paper is in accordance with the publication guidelines for this journal. The data collection instruments used for the research reported in this paper are presented in Appendices E to K.
Community-based roles promoting youth mental health: comparing the roles of teachers and coaches in promotion, prevention and early intervention

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7.2 Abstract: Mental health is an issue for the whole community. Effective support and intervention for mental health can be carried out across a range of contexts. This paper investigated teachers’ and coaches’ relative involvement in promotion, prevention and early intervention activities for young people’s mental health. A set of activities representing promotion, prevention and early intervention for mental health was developed through expert consensus and was used in an online survey completed by 124 teachers and 147 coaches within Canberra, Australia. Results indicated both teachers and coaches frequently performed activities which promote young people’s mental health. Teachers more commonly engaged in behaviour that supported prevention and early intervention for mental health than coaches. Encouraging adults in community-based roles to take early action in supporting young people’s mental health is important to reduce the burden of mental health problems among young people and strengthen available pathways to mental health care.

7.3 Keywords: youth mental health; teachers; sports coaches; mental health promotion; community

7.4 Introduction

It is clear there is a high and growing burden of mental health problems among young people between the ages of 12 and 18 years (Australian Bureau of Statistics [ABS], 2010). Young people are faced with many challenges and transitions throughout adolescence – including physical, emotional and sexual changes, increasing the need for independence, development of self-identity, shifting peer and family relationships, and enhanced academic expectations (Commonwealth Department of Health and Aged Care [CDHAC], 2000; Lerner, Boyd, & Du, 2010) – all of which can increase the risk of developing mental health problems (Headspace, 2011). Many mental disorders first emerge during this lifestage; half of all mental disorders have their first onset before the age of 14 and three-quarters before 25 years (Kessler et al., 2009).

7.4.1 Promotion, prevention and early intervention

Improving mental health and well-being via mental health promotion, prevention and early intervention has been a primary focus of the Australian Government for the past decade (CDHAC, 2000; Commonwealth of Australia [CoA], 2009). Mental health promotion consists in a variety of activities that seek to positively impact mental health and well-being. Prevention aims to avoid the development of a mental disorder, generally
by reducing known risk factors. Early intervention endeavours to reduce the impact and burden of mental illness by taking effective action in the early stages of its development (Mrazek & Haggerty, 1994). Adolescence is a critical period for promotion, prevention and early intervention in mental health as it provides unique opportunities to intervene to prevent a range of problems in later life including obesity, criminality, unemployment, homelessness and excessive financial strain (Queensland Health, 2009).

7.4.2 Community

Mental health is an issue for the whole community. Individuals, families, professionals and other community members share roles in promotion, prevention and early intervention for mental health (CoA, 2009; Mazzer & Rickwood, 2009). Effective intervention to enhance mental health can be carried out across a range of contexts and need not be confined to traditional mental health services. Schools, workplaces and communities have been targeted by the Australian Government as settings to deliver interventions aiming to improve mental health and well-being (CoA, 2009). Adults within these settings, such as teachers and coaches, often occupy positions of care or responsibility for young people and can make a major contribution to the mental health of those young people (Donovan et al., 2006).

7.4.3 Role of teachers

Most Australian young people aged 12–18 years attend school, and a significant proportion of these young people have high needs for mental health support (Headspace, 2011). Schools are a key setting to promote mental health and well-being. They also provide opportunity for young people at risk of developing mental health problems to be identified and supported (Finney, 2006). Teachers are well placed to recognize issues concerning young people’s social and emotional well-being and can play a valued role in the help-seeking process (Graham, Phelps, Maddison, & Fitzgerald, 2011; Johnson, Eva, Johnson, & Walker, 2011). Encouragingly, teachers have generally been found to acknowledge that they have a responsibility to care for and address the mental well-being and concerns of young people (Reinke, Stormont, Herman, Puri, & Goel, 2011). Mazzer and Rickwood (2013) show that teachers consider this as a fundamental part of their role as a teacher, but expressed concerns that they lacked the knowledge and skills required to fully address their students’ mental health needs.

7.4.4 Role of coaches

Youth sport coaches can also act through their community-based role to support young people’s mental health. Approximately 75% of young Australian people (aged 15–24) participate at least weekly in physical exercise, many specifically through organized sport involving coaches (Australian Sports Commission [ASC], 2010). Participation in regular physical activity and sport has been strongly promoted as it has clear benefits for young people across a number of domains, including physical, psychological, intellectual and social health (Danish, Forneris, & Wallace, 2005; Fraser-Thomas, Cote, & Deakin, 2005). Coaches assist young people to reap these natural benefits of sport and exercise.

The role of the youth sport coach carries great responsibility and extends far beyond winning games (Bloom, Durant-Bush, Schinke, & Salmela, 1998; Fraser-Thomas et al., 2005). Coaches are able to use sports as a setting in which to facilitate the development of
useful life skills and values, such as leadership, self-motivation, confidence, discipline, problem solving, decision-making, effective communication, concentration and personal growth (Bell, 1997; Danish et al., 2005).

The sporting environment has been identified as a particularly valuable setting for accessing and supporting at-risk youth, with the development and implementation of targeted programmes – such as midnight basketball, a national social inclusion programme which provides food, transport, life skills workshops and basketball games – to help youth identify and embrace positive opportunities (Midnight Basketball Australia, 2011).

Mazzer, Rickwood, and Vanags (2012), in a recent Australian qualitative investigation of teachers and coaches supporting young people’s mental health, found that teachers viewed their involvement in supporting young people’s mental health to occur more commonly through early intervention than promotion or prevention. Coaches viewed their role as being more frequently involved in promotion than prevention or early intervention. Further exploration of the role of community-based adults and their influence on young people’s mental health is required (Mazzer & Rickwood, 2009).

7.4.5 Aims and hypotheses
This study seeks to confirm or disconfirm the qualitative findings of Mazzer et al. (2012) by investigating teachers’ and coaches’ involvement in promotion, prevention and early intervention activities for young people’s mental health using quantitative methods. It was recognized, however, that a barrier to such an investigation is that there is currently no standardized measure of promotion, prevention and early intervention behaviour, and the activities that comprise each of these categories are not well defined.

This paper, therefore, has two primary aims. First, it aims to develop a set of activities that characterize promotion, prevention and early intervention for mental health. Second, the paper aims to identify and compare teachers’ and coaches’ relative engagement in promotion, prevention and early intervention activities for young people’s mental health. It is hypothesized that teachers will have greater engagement in promotion, prevention and early intervention activities, overall, than coaches. It is also hypothesized that teachers will have a greater engagement in early intervention activities than in promotion or prevention activities. Coaches are hypothesized to have the most engagement in promotion activities rather than in prevention or early intervention.

7.4.6 Design
This study was conducted in two phases. Phase I used expert consensus to develop a set of items that characterize promotion, prevention and early intervention behaviour. An inductive approach to survey development and data analysis was then taken, whereby findings from Phase I were used to inform the development of an online survey completed by teachers and coaches in Phase II (Thomas, 2006).

7.5 Phase I: Development of promotion, prevention and early intervention activities
7.5.1 Method
7.5.1.1 Participants
Ten experts in the field of promotion, prevention and early intervention for mental health took part in the study. These experts included those demonstrating national prominence in policy concerning promotion, prevention and early intervention for mental health and
those motivating advances in youth mental health. The experts were selected through consultation among the research team.

7.5.1.2 Procedure
A pool of 70 potential items was initially created. Each item described an activity that may be performed by adults in community-based roles that can affect young people’s mental health, as identified by teachers and coaches through interviews reported in Mazzer et al. (2012). The activities were tentatively categorized into three groups by the researchers: activities that benefit the promotion of mental health (promotion), activities that support the prevention of mental health problems (prevention) and activities that represent early intervention for mental health problems (early intervention). An additional category was formed for activities that fell outside the scope of these three areas.

Ten to fifteen activities proposed by the researchers as depicting the range and diversity of activities within each of the three categories – promotion, prevention and early intervention – were selected from the pool of 70 potential items for inclusion in the 40-item promotion, prevention and early intervention activity checklist. To minimize researcher bias and to examine the validity of the proposed categorization of activities, the 10 experts in the field of promotion, prevention and early intervention for mental health were consulted. To avoid the influence of one respondent on another, experts were recruited and responded independently via email.

7.5.1.3 Measures
Experts were asked to complete an activity checklist comprising the 40 selected items by rating whether they thought each activity was best categorized as: the promotion of mental health, the prevention of mental health problems, early intervention in mental health, or unclear or not represented by any category (none/unclear). Selecting more than one category for a given activity was allowed if a single category was not able to be determined. Items were scored one point for each expert rating in a category.

7.5.2 Results
7.5.2.1 Expert activity ratings
Ratings of activity classification were compared across the 10 expert responses. Items were scored and ranked from most to least consensus within their highest rating category. Results yielded varying degrees of agreement across activities. Some activities rated similarly in the promotion, prevention and early intervention categories, meaning that these activities were considered to fit within more than one behaviour category. This was not a surprising result as it is well documented that although the goals of promotion, prevention and early intervention differ, there is often considerable overlap in the continuum, and it can be difficult in practice to classify an activity as purely promotion, prevention or early intervention as many activities combine elements of all of these. For instance, an activity aimed at improving well-being in a community (promotion) may also impact and reduce the incidence of mental health problems (prevention; CDHAC, 2000).

The five activities with the greatest expert consensus for each behaviour category were selected to form a 15-item set (see Table 1). Restricting item inclusion to this small number ensured that only archetypal activities of each category were selected and ambiguous activities avoided, i.e. activities that rated similarly across more than one
category. This enabled greater discriminant validity of the behaviour categories. The final 15 items had moderate to high levels of expert consensus, ranging from 100% agreement (i.e. rated by all 10 experts into the same category) to a minimum of 50% agreement.

The promotion and early intervention categories recorded high levels of consistency across responses, with the selected five activities categorized into the respective groups by at least 8 of 10 experts. There was greater variance in activities recorded as representing the prevention category, with the selected five activities categorized to prevention by between 5 and 8 of 10 respondents. The item ‘Have an “open door” approach for young people to speak with you’ received the second largest agreement in the prevention category; however, it was excluded from the measure as the researchers in consideration of the promotion, prevention and early intervention continuum (as described by Mrazek & Haggerty, 1994) deemed that it was not exclusively a prevention activity and may more accurately be considered an ambiguous activity also representative of promotion behaviour. Consequently, the sixth most endorsed prevention activity ‘Identify and stop bullying’ was included in the final set. Expert ratings of the final 15 selected activities were otherwise consistent with the researchers’ initial categorization.

To allow for exploration of the boundaries of activities within teachers’ and coaches’ roles, care was also taken when selecting items for both the behaviour checklist and final 15-item set, to ensure inclusion of items that were likely to capture a range of endorsements from teachers and coaches, i.e. including activities that were likely to be performed frequently and other activities that were less frequent. Consequently, a confirmatory factor analysis was not done to confirm categorization of the activities within the subscales of promotion, prevention and early intervention as activities were purposefully selected to

<table>
<thead>
<tr>
<th>Activity</th>
<th>Expert activity rating ((N = 10))</th>
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<tbody>
<tr>
<td><strong>Promotion</strong></td>
<td></td>
</tr>
<tr>
<td>Encourage inclusivity and participation of all young people in activities</td>
<td>9</td>
</tr>
<tr>
<td>Promote healthy lifestyle and exercise</td>
<td>9</td>
</tr>
<tr>
<td>Encourage young people to participate in their community</td>
<td>8</td>
</tr>
<tr>
<td>Actively advocate for young people’s voice in policies</td>
<td>8</td>
</tr>
<tr>
<td>Encourage young people to build positive attitudes towards people with mental illness</td>
<td>8</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
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<tr>
<td>Assist young people in learning how to manage stress</td>
<td>8</td>
</tr>
<tr>
<td>Have an ‘open door’ approach for young people to speak with you</td>
<td>7</td>
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<tr>
<td>Identify and stop bullying</td>
<td>6</td>
</tr>
<tr>
<td>Use behaviour management strategies to assist young people to reduce or prevent behaviour problems</td>
<td>6</td>
</tr>
<tr>
<td>Talk about early warning signs of mental illness</td>
<td>6</td>
</tr>
<tr>
<td>Encourage a young person to talk to their parents about their personal problems</td>
<td>5</td>
</tr>
<tr>
<td><strong>Early intervention</strong></td>
<td></td>
</tr>
<tr>
<td>Refer a young person to other sources of help (e.g. General Practitioner [GP], psychologist, counsellor)</td>
<td>10</td>
</tr>
<tr>
<td>Notify and consult colleagues about concerns you have for a young person’s mental health</td>
<td>9</td>
</tr>
<tr>
<td>Personally contact the parents of a young person whose mental health you are concerned about</td>
<td>9</td>
</tr>
<tr>
<td>Offer advice to a young person about their mental health concerns</td>
<td>8</td>
</tr>
<tr>
<td>Ask a young person about suicide risk</td>
<td>8</td>
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</table>
reflect a range of frequency of involvement, and so, activities within categories would not be expected to load similarly on the categories according to frequency of endorsement.

7.6 Phase II: Relative involvement of teachers and coaches in promotion, prevention and early intervention activities

7.6.1 Method

7.6.1.1 Participants

Participants were 124 teachers (76 female, 45 male and 3 did not report) and 147 coaches (50 female, 96 male and 1 did not report) of 12–18-year-old from Canberra, Australia, creating a total sample of 271. The age of teacher participants ranged from 22 to 69 years, with a similar mean age of 41.88 (SD = 12.07). The age range of coach participants was slightly greater from 18 to 73 years, with a mean age of 39.33 (SD = 12.21). Participants’ length of experience in their role ranged from less than 1 to 50 years, with teachers’ mean experience of 14.55 years (SD = 11.43) being slightly greater than coaches’ mean experience of 9.39 years (SD = 8.46).

Teachers from eight schools within the Canberra participated in the study. Most (n = 80) teachers were employed at co-educational schools, rather than single sex schools (n = 36; 8 not reported). Sixty-nine taught at government high schools or colleges and 55 at non-government (private or independent) schools. Teachers who participated in the study taught a range of subjects including mathematics (n = 21), science (n = 11), English and social studies (n = 34), physical education (PE; n = 15) and other (elective) subjects such as drama, information technology and religion (n = 40; 3 did not report).

Coaches from four sports participated – soccer (football; n = 55), netball (n = 30), basketball (n = 39), Australian Rules Football (AFL) (n = 20; 3 did not report). Slightly more coaches worked with girls only (n = 64) than boys only (n = 54) or mixed gender groups (n = 31). The level of sport competition that participants coached included social (n = 55), competitive (n = 118) and elite (n = 20) sport, with many (n = 46) reporting they coach across a variety of levels.

7.6.1.2 Procedure

The project was approved by the Committee for Human Research Ethics at the University of Canberra, the ACT Government Education and Training Directorate, and the Archdiocese of Canberra and Goulburn Catholic Education Office. Final permission was sought and obtained from the principal of each school prior to the research proceeding at their site. The club president or club contact of each sporting club was also consulted prior to involvement in the project. Principals and presidents of each selected school and sports club were initially contacted by phone and/or email. Those who gave permission for involvement in the research forwarded an email from the primary researcher with a link to the online survey inviting teachers and coaches of young people aged 12–18 to participate in the research. Participants then completed the survey online. Reminder emails were sent to principals and presidents to relay to teachers and coaches to increase participation rate. To encourage greater participation, all participants were given the opportunity to enter a prize draw to win an Apple iPad (Cobanoglu & Cobanoglu, 2003; Evans & Mathur, 2005).

7.6.1.2.1 Recruitment of teachers. Teachers were recruited through their schools. To ensure that a representative cross-section of schools and school characteristics was
included in the research, a multi-stage sampling technique combining a number of sampling methods was used. This involved alphabetically sorting and stratifying a list of all schools within Canberra (obtained from Directorate of Education and Training website) into categories: government high schools, government colleges, non-government independent schools and non-government Catholic schools. Systematic random sampling was then used to select every second school for inclusion. Twenty-three schools were invited to participate in the study; eight of these schools agreed and were included in the final sample. Reasons for refusal were generally that the school had too many other commitments to participate at this time. All teachers of 12–18-year-old from the selected schools were then invited to participate in the study.

7.6.1.2.2 Recruitment of coaches. Multi-stage sampling was similarly used for the recruitment of coaches in the study. Coaches were accessed through sports clubs of the four most popular team sports in Australia: football (soccer), netball, basketball and AFL (ASC, 2010). These sports were chosen to increase the representativeness of findings by accessing a large pool of coaches with contact to a greater proportion of young people. Individual sports were not targeted as coaching individuals entail dynamics different from coaching teams, and team coaches are more similarly comparable with school teachers by having contact with large number of young people in group situations. A list of eligible sports clubs was developed by accessing each sport’s state organization website. All sports clubs based within Canberra that were listed on their respective sports’ state organization website and involved young people aged between 12 and 18 years were selected. Thirty-one sports clubs fit these inclusion criteria and were invited to participate in the research, of which 21 clubs agreed to participate, including 6 football (soccer), 4 netball, 4 basketball and 7 AFL clubs. All coaches of 12–18-year-old within the selected sports clubs were then invited to participate.

7.6.1.3 Measures

7.6.1.3.1 Behaviour. The final 15 items selected in Phase I were used to measure teachers’ and coaches’ engagement in promotion, prevention and early intervention activities. Participants were asked to indicate the extent to which they engaged in each activity in their role as a teacher or coach. Responses were given on a 5-point scale, from 1 (never) to 5 (very often). The three subscales contained five items each and were calculated by averaging the relevant item scores. Higher scores indicated greater engagement in that behaviour category. The promotion, prevention and early intervention subscales demonstrated adequate to high internal consistency, reporting Cronbach α’s of 0.69, 0.82 and 0.88. The reduced reliability of promotion is likely due to the construct of promotion itself being more broadly defined and inclusive of a larger range of activities than either prevention or early intervention.

7.6.2 Results

7.6.2.1 Engagement in activities

The mean levels of engagement in each of the 15 activities were ranked and compared for teachers and coaches. Overall, teachers most frequently engaged in the activities of ‘Encourage inclusivity and participation of all young people in activities’, ‘Use behaviour management strategies to assist young people to reduce or prevent behaviour problems’, ‘Identify and stop bullying’ and ‘Notify and consult colleagues about concerns you have for a young person’s mental health’. Coaches, although reporting lower engagement levels
than teachers overall, most commonly engaged in ‘Encourage inclusivity and participation of all young people in activities’, ‘Promote healthy lifestyle and exercise’, ‘Identify and stop bullying’ and ‘Encourage young people to participate in their community’. Both teachers and coaches least commonly engaged in ‘Ask a young person about suicide risk’, ‘Talk about early warning signs of mental illness’, ‘Offer advice to a young person about their mental health concerns’ and ‘Personally contact the parents of a young person whose mental health you are concerned about’. Engagement in suicide risk was exceedingly low, particularly for coaches ($M = 1.38$, $SD = 0.70$) but also for teachers ($M = 2.16$, $SD = 0.98$).

Consistent with the intention of the measure when designed, the level of engagement in specific activities varied within each category. In general, activities directly relating to or involving mental illness were less commonly engaged than other supportive activities.

7.6.2.2 Comparison of engagement

A $2 \times 3$ mixed design analysis of variance was conducted to compare engagement in promotion, prevention and early intervention behaviour between teachers and coaches. The three behaviour categories were significantly correlated. Promotion was moderately correlated with both prevention ($r = 0.66$, $p < 0.001$) and early intervention ($r = 0.62$, $p < 0.001$). Prevention and early intervention had a strong positive relationship ($r = 0.85$, $p < 0.001$).

Mauchly’s test of Sphericity was significant ($\chi^2 (2) = 0.93, p < 0.001$); consequently, results were obtained through the Greenhouse–Geisser statistics. Table 2 presents descriptive statistics of teachers’ and coaches’ engagement in each type of behaviour.

The main effect of type of participant was significant ($F(1,269) = 85.91$, $p < 0.001$, $\eta^2 = .24$), with teachers’ overall mean engagement in promotion, prevention and early intervention behaviour being greater than those of coaches. The main effect of type of behaviour was also significant ($F(1.87, 503.83) = 605.47$, $p < 0.001$, $\eta^2 = 0.69$) and explained 69% of the within subjects variance.

The interaction effect between participant type and behaviour was also significant ($F(1.87, 503.83) = 88.33$, $p < 0.001$, $\eta^2 = 0.25$). Twenty-five per cent of variance among the groups was explained by this interaction. Figure 1 illustrates the interaction effect. To further examine this, simple effects were considered. Simple effects between groups revealed no significant difference between teachers’ and coaches’ engagement in promotion behaviour ($t(269) = -2.77$, $p = 0.10$) but that teachers engaged significantly more than coaches in both prevention ($t(268.49) = 10.42$, $p < 0.001$) and early intervention behaviour ($t(269) = 10.99$, $p < 0.001$). In addition, simple effects within groups indicated no significant difference between teachers’ engagement in promotion and prevention behaviour ($t(123) = 2.39$, $p = 0.018$), but that their engagement in early intervention activities was significantly less than that in both promotion ($t(123) = 12.98$, $p < 0.001$) and prevention ($t(123) = 15.33$, $p < 0.001$). Coaches’ engagement in promotion was significantly greater than their engagement in both prevention ($t(146) = 16.32$, $p < 0.001$) and early intervention ($t(146) = 31.66$, $p < 0.001$), and engagement in prevention behaviour was significantly greater than in early intervention ($t(146) = 18.59$, $p < 0.001$).

7.7 Discussion

This study investigated teachers’ and coaches’ relative involvement in activities that support young people’s mental health through promotion, prevention and early
<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Teacher Mean (SD)</th>
<th>Rank</th>
<th>Coach Mean (SD)</th>
<th>Rank</th>
<th>Total Mean (SD)</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Promotion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage inclusivity and participation of all young people in activities</td>
<td>4.67 (.54)</td>
<td>1</td>
<td>4.65 (.52)</td>
<td>1</td>
<td>4.66 (.53)</td>
<td>1</td>
</tr>
<tr>
<td>Promote healthy lifestyle and exercise</td>
<td>4.03 (.84)</td>
<td>5</td>
<td>4.48 (.71)</td>
<td>2</td>
<td>4.28 (.80)</td>
<td>2</td>
</tr>
<tr>
<td>Encourage young people to participate in their community</td>
<td>3.78 (.83)</td>
<td>8</td>
<td>3.70 (1.09)</td>
<td>4</td>
<td>3.74 (.98)</td>
<td>5</td>
</tr>
<tr>
<td>Actively advocate for young people’s voice in policies</td>
<td>3.62 (1.01)</td>
<td>11</td>
<td>3.18 (1.13)</td>
<td>6</td>
<td>3.38 (1.10)</td>
<td>7</td>
</tr>
<tr>
<td>Encourage young people to build positive attitudes towards people with mental illness</td>
<td>3.83 (.99)</td>
<td>6</td>
<td>2.83 (1.28)</td>
<td>9</td>
<td>3.29 (1.26)</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>4.01 (.57)</td>
<td>1</td>
<td>3.80 (.67)</td>
<td>1</td>
<td>3.87 (.65)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Identify and stop bullying</td>
<td>4.24 (.80)</td>
<td>3</td>
<td>3.76 (.96)</td>
<td>3</td>
<td>3.98 (.92)</td>
<td>3</td>
</tr>
<tr>
<td>Use behaviour management strategies to assist young people to reduce or prevent behaviour problems</td>
<td>4.49 (.67)</td>
<td>2</td>
<td>3.26 (1.25)</td>
<td>5</td>
<td>3.83 (1.19)</td>
<td>4</td>
</tr>
<tr>
<td>Assist young people in learning how to manage stress</td>
<td>3.82 (.82)</td>
<td>7</td>
<td>3.16 (1.01)</td>
<td>7</td>
<td>3.46 (.98)</td>
<td>6</td>
</tr>
<tr>
<td>Encourage a young person to talk to their parents about their personal problems</td>
<td>3.76 (.95)</td>
<td>9</td>
<td>2.97 (1.15)</td>
<td>8</td>
<td>3.33 (1.13)</td>
<td>8</td>
</tr>
<tr>
<td>Talk about early warning signs of mental illness</td>
<td>3.10 (1.13)</td>
<td>13</td>
<td>1.78 (.92)</td>
<td>14</td>
<td>2.39 (1.22)</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>3.89 (.64)</td>
<td>2</td>
<td>3.03 (.76)</td>
<td>2</td>
<td>3.40 (.85)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Early intervention</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notify and consult colleagues about concerns you have for a young person’s mental health</td>
<td>4.10 (.77)</td>
<td>4</td>
<td>2.50 (1.09)</td>
<td>10</td>
<td>3.24 (1.25)</td>
<td>10</td>
</tr>
<tr>
<td>Refer a young person to other sources of help (e.g. GP, psychologist, counsellor)</td>
<td>3.67 (.95)</td>
<td>10</td>
<td>2.43 (1.18)</td>
<td>11</td>
<td>3.00 (1.24)</td>
<td>11</td>
</tr>
<tr>
<td>Offer advice to a young person about their mental health concerns</td>
<td>3.24 (1.09)</td>
<td>12</td>
<td>2.19 (1.10)</td>
<td>13</td>
<td>2.67 (1.21)</td>
<td>12</td>
</tr>
<tr>
<td>Personally contact the parents of a young person whose mental health you are concerned about</td>
<td>3.00 (1.17)</td>
<td>14</td>
<td>2.27 (1.16)</td>
<td>12</td>
<td>2.60 (1.22)</td>
<td>13</td>
</tr>
<tr>
<td>Ask a young person about suicide risk</td>
<td>2.16 (.98)</td>
<td>15</td>
<td>1.38 (.70)</td>
<td>15</td>
<td>1.74 (.93)</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>3.24 (.79)</td>
<td>3</td>
<td>2.19 (.82)</td>
<td>3</td>
<td>2.65 (.97)</td>
<td>3</td>
</tr>
</tbody>
</table>
intervention. Consistent with our hypothesis, teachers more frequently performed activities that support young people’s mental health than coaches. As expected, coaches engaged more in promotion behaviour than in prevention or early intervention behaviour. Surprisingly, teachers also had the greatest engagement in promotion as well as in prevention behaviour rather than in early intervention.

A number of activities, such as encouraging participation and inclusivity, dealing with bullying, and using behaviour management strategies, which are performed as part of the role of teachers and coaches for an alternative primary purpose, also have a secondary benefit on young people’s mental health. These along with activities that are more aligned with the traditional focus of teachers’ and coaches’ roles were most commonly performed. For instance, exercise and health are core motivations for participation and performance in sport, and consequently of a coach’s role; so, it was not surprising that promoting a healthy lifestyle and exercise was among the most commonly performed activities by coaches to support mental health and was the only activity engaged in more frequently by coaches than teachers.

In contrast, activities directly related to mental illness, including asking a young person about suicide risk and discussing warning signs of mental illness, were less commonly performed. These activities likely require greater knowledge and more specific skills in mental health, which teachers and coaches may not fully possess. Unexpectedly, personally contacting the parents of a young person, whose mental health they were concerned about, was also among the least performed activities for both teachers and coaches. This result was surprising as communicating with parents is an important element of the role of adults supervising young people (Barge & Loges, 2003). Teachers and coaches were, however, still found to be encouraging of parents’ involvement in supporting young people’s concerns, but reported more frequently encouraging a young person to talk to their parents about their personal problems, rather than contacting them personally. Notably, this approach may better maintain their established trust and relationships with young people.
Of some concern was that both teachers’ and coaches’ engagement in asking a young person about suicide risk was exceedingly low and notably lower than any other activity, with results showing it was rarely or never engaged in. Fullagar, Gilchrist, and Sullivan (2007) explored suicide as a community issue and found that adults, including teachers and coaches, held divided opinions of whether youth suicide should be addressed or discussed openly. Teachers and coaches may be afraid to broach the topic of suicide as people often fear this will invite further thoughts or ideas of suicide. However, this effect has not been demonstrated, and avoiding or withholding discussion of suicide may negatively affect support for those experiencing suicidal ideation and reduce access to services (Fullagar et al., 2007). A need for further training on youth suicide and recognizing suicidal behaviour for adults in the education and youth recreation sectors, as partners in suicide prevention, has been identified (Crawford & Caltabiano, 2009). Another explanation for teachers’ and coaches’ lack of involvement in discussing suicide with young people may be that they feel this is outside the scope of their role. Future research should explore promotion, prevention and early intervention activities, including discussion of suicide, to determine which activities community-based adults think they can and should perform to support young people with their mental health.

Over recent years, the role of schools and teachers in young people’s social and emotional health has gained increasing attention and has led to the development of a number of school-based interventions (Department of Health & Ageing, 2003). In contrast, little research has considered the role of coaches in young people’s mental health, although Mental Health First Aid training has been provided to a small number of coaching samples with promising results (Bapat, Jorm, & Lawrence, 2009; Pierce, Liaw, Dobell, & Anderson, 2010). Teachers were therefore expected to have more involvement in young people’s mental health than coaches, which was the case overall in this study. Teachers exceeded coaches’ involvement in both prevention and early intervention behaviour. This finding may be a result of teachers having greater knowledge of structured pathways and procedures to support young people with mental health problems than coaches, who receive less guidance in this area (Mazzer et al., 2012). Encouragingly, both teachers and coaches were found to be actively and regularly involved in promoting young people’s mental health.

Teachers are in a position to be a valuable source of support and influence for young people’s mental health. Mazzer et al. (2012) revealed that teachers more commonly reported performing activities for early intervention of young people’s mental health, above that of promotion or prevention activities. Reinke et al. (2011) also highlighted teachers’ involvement, finding that 75% of teachers had worked with or referred students with mental health issues over a one-year period. The hypothesis that teachers would have greatest involvement in early intervention behaviour was not supported by the results of this study, instead finding that teachers were more frequently involved in both the promotion and prevention of mental health than in early intervention. Discrepancies between these findings may be attributable to the differing methodologies used. More specifically, Mazzer et al. (2012) required teachers to recall in interview (without cues) activities they performed to support mental health, whereas this study requested teachers to indicate their involvement in a provided list of activities. It is likely that early intervention activities are more commonly identified and associated with supporting mental health as they directly involve mental health problems, than promotion or prevention activities, which intend to precede any observable mental health problem. Consequently, the greater early intervention involvement reported in Mazzer et al. (2012)
may have been a reflection of those activities being more obviously identifiable or associated with mental health rather than representing more frequent involvement.

The role of a coach is closely aligned with health promotion (Kokko, Kannas, Villberg, & Ormshaw, 2011). Results of this study show that this extends to promotion of mental health. Consistent with our hypothesis, coaches reported significantly more involvement in promoting young people’s mental health than in prevention or early intervention activities. Sport is important to many young people and can be used to make a difference in their lives (Danish & Nellen, 1997). It is an opportunistic and valuable setting in which to identify and support young people vulnerable to mental health problems (Fraser-Thomas et al., 2005). It may be a particularly valuable avenue for accessing at-risk youth who may no longer be attending school or for contacting those who are unwilling or unable to seek help from traditional sources of help (e.g. counsellor). However, coaches are less frequently engaged in prevention behaviour and rarely engaged in any early intervention activity for young people’s mental health. Again, these findings may be attributable to coaches being more proficient in promoting health and skill development, consistent with the promotion of mental health, as they are components of a coach’s core role, and possessing less knowledge specifically regarding mental health problems and how to combat them, required for prevention and early intervention. To capitalize on the opportunity that the sports environment provides for early intervention, educating coaches on how to identify and assist a young person experiencing a mental health problem may be valuable in encouraging greater coach involvement. However, further research is required to determine whether coaches have the ability and scope within their role to carry out these early intervention activities.

Methodological limitations were identified that could potentially have impacted this study. Response rate may have been reduced by the use of an online survey format; however, given that target participants were busy working adults from multiple sites, an online survey was used to benefit timeliness of distributing the survey and enhance convenience for participants to respond at a time most suitable to them (Evans & Mathur, 2005). The study was conducted solely in one Australian city, but efforts were made to extend the generalizability of findings by targeting a range of sites, schools and sports clubs, varying in demographics to participate. A further limitation was that given that there was no appropriate standardized measure available, the questionnaire was developed for this study and has not previously been used in full. In addition, the survey measured only five activities within each category of promotion, prevention and early intervention. Efforts were made to ensure these activities were appropriately representative of the range of possible activities within each category; however, it is possible that the inclusion of different or additional activities may have affected findings. Future research should continue to investigate the range of activities that adults in community-based roles perform to support young people’s mental health. Factors that may influence their involvement in supportive behaviour, such as their perceived ability to help, should also be explored.

7.8 Conclusion

Teachers and coaches both have important but different roles in the lives of young people, and this extends to supporting their mental health. Teachers have valuable involvement across promotion, prevention and to a lesser extent, early intervention for young people’s mental health. Coaches predominantly benefit young people’s mental health through promoting positive mental health, by encouraging exercise and community involvement, but are less involved in prevention and early intervention. However, the sports environment
provides coaches an opportunity to effectively support early intervention for young people’s mental health and may benefit from training and support to assist them. Taking early action to support young people’s mental health through promotion, prevention and early intervention will assist to reduce the burden of mental health problems among young people. Encouraging adults in community-based roles to support young people’s mental health will strengthen the pathways available to mental health care and may be particularly valuable for young people who are unwilling or unable to access traditional sources of mental health care.

7.9 Note
1 Email: Debra.Rickwood@canberra.edu.au.

7.10 References


CHAPTER EIGHT
Paper five: Teachers’ and Coaches’ Role Perceptions for Supporting Young
People’s Mental Health: Multiple Group Path Analyses

8.1 Chapter Introduction

This chapter comprises the fifth and final research article prepared during the course of
candidature, which has been accepted for publication (pending minor revisions) in the Australian
Journal of Psychology. This paper investigates the influence that four specific types of role-
related perceptions have on teachers’ and coaches’ involvement in promotion, prevention and
early intervention for young people’s mental health. The format of the paper is in accordance
with the manuscript submission guidelines for this journal. The data collection instruments used
for the research reported in this paper are presented in Appendices G to K.
Teachers’ and Coaches’ Role Perceptions for Supporting Young People’s Mental Health: Multiple Group Path Analyses

8.2 Abstract

Teachers and youth sports coaches are in prominent positions to support young people and their mental health. However, the way these professionals perceive their roles is likely to be a powerful influence on such behaviour. This paper investigates and compares the effect of four types of role perceptions—role breadth, instrumentality, efficacy, and discretion—on teachers’ and coaches’ engagement in helping behaviour that supports young people’s mental health through promotion, prevention and early intervention. An online survey was completed by 117 teachers and 131 coaches. Results from three multiple group path analyses revealed role breadth, instrumentality, and efficacy significantly influenced teachers’ and coaches’ helping behaviour. The extent to which role perceptions predicted helping behaviour did not differ between teachers and coaches. Assisting teachers and coaches to carry out promotion, prevention and early intervention behaviour increases young people’s access to mental health support and may help to reduce the burden of mental health problems among Australian young people.

8.3 Key words: Mental health promotion; self-efficacy; sports coaches; teachers; youth mental health.
Young people have the highest prevalence of mental health problems across the lifespan, but they tend not to seek help and have the lowest rate of mental health service use (ABS, 2010; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Adolescence and young adulthood are, therefore, critical periods in which to promote mental health and provide assistance to access support and interventions for mental health problems. Taking early and effective action is critical to minimise the impact and progression of mental health problems. Consequently, improving young people’s mental health and wellbeing through promotion, prevention and early intervention are priorities for mental health in Australia (Commonwealth of Australia, 2009).

Promotion, prevention and early intervention (PPEI) can be carried out across a range of contexts and many adults in community-based roles, such as teachers and sports coaches, can help (Commonwealth of Australia, 2009). Both teachers and coaches are in regular contact with a large number of young people, have established relationships with young people, occupy positions of care and responsibility for young people, impart learning primarily in areas such as academic or physical performance but also invaluable life skills, and contribute to positive youth development (Graham, Phelps, Maddison, & Fitzgerald, 2011; Mazzer & Rickwood, 2013a). Collectively, this places teachers and youth sports coaches in prominent positions to make a major contribution to young people’s mental health (Donovan et al., 2006).

Although teachers, coaches, and other community-based adults may have the potential to support young people’s mental health, how they should or could be involved is not well defined. There is growing interest in the extent to which promotion, prevention and early intervention fit within the roles of a teacher or coach, but little understanding of how this occurs and can be supported. Mazzer and Rickwood (2013a) recently explored this area, finding that both teachers and coaches often engage in activities that promote young people’s mental health, but that there
is significant variability. While both were similarly involved in promotion, teachers were found to more commonly engage in behaviour to prevent and intervene early in mental health problems than coaches.

It is also important to understand factors that may influence teachers’ and coaches’ involvement in PPEI for young people’s mental health in order to determine ways to support their performance in this regard. The ways individuals perceive their roles can be a powerful influence on behaviour (Morrison, 1994; Parker, 2007), but little is known about teachers’ and coaches’ views regarding their role in supporting young people’s mental health.

Previous research examining individuals’ views of their working roles has focused on four main types of role-related perceptions: perceived role breadth, perceived instrumentality, perceived role efficacy, and perceived role discretion. These role perceptions have been found to have a substantial impact on employees’ interpersonal helping behaviour at work when such behaviour may be considered above and beyond the formal requirements of a job (McAllister, Kamdar, Morrison, & Turban, 2007), as may be the case with PPEI behaviour for teachers and coaches.

8.4.1 Role Breadth

Perceived role breadth is the most studied role-related perception and refers to whether an individual regards particular activities or behaviours as part of their job (McAllister, et al., 2007). Role breadth is subject to an individual’s perception; so, two people holding the same formal position can differ in how broadly they each define that job. Previous studies have shown perceived role breadth to directly predict behaviour, whereby, individuals are more likely to perform behaviour they perceive as within their role breadth (Coyle-Shapiro, Kessler, & Purcell, 2004; Morrison, 1994). Furthermore, McAllister et al. (2007) found role breadth to be the
strongest predictor of employee’s interpersonal helping behaviour when compared to perceived instrumentality, perceived role efficacy, and perceived role discretion. Research investigating the role breadth of teachers and coaches in relation to young people’s mental health is limited, however, two recent studies have indicated that both teachers and coaches perform a number of activities which support young people’s mental health as part of their role (Donovan, et al., 2006; Mazzer, Rickwood, & Vanags, 2012).

8.4.2 Instrumentality

Perceived role instrumentality can be defined as whether an individual perceives a relationship between performance of behaviour and outcomes such as rewards and punishment (McAllister, et al., 2007). Behaviour that is linked to valued outcomes is more likely to be performed (Bandura & McClelland, 1977). McAllister et al. (2007) reported instrumentality to be a significant predictor of employees' interpersonal helping behaviour. The role instrumentality of teachers and coaches for supporting young people’s mental health has not previously been investigated.

8.4.3 Efficacy

Role efficacy refers to a specific form of self-efficacy relating to an individual’s perception of their competence in performing a given type of behaviour (Bandura, 1977; McAllister, et al., 2007). Self-efficacy is a well-established predictor of behaviour and performance (Bandura, 1986; Beauchamp, Bray, Eys, & Carron, 2002). Low self-efficacy has been identified by teachers and coaches to be a limitation to their willingness for involvement in supporting young people’s mental health (Mazzer & Rickwood, 2013b).
8.4.4 Discretion

Role discretion refers to the extent to which an individual perceives choice with respect to performing particular behaviour (McAllister, et al., 2007). Behaviour that is considered discretionary can vary from person to person and across different situations (Organ, 1997). The degree to which teachers and coaches have freedom to choose to perform PPEI activities may influence their actions.

8.4.5 Aims and Hypotheses

The aim of this study was to investigate how role-related perceptions impact on teachers’ and coaches’ undertaking of promotion, prevention and early intervention in order to better understand ways to assist and improve their performance of such activities. We examined the relative effects of four role perceptions—role breadth, instrumentality, efficacy, and discretion—as proposed by McAllister, et al. (2007) on teachers’ and coaches’ engagement in helping behaviour to support young people’s mental health through PPEI. It was hypothesised that role breadth would be the strongest predictor for helping behaviour. The study also sought to determine whether the effects of role perceptions on helping behaviour were equivalent for teachers and coaches. In the absence of any evidence to suggest otherwise, it was hypothesised that there would be group invariance, that is, these effects will be similar across the teacher and coach groups. Figure 8.1 displays the proposed saturated model for predicting the three types of helping behaviour (promotion, prevention and early intervention).
8.5 Method

8.5.1 Participants

Participants were 117 teachers (71 female, 43 male, and 3 did not report) and 131 coaches (49 female, 81 male, and 1 did not report) of 12-18 year olds from Canberra, Australia, creating a total sample of 258. The age of teacher participants ranged from 22 to 69 years, with a mean age of 41.59 ($SD = 12.27$). The age range of coach participants was 18 to 58 years, with a similar mean age of 39.11 ($SD = 11.90$). Participants’ length of experience in their role ranged from less than one year to 50 years, with teachers’ mean experience of 14.60 years ($SD = 11.62$) being greater than coaches’ mean experience of 9.75 years ($SD = 8.64$).

Teachers from eight schools within Canberra participated in the study. Most ($n = 74$) teachers were employed at co-educational schools, rather than single sex schools ($n = 35$; 8 not
Sixty-four taught at government high schools or colleges and 53 at non-government (private or independent) schools. Teachers who participated in the study taught across a range of subjects including: mathematics \((n = 20)\); science \((n = 11)\); English and social studies \((n = 33)\); physical education \((PE; n = 14)\); and other (elective) subjects such as drama, information technology, and religion \((n = 36; 3 \text{ did not report})\).

Coaches from four sports participated: soccer \((n = 49)\); netball \((n = 28)\); basketball \((n = 34)\); AFL \((n = 17; 3 \text{ did not report})\). Slightly more coaches worked with girls only \((n = 61)\) than boys only \((n = 40)\) or mixed gender groups \((n = 30)\). The level of sport competition that participants coached included social \((n = 52)\), competitive \((n = 104)\), and elite \((n = 17)\) sport, with many \((n = 42)\) reporting they coached across a variety of levels.

### 8.5.2 Procedure

The project was approved by the Committee for Human Research Ethics at the University of Canberra, the ACT Government Education and Training Directorate, and the Archdiocese of Canberra and Goulburn Catholic Education Office. Final permission was sought and obtained from the principal of each school prior to the research proceeding at their site. The club president or club contact of each sporting club was also consulted prior to involvement in the project. Principals and presidents of each selected school and sports club were initially contacted by phone and/or email. Those who gave permission for involvement in the research forwarded an email from the primary researcher with a link to the online survey inviting teachers and coaches of young people aged 12 to 18 to participate in the research. Participants then completed the survey online. To encourage greater participation, all participants were given the opportunity to enter a prize draw to win an Apple iPad (Cobanoglu & Cobanoglu, 2003).
8.5.2.1 Recruitment of Teachers. Teachers were recruited through their schools. To ensure a representative cross-section of schools and school characteristics, a multi-stage sampling technique combining a number of sampling methods was employed. This involved alphabetically sorting and stratifying a list of all schools within Canberra. Every second school \((n = 23)\) was invited to participate; eight schools agreed and were included in the final sample. All teachers of 12-18 year olds from the recruited schools were invited to participate in the study.

8.5.2.2 Recruitment of Coaches. Multi-stage sampling was similarly used for the recruitment of coaches, who were accessed through sports clubs of the four most popular team sports in Australia: soccer, netball, basketball, and AFL (Australian Sports Commission, 2010). All 31 sports clubs based within Canberra, involving young people aged 12 to 18 years, and listed on their respective sports’ state organisation website were invited to participate. Twenty-one clubs agreed to participate, including six soccer, four netball, four basketball, and seven AFL clubs. All coaches of 12-18 year olds within the recruited sports clubs were invited to participate.

8.5.3 Measures

8.5.3.1 Helping Behaviour. 15 items developed by Mazzer and Rickwood (2013a) assessed teachers’ and coaches’ engagement in the three types of helping behaviour. Promotion behaviour was measured by items such as ‘Encourage inclusivity and participation of all young people in activities’ and ‘Promote healthy lifestyle and exercise’. Prevention activities included ‘Identify and stop bullying’ and ‘Assist young people in learning how to manage stress’. Early intervention items included ‘Notify and consult colleagues about concerns you have for a young person’s mental health’ and ‘Refer a young person to other sources of help (e.g. GP, psychologist, counselor)’. Participants indicated the extent to which they engage in each item within their role as a teacher or coach. Responses were given on a 5-point scale, from 1 ‘Never’
to 5 ‘Very Often’. The three subscales contained five items each and were calculated by averaging the relevant item scores\(^1\). Higher scores indicated greater engagement in that type of helping behaviour. The Promotion, Prevention and Early Intervention subscales demonstrated adequate to high internal consistency, reporting Cronbach’s alphas of .69, .82, and .88, respectively. Full methodology for the development of the behaviour items can be found in Mazzer and Rickwood (2013a).

**8.5.3.2 Role Perceptions.** Four types of role perceptions used by McAllister et al. (2007) were measured—Perceived Role Breadth, Instrumentality, Efficacy, and Discretion. For each of the five helping behaviours across each of the domains of promotion, prevention and early intervention, role breadth was measured with the statement “This behaviour is an expected part of my job”. Similarly, instrumentality was measured by the statement “I see a direct connection between whether I engage in this behaviour and my outcomes at work”; efficacy was measured with the statement “I am completely confident in my capabilities when engaging in this behaviour”; and role discretion was measured by the statement “I have complete freedom to choose whether or not I engage in this behaviour”. Participants indicated their level of agreement with each of the four role perception statements for the 15 helping behaviour items. Responses were given on a 5-point scale, from 1 ‘Strongly Disagree’ to 5 ‘Strongly Agree’. By averaging across the relevant items, 12 subscales were created, which all showed good internal reliability with Cronbach’s alpha statistics ranging from .67 to .88 (see Table 8.1).

\(^1\) A confirmatory factor analysis has not been performed to confirm categorization of the items within the subscales of this measure. The reason for this was that the scale was designed to allow for exploration of the boundaries of activities within teachers’ and coaches’ roles. Care was taken to ensure inclusion of items that were likely to capture a range of endorsements from teachers and coaches, that is, including activities that were likely to be performed frequently as well as activities that were less frequent. Therefore, items would not have been expected to load similarly within PPEI categories but rather would load according to frequency of endorsement.
8.5.4 Data Analysis

Data were screened and checked for normality. To explore differences between teachers’ and coaches’ role perceptions and PPEI helping behaviour descriptive analyses and t-tests were conducted using SPSS Version 21 (IBM Corp, 2012b). To examine and compare, for teachers and coaches, the effect of role perceptions in predicting PPEI behaviour, three multiple group path analyses were conducted using AMOS Version 21 (IBM Corp, 2012a)².

Multiple group path analysis examines group differences by testing for the equality of structural parameters across distinct groups and determines whether group membership moderates the effects specified in the model (Kline, 2010). This analytic approach was employed in order to simultaneously estimate and compare regression weights for the teacher and coach groups (Kline, 2010). Assessing equivalence across groups involves testing sets of parameters in an increasingly restrictive manner through hierarchical ordering of nested models, where each model constrains more parameters than the preceding model (Arbuckle, 2012; Byrne, 2004). Four nested models (unconstrained, structural weights, structural covariances, and structural residuals models) which tested three sets of structural parameters (regression paths, covariance of predictor variables, and covariance of residuals) were produced for each of the three path analyses in the current study (see Table 8.1). Note that testing for the invariance of error parameters is considered an overly restrictive test of little importance (Byrne, 2004) and, consequently, the structural residuals models are not reported.

² Saturated models were used for the three multiple group analyses as the current research hypotheses were concerned with assessing group invariance of regression weights predicting behaviour rather than specifying the model fit.
8.6 Results

8.6.1 Descriptives, t-tests and inter-correlations

Assumption testing revealed minor violations of normality, however, the sample size was sufficiently large for tests to be robust against these violations. Descriptive statistics and t-test comparisons are displayed in Table 8.1. Participants reported most frequent (‘often’) engagement in promotion behaviour, followed by prevention which was engaged in ‘sometimes’ to ‘often’. Early intervention behaviour was ‘rarely’ to ‘sometimes’ engaged in. t-tests revealed no significant difference between teachers’ and coaches’ engagement in promotion behaviour. Teachers engaged significantly more than coaches in both prevention and early intervention behaviour. Mean scores for role perception variables were all above the scale midpoint, indicating participants’ role perceptions were generally supportive. t-tests indicated no significant differences between teachers’ and coaches’ role breadth, instrumentality, efficacy, and discretion for promotion behaviour. Teachers had significantly greater role breadth, instrumentality, and efficacy for prevention and early intervention behaviour than coaches. Coaches had significantly greater role discretion for prevention behaviour than teachers. No significant difference was found between teachers’ and coaches’ role discretion for early intervention behaviour.

Inter-correlations for the total sample are displayed in Table 8.2. Promotion was strongly correlated with both prevention and early intervention. Prevention and early intervention had a very strong positive relationship. Helping behaviour measures were also strongly correlated with the hypothesized predictors of role breadth, instrumentality, and efficacy for their respective type of helping behaviour, but not with discretion which had predominantly weak and non-significant relationships with all other variables.
Table 8.1

*Reliability Estimates and Descriptive Statistics of Teachers’ and Coaches’ Helping Behaviour and Role Perceptions*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Coach (n = 131)</th>
<th>Teacher (n = 117)</th>
<th>95% CI of MD</th>
<th>t</th>
<th>df</th>
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<td>3.77 (.67)</td>
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<td>2.99 (.78)</td>
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<td>2.15 (.82)</td>
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<td>[-1.28, -.89]</td>
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<td>3.91 (.58)</td>
<td>3.97 (.65)</td>
<td>-.06 (.08)</td>
<td>[-.21, -.09]</td>
<td>-.78</td>
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<td>3.74 (.62)</td>
<td>3.95 (.63)</td>
<td>-.21 (.08)</td>
<td>[-.37, -.06]</td>
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<td>Promotion Efficacy</td>
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<td>3.89 (.64)</td>
<td>-.03 (.08)</td>
<td>[-.19, .12]</td>
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<td>3.65 (.74)</td>
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<td>3.11 (.88)</td>
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Note. MD = mean difference; CI = confidence interval.
* p < .001
Table 8.2

Inter-correlations

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* $p < .001$
8.6.2 Multiple Group Path Analysis 1: Predicting promotion behaviour

The results of the multiple group analysis for promotion behaviour comparing the unconstrained and structural weights model yielded a Chi-square of $\chi^2 = 5.63$, $df = 4$, $p = .228$. This Chi-square was not significant, demonstrating no difference between the unconstrained and constrained models and, therefore, no significant difference in the effect of role perceptions predicting promotion behaviour for the teacher and coach groups.

As the structural weights were equivalent across groups, the structural covariances model was able to be interpreted. A non-significant Chi-square ($\chi^2 = 11.70$, $df = 10$, $p = .306$) showed the structural covariances model did not fit the data significantly worse than the structural weights model. This result demonstrates teachers and coaches had similar inter-correlations between role perceptions. Consistent with the correlations presented in Table 8.2, role perceptions were found to be strongly inter-correlated, with the exception of discretion, in this model.

8.6.2.1 Interpreting the model for promotion. As groups did not significantly differ, the structural (regression) weights are presented using estimates for the total sample rather than for individual groups. The saturated model and estimates predicting promotion behaviour are illustrated in Figure 8.2. This saturated model accounted for 50% of the variance in participants’ promotion behaviour. Role efficacy was the strongest predictor of promotion behaviour, followed by instrumentality, and breadth. Discretion was not a significant predictor of promotion behaviour.

---

3 When the structural weights model is not accepted as equivalent across groups, subsequent models cannot be interpreted (Arbuckle, 2012)
4 All models that find no significant group difference are presented with the total sample estimates
8.6.3 Multiple Group Path Analysis 2: Predicting prevention behaviour

The multiple group analysis for prevention behaviour revealed structural regression weights to be equivalent across the teacher and coach groups, as reflected by a non-significant Chi-square ($\chi^2 = 2.93, df = 4, p = .569$) between the unconstrained and structural weights models.

Given the equivalence of structural weights across groups, testing for the equality of structural covariances proceeded. The significant Chi-square ($\chi^2 = 28.64, df = 10, p = .001$) shows the structural covariances model fit significantly worse than the structural weights model, revealing inter-correlations for role perceptions were not equivalent for teachers and coaches. Consequently, follow-up tests to determine which individual paths significantly differed were indicated. Six additional nested models, constraining one covariance path at a time to be constant
across groups, assuming the structural weights model to be correct, were conducted. These tests found that, while strong for both groups, the covariance between role breadth and instrumentality for prevention behaviour was significantly stronger ($\chi^2 = 4.89$, $df = 1$, $p = .027$) for coaches ($r = .74$) than teachers ($r = .63$). All other inter-correlations in this model were consistent with those presented in Table 8.2.

8.6.3.1 **Interpreting the model for prevention.** The saturated model and estimates predicting prevention behaviour are presented in Figure 8.3. The saturated model accounted for 52% of the variance in participants’ prevention behaviour, with role efficacy shown to be the strongest predictor of prevention behaviour, followed by instrumentality, and breadth. Discretion was not a significant predictor of prevention behaviour.

![Figure 8.3 Model predicting prevention behaviour.](image)

*Note: Unless indicated otherwise, estimates represent the combine total sample.*

$p = .05$
8.6.4 Multiple Group Path Analysis 3: Predicting early intervention behaviour

A non-significant Chi-square was obtained when comparing the unconstrained and the structural weights model for early intervention ($\chi^2 = 5.17, df = 4, p = .271$). This again demonstrates that role perceptions had similar influence in predicting early intervention behaviour for teachers and coaches. This allowed testing of the structural covariances model to proceed. A significant Chi-square ($\chi^2 = 33.98, df = 10, p < .001$) showed the structural covariances model fit significantly worse than the structural weights model, revealing role perceptions had differing inter-correlations for the teacher and coach groups.

Follow-up tests constraining individual covariance paths one at a time were again indicated. Six additional nested models were conducted. While the overall analysis of the structural covariance model had sufficient power to produce a significant Chi-square, no single path was found to differ significantly between the groups when individually tested. The role perceptions’ inter-correlations for this model were, therefore, consistent with those presented in Table 8.2.

8.6.4.1 Interpreting the model for early intervention. The saturated model and estimates predicting early intervention behaviour are illustrated in Figure 8.4. The saturated model accounted for 51% of the variance in participants’ early intervention behaviour. Role instrumentality was overwhelmingly the strongest predictor of early intervention behaviour, followed by efficacy. Role breadth and discretion were not significant predictors of early intervention behaviour.
Figure 8.4 Model predicting early intervention behaviour.

Note: Estimates represent the combine total sample.

*p $p < .05$

8.7 Discussion

This study examined the influence of role perceptions on teachers’ and coaches’ engagement in PPEI behaviour for young people’s mental health. Role efficacy, instrumentality, and breadth significantly influenced teachers’ and coaches’ helping behaviour, whereas, role discretion did not. These effects did not vary between teachers and coaches; while teachers’ role perceptions for supporting young people’s mental health tended to exceed coaches’, the extent to which their involvement in helping behaviour from these perceptions could be predicted was comparable.

In contrast to our first hypothesis and McAllister et al. (2007), role breadth was not the strongest predictor of helping behaviour; efficacy and instrumentality had stronger effects. The reduced influence of role breadth may be a consequence of the type of professionals included in
the sample. Teachers and coaches are often caring in nature, which leads to these career choices. They may be motivated by more intrinsic values (e.g. helping young people in need) than other employees, such as the engineers recruited in McAllister et al. (2007). These intrinsic values may drive engagement in helping behaviour more than formal role expectations or duties for teachers and coaches. While not the strongest perception in predicting helping behaviour, role breadth still had an important influence on helping behaviour. Mazzer et al. (2012) found teachers to have greater awareness of guidelines and structured procedures for assisting young people’s mental health than coaches who reported receiving less guidance in this area. Coaches, and teachers to a lesser extent, may benefit from the development of clearer role requirements for supporting young people’s mental health.

Role efficacy was the strongest predictor of both promotion and prevention behaviour. Surprisingly McAllister et al. (2007) did not find self-efficacy to predict helping behaviour, however, current findings are congruent with much previous research demonstrating that self-efficacy greatly affects behaviour (Beauchamp, et al., 2002; Ross, Bradley Cousins, & Gadalla, 1996). Previous research has found teachers and coaches to perceive deficits in their skills and knowledge of mental health related areas (Graham et al., 2011; Mazzer, et al., 2012). Mazzer and Rickwood (2013b) found that Canberra-based teachers had generally received some training in mental health related areas, but that many desired and needed further training and support. Indeed, a number of studies of teachers’ views on supporting mental health have revealed a common desire among teachers for further mental health training and support (Askell-Williams, Lawson, & Murray-Harvey, 2007; Cohall, Cohall, Dye, Dini, Vaughan, & Coots, 2007).

The past 15 years have seen significant developments in school-based mental health and a number of programs for teacher support have emerged (Weare & Nind, 2011). MindMatters
has been the main support in Australia for teachers, providing teacher education, classroom activities, and tools to support a whole-school approach to mental health (MindMatters, 2009). ResponseAbility provides resources specific to pre-service teacher education (Hunter Institute of Mental Health, 2012). Teacher education and resources for mental health are also available from the ReachOut Teachers Network (Inspire Foundation, 2013), HeadStrong (Black Dog Institute, 2013), and SenseAbility (beyondblue, 2013). However, while there is a growing range of high-quality resources available, they are not routinely incorporated within tertiary teacher training programs nor ongoing professional development.

Coaches have received less attention and have fewer available training options. However, Mental Health First Aid [MHFA], which aims to increase mental health literacy (Kitchener & Jorm, 2002), has been applied to both teachers and coaches with promising results (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010; Pierce, Liaw, Dobell, & Anderson, 2010). MHFA training was found to improve participants’ knowledge of mental disorders, capacity to recognize mental illness, and confidence in helping someone with a mental health problem.

Instrumentality had a significant effect on helping behaviour and was particularly influential in early intervention. This finding was consistent with McAllister et al. (2007) who also found instrumentality to predict employees’ interpersonal helping behaviour. Highlighting and reinforcing to teachers and coaches the impact that helping behaviours have in leading to desired and rewarding outcomes, such as improved mental health and wellbeing for young people, and the positive contribution that relatively small actions (like encouraging young people to participate in activities) can have for a young person’s mental health, are ways of increasing instrumentality and motivating behaviour. Furthermore, explicitly including actions that support young people’s mental health in key performance indicators, performance and development
reviews, and formal job descriptions would further encourage teachers’ and coaches’ involvement in such behaviour.

Role discretion did not significantly influence PPEI behaviour for teachers or coaches. This result is consistent with McAllister et al. (2007) who found, while role discretion did influence some types of behaviours, it did not predict interpersonal helping behaviour. The extent to which people perceive that they can choose to carry out helping behaviour within their work role does not influence their performing such behaviours.

Behaviour that supports the promotion of mental health and prevention of mental illness was affected by role perceptions in a similar way, but a different predictive pattern was revealed for early intervention behaviour. Role efficacy was the strongest predictor of both promotion and prevention behaviour, whereas early intervention was predominantly influenced by role instrumentality. Promotion and prevention both aim to act before the onset of a mental illness (Mrazek & Haggerty, 1994), whereas early intervention actions are more directly related to assisting mental health problems, which may require a different set of skills and be driven by alternate or additional factors. Current results showed both teachers and coaches felt less capable to carry out early intervention behaviours which may explain the greater influence that instrumentality had for these activities; additional motivation may be required for teachers and coaches to carry out early intervention actions due to their reduced confidence in their ability to perform them effectively. The link between helping behaviour and rewarding outcomes may be more important in this area and could provide the additional motivation required to perform the behaviour.
8.7.1 Strengths and Limitations

While the results of the current study have implications for the role of teachers and coaches in supporting youth mental health, it is important to note that the volunteer nature of the sample may affect the findings by including participants particularly committed to youth mental health. Nevertheless, one of the strengths of the study was that the recruitment process targeted a variety of sites and captured a diverse range of participants across ages, experience, subjects taught, and sports coached, which should attenuate this limitation. Future research could, however, investigate other participant characteristics, such as gender as there may be important differences between the ways that males and females in these roles engage in such helping behaviour. Teachers’ and coaches’ level of previous training in mental health is also likely to be influential factor, and this was not considered in the current study.

A further limitation stemmed from the lack of an available measure of PPEI activities. The items developed by Mazzer and Rickwood (2013a) needed to be relevant to different occupation groups, and were derived directly from discussions with teachers and coaches. However, the measure requires further validation beyond this initial study. A significant strength, however, was the simultaneous examination of the influence of teachers’ and coaches’ role perceptions on helping behaviour. Finding that these role perceptions had similar predictive qualities across the occupational groups enhances the generalisability of the current findings to apply to other relevant community-based roles, such as youth workers. Future research should continue to investigate the range of activities that adults in community-based roles perform to support young people’s mental health.
8.8 Conclusion

Community-based adults can be valuable sources of support for young people’s mental health. This study revealed that role perceptions are influential in predicting teachers’ and coaches’ involvement in supporting young people’s mental health through promotion, prevention and early intervention. Both occupations are more likely to perform helping behaviour when they perceive themselves as capable, when the behaviour is linked to desired outcomes and rewards, and when the actions are expected or required within their work. Assisting adults in community-based roles to engage in promotion, prevention and early intervention may strengthen and diversify young people’s access to mental health support and help to reduce the burden of mental health problems.
8.9 References


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CHAPTER NINE: DISCUSSION AND CONCLUSION

9.1 Chapter Introduction

This final chapter reviews the aims of the research, outlines the main contributions of each of the five papers and draws together the key findings of the thesis. The chapter establishes the significance of the current research and discusses the conceptual contributions and clinical implications. The strengths and limitations of the research are identified and directions for future research are offered. Finally, the chapter provides concluding comments from the research.

9.2 Summary of Findings

This research sought to assist in improving the mental health and wellbeing of Australian young people by exploring the roles of community-based adults in supporting young people’s mental health. This investigation is important as there is a high prevalence of mental health problems among Australian young people but they tend not to seek professional help. Community-based adults who have pre-existing relationships with young people are in valuable positions to positively influence their mental health and facilitate access to appropriate care. In particular, the research sought to contribute knowledge of whether and how teachers and coaches are actively involved in promotion, prevention, and/or early intervention for young people’s mental health.

The foundation of the thesis comprised five papers prepared for publication based on a mixed methods research program. Each of the five papers contributed to the overall aims of the thesis. Although each paper and phase of research was distinct, the overall research program was sequential and developmental in nature, whereby the findings from each phase informed the subsequent phases. The first three papers reported on the qualitative investigation conducted via
interviews with teachers and coaches in phase I of the research. The fourth paper reported on the development of the PPEI measure through a consensus technique in phase II and outlined the application of this quantitative measure in an online survey in phase III. Paper five also reported on the quantitative investigation of phase III. This sequential mixed method design enabled fluid and flexible examination of concepts throughout the research with new aspects relating to teachers’ and coaches’ roles in supporting young people’s mental health being explored as they emerged. Findings were also able to be corroborated across differing methodologies and expanded throughout the research phases.

The first aim of this research was to investigate teachers’ and coaches’ awareness, acceptance, and involvement of their roles in promotion, prevention and early intervention for young people’s mental health. Interviews with teachers and coaches confirmed that they both viewed supporting young people’s mental health as relevant and important to their roles and recognised the opportunity they have to positively impact young people’s mental health. Consistent with previous research (Graham et al., 2011; Reinke et al., 2011; Rothi et al., 2008), many teachers viewed supporting mental health as ‘just part of the job’ and perceived a level of responsibility incumbent in their role to care for and communicate with young people regarding their mental health. Coaches recognised that their role allows them to be a useful source of support for young people and held expectations of themselves to promote mental health and respond to any mental health concerns.

The second core aim of this research was to identify and define specific types of promotion, prevention and early intervention activities that teachers and coaches may perform to support young people’s mental health. Actions identified by teachers and coaches that promote mental health included: encouraging inclusivity and participation of all young people in
activities; promoting healthy lifestyle and exercise; encouraging young people to participate in their community; actively advocating for young people’s voice in policies; and encouraging young people to build positive attitudes towards people with mental illness. Prevention behaviours that teachers and coaches identified included: assisting young people in learning how to manage stress; having an ‘open door’ approach for young people to speak with them about issues or concerns; identifying and stopping bullying; using behaviour management strategies to assist young people to reduce or prevent behaviour problems; talking about early warning signs of mental illness; and encouraging a young person to talk to their parents about their personal problems. Actions for early intervention that were identified included: referring a young person to other sources of help (e.g. General Practitioner [GP], psychologist, counsellor); notifying and consulting colleagues about concerns they have for a young person’s mental health; personally contacting the parents of a young person whose mental health they are concerned about; offering advice to a young person about their mental health concerns; and asking a young person about suicide risk.

This research further aimed to investigate and compare teachers’ and coaches’ involvement in promotion, prevention and early intervention activities for young people’s mental health. Teachers and coaches perceived having somewhat different roles to play in promotion, prevention and early intervention. In interviews, teachers conveyed that their involvement in supporting young people’s mental health occurred predominantly through early intervention, whereas coaches viewed they were more frequently involved in promoting positive mental health and wellbeing. Interestingly, however, more detailed investigation of this in the survey indicated that both teachers and coaches most frequently, and to a similar extent, performed activities that promote young people’s mental health. Teachers’ contributions were spread more evenly across
PPEI activities than coaches who engaged in prevention and early intervention significantly less often.

Another aim of this thesis was to identify and explore predictors of teachers’ and coaches’ involvement in supporting young people’s mental health in relation to role perceptions. Role breadth, instrumentality, and efficacy significantly influenced teachers’ and coaches’ PPEI behaviour, whereas, role discretion did not. In contrast to the hypothesis, role breadth was not found to be the strongest predictor; both efficacy and instrumentality had stronger effects. As expected, these effects did not vary between; while teachers’ role perceptions for supporting young people’s mental health tended to exceed coaches’, the extent to which their involvement in PPEI behaviour from these perceptions could be predicted was comparable.

The final aim was to investigate barriers or challenges to supporting young people’s mental health within the teacher and coach roles. Both teachers and coaches perceived a lack of knowledge and skills in mental health related areas. Consistent with the findings of Graham et al. (2011), teachers also identified demanding workloads and limited time as challenges to their involvement in supporting young people’s mental health. Coaches reported worrying that the advice or action they take in efforts to support young people could negatively impact a young person’s mental health, as well as concerns regarding self-protection from being viewed as ‘too close’ to a young person.

Overall the current findings confirm that both teachers and coaches play important roles in PPEI and highlight the positive contributions adults in community-based roles can make to the mental health of young Australians.
9.3 Role of Teachers

The importance of the school setting in young people’s mental health and wellbeing has been established for some time (Wyn et al., 2000). In line with this, the role of a teacher has evolved and broadened over time and teachers have been increasingly expected to address students’ mental health and wellbeing (Finney, 2006). The current study adds to evidence that teachers now accept the importance of playing a broader role in the lives of young people beyond education and view supporting mental health as ‘just part of the job’ (e.g., Cohall et al., 2007).

Traditionally, methods used to deliver school-based mental health have tended to focus on pastoral care and support for behavioural and other problems (Rowling, Martin, & Walker, 2002). While this remains important, current evidence suggests schools now need to adopt positive models of mental health that demonstrate a full continuum of practice across mental health promotion, prevention and early intervention (Rowling, 2007a; Weare, 2010; Weare & Nind, 2011). Such models not only benefit young people’s mental health but are now also recognised as having educational benefits (Borg, 2009; Collaborative for Academic Social and Emotional Learning [CASEL], 2013; Hearn et al., 2006; IUHPE, 2000). This shift toward mental health promotion and prevention has seen an increased focus on young people’s social and emotional learning (SEL) at school. SEL concentrates on expanding students’ capacity to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish positive relationships, and make responsible decisions (CASEL, 2013; Zins & Elias, 2007).

A large number of school-based programs, projects, interventions, and initiatives aiming to enhance SEL, mental health promotion and prevention, now exist and are in operation across the world (Weare & Nind, 2011). These programs take either a targeted or universal approach
Universal programs are designed to address the mental health and wellbeing of all young people, whereas targeted interventions are aimed at specific or vulnerable groups and those with greater mental health needs (CDHAC, 2000b; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). A large-scale systematic review of previously conducted reviews on mental health in schools by Weare and Nind (2011) has indicated that school-based mental health initiatives are most effective when designed and implemented as a whole-school approach. This requires a multi-modal approach to mental health typically involving: changes to the curriculum, including teaching skills and linking with academic learning; improving school ethos; student engagement in positive activities (in and out of the classroom); teacher education, liaison with parents; parenting education; community involvement; and coordinated work with external agencies (CASEL, 2013).

The USA is the world leader having generated and implemented the greatest number of school-based mental health interventions or programs at both targeted and universal levels (Weare, 2010). Over the last 15 years, Australia has also had a significant focus on mental health in schools. MindMatters is the predominant mental health program in Australian secondary schools. It advocates a whole-school approach to improve mental health and wellbeing, reduce mental health problems, and increase support for students experiencing mental health issues through the interrelationship of curriculum, environment, partnerships and services (MindMatters, 2009; Rowling & Jeffreys, 2006). In order to be effective, these school-based mental health programs rely on a high level of commitment from the school and its teachers.

### 9.3.1 Mental health promotion

Teachers are key contributors to school-based mental health (Weare & Markham, 2005; Weare & Nind, 2011; Wyn, 2007). Moreover, the introduction of SEL and mental health
programs in schools has greatly enhanced teachers’ role in mental health promotion and prevention (Rowling & Mason, 2005). The current study found teachers commonly promote mental health particularly through encouraging inclusivity and participation of all young people in activities, and providing a positive and safe environment. The importance of school environments and school ethos—including aspects such as the underlying culture, values, and attitude the school represents, the manner in which staff and students treat each other and the development of positive relationships between them, and increased opportunities and recognition for youth participation in positive social activities—has long been documented (Weare & Nind, 2011). There is a strong view that teachers should model a school environment that is warm, respectful, organised, inclusive, participative and creative, to assist students in developing skills and characteristics that enhance wellbeing (Weare, 2010). Correspondingly, school ethos is a key component of the Health Promoting Schools framework endorsed within Australia (CDHAC, 2000a; WHO, 1998).

9.3.2 Prevention

Experiencing victimisation or bullying is a particularly prominent mental health risk factor relevant to schools, with one in four Australian students reportedly being bullied on a regular basis (AIHW, 2011; Cross et al., 2009). Bullying often causes immediate harm and distress, and can also have detrimental effects on young people’s psychosocial development and long-term mental health outcomes (Arseneault et al., 2010). The emergence of new technologies and the rapid uptake of social media among young people have intensified the impact and occurrence of covert and cyberbullying, adding further complexity to the scope of bullying and victimisation that schools and teachers are contending with (Cross et al., 2009; Kiriakidis & Kavoura, 2010; Pearce, Cross, Monks, Waters, & Falconer, 2011).
Australian schools have widely implemented bullying prevention and safe school practices guided by both national policy, namely the National Safe Schools Framework for the prevention and management of violence, bullying and other aggressive behaviour (MCEECDYA, 2011), and anti-bullying programs such as Friendly Schools PLUS (Friendly Schools PLUS, 2013). Congruent with this, the current research revealed teachers have a primary focus on identifying and intervening in bullying among students. An extensive systematic review and meta-analysis conducted by Ttofi and Farrington (2011) reported that the efforts of schools and teachers in implementing school-based anti-bullying programs are valuable and effective, with these programs decreasing bullying and victimisation by approximately 20% on average.

As evident in the results of the current research, another prevention-focused activity that teachers are involved in is using behaviour management strategies to assist young people to help reduce or prevent behaviour problems, which contribute to the development of mental health problems. Additionally, by developing young people’s social and emotional skills at school, teachers can contribute to the reduction of other mental health risk factors such as substance use, violence, and school drop-out, as well as enhance resilience and protective factors including young people’s coping skills and ability to make positive connections with peers and others (CASEL, 2013; Stewart & Wang, 2012).

### 9.3.3 Early intervention

In interviews, teachers in the current research perceived their role to have more involvement with early intervention compared to promotion or prevention behaviour. However, examination of specific behaviours in the survey revealed teachers had more frequent involvement with both promotion and prevention activities, and that they least commonly engaged in early intervention. Discrepancies between these findings may be attributable to the
different approaches used to gather information and individuals’ typical interpretations of what mental health includes. Specifically, as the term ‘mental health’ has tended to be imprecisely viewed as synonymous with mental illness (Weare & Markham, 2005), it is likely that early intervention activities, which tend to directly involve mental health problems or disorders, are more commonly associated with supporting mental health by teachers than are promotion or prevention behaviours, which intend to precede any observable mental health problem. Additionally, mental health promotion can be difficult to identify due to its broad scope and universal focus that tends to positively influence mental health in a more global sense, which can be difficult to differentiate and measure (CDHAC, 2000b).

Therefore, despite being provided definitions for mental health promotion, prevention and early intervention, many teachers when required to recall, without cues in interview, activities that they performed to support mental health may have accounted for young people’s mental health only in relation to defined disorders such as anxiety, depression, or autism and associated their role in mental health as focused on helping identifying young people with mental health problems. The survey, on the other hand, provided a set list of PPEI activities which enabled teachers to indicate their level of engagement in specific, predetermined PPEI activities rather than relying on their ability to identify and recall types of activities associated with the term ‘mental health’. For these reasons, it is likely that the greater early intervention involvement reported by teachers in interviews may have been a reflection of those activities being more obviously associated with mental health rather than representing more frequent involvement. Notably, a major shift towards a more holistic view of mental health incorporating positive emotional and social wellbeing has been developing in the field to address this barrier (Weare & Markham, 2005).
Teachers viewed their ability to establish trusting and enduring relationships with young people as a major factor contributing to their ability to assist in early intervention for young people’s mental health. They acknowledged that the relationships they are able to build with young people as a result of regular contact over an extended period of time enables teachers to act as trusted outlets, or support people, for young people. They further identified that this places them in a position to monitor behaviour change and, where appropriate, approach young people regarding their concerns. These findings are consistent with the body of help-seeking research indicating young people are more likely to seek help from people they have established relationships with rather than directly seeking care from professionals for mental health problems (Rickwood et al., 2005; Stiffman et al., 1999). Moreover, this affirms the importance of teachers as key contacts in the lives of young people to whom they are likely to turn to for support.

Although teachers had less involvement in early intervention activities than promotion or prevention activities, the specific act of notifying and consulting colleagues about concerns for a young person’s mental health was among their most frequently performed PPEI behaviour. Teachers in the current study reported that when concerned for a young person’s mental health they would inform and communicate with other personnel within the school setting, including school counsellors, pastoral care advisors, and year coordinators. This finding highlights the importance of pastoral care systems within schools and interdisciplinary cooperation between school-based clinicians and education staff (see section 9.6 for further discussion of teachers working with school-based clinicians).

### 9.3.4 Challenges to address

There are many challenges to providing effective school-based mental health support. In particular, mental health programs must be integrated into the school’s systems and ‘the heart of
the school’ in order to maximise potential for success and sustainability (Cardoso, Thomas, Johnston, & Cross, 2012; Zins & Elias, 2007). However, while whole-school approaches may lead to the greatest benefits to young people’s mental health and wellbeing, they require substantial commitment and change within schools, which can be difficult to achieve and may not always be practical. For instance, though most Australian secondary schools are aware of MindMatters, only a small proportion implement the MindMatters model in their school (headspace, 2011). There are reports that the implementation of MindMatters as a whole-school approach is overwhelming for many schools (Askell-Williams, Lawson, & Murray-Harvey, 2007). A major challenge for schools, therefore, is how to make mental health and SEL core elements of the curriculum and culture of the school as well as how to implement mental health programs and practices in ways that are integrated, achievable, and sustainable within the school system (Durlak et al., 2011; Zins & Elias, 2007).

In addition to challenges faced by schools as a whole, teachers face barriers that impact their involvement and effectiveness of supporting mental health as a professional group. Teachers in the current research reported similar challenges to those revealed by Graham et al. (2011) in their survey of Australian teachers, which included restrictions in their capacity to support young people’s mental health due to the demanding workload of their core professional role that is constantly changing, the volume of young people they support, lack of available time, and professional boundaries. Existing accountability measures for education standards, as well as a crowded curriculum, have also been reported to generate concerns about diverting teachers attention from the core business of schools in learning and achievement (Askell-Williams et al., 2007; Rowling, 2007b). Such challenges must be considered and overcome in order to meet the
urgent need to support the mental health and wellbeing of young people currently within the school system (Weare, 2010).

In order for school-based interventions to be sustainable and embedded in the life of the school, teachers need to be involved and skilled in delivery and committed to the approach (Weare & Nind, 2011). Yet, despite being recognised as part of their role for some time now, teachers still lack the knowledge, skills and confidence to effectively support students’ mental health needs (Finney, 2006; Kidger et al., 2010; Knightsmith, Treasure, & Schmidt, in press; Reinke et al., 2011). Current findings highlight a mismatch between the actions teachers perceived to be expected of their role and the extent to which they felt confident and capable to carry out such behaviours. Teachers felt most confident performing actions for mental health promotion, but there was a disjunction between teachers’ broad role and their perceived efficacy to perform prevention and early intervention behaviours (see Appendix P for paired samples t-tests of teachers’ role breadth and efficacy for PPEI, which are not reported in Papers 1-5).

Reinke et al. (2011) found a similar discrepancy, reporting that nine out of 10 teachers agreed that schools should be involved in addressing the mental health needs of young people, but only one-third felt they had the necessary skills to support these needs. So, while teachers perceive the need and expectation to support the mental health of young people, many feel inadequately prepared to do so (Kratochwill & Shernoff, 2004; Reinke et al., 2011).

9.3.5 **Provision of teacher training in mental health**

The training of teachers is an essential ingredient for school-based mental health (Rowling, 2009). In-depth and extensive professional development is needed to support mental health initiatives within the school setting (Askell-Williams et al., 2007; Weare, 2010). The current research found that teachers had generally received some training in mental health related
areas, but that many desired and needed further training and support. Indeed, a number of studies of teachers’ views on supporting mental health have exposed a common desire among teachers for further mental health training and support (Askell-Williams et al., 2007; Cohall et al., 2007; Graham et al., 2011).

Over the past decade, the main mental health support in Australia for teachers and schools has been MindMatters. This program, which is currently being redeveloped by beyondblue, provides teacher education, classroom activities and tools to support a whole-school approach to mental health. ResponseAbility has also had a significant role in pre-service teacher education. It provides free multimedia resources, materials and support for teacher education and training to promote resilience and wellbeing in students and respond to those who may have particular needs in regard to their mental health, feelings or behaviour (Hunter Institute of Mental Health, 2012). However, the program is not routinely incorporated within tertiary teacher training programs.

Additionally, a group of national mental health organisations—including beyondblue, headspace, the Black Dog Institute, and the Inspire Foundation—have collaborated to form the ‘Australian partners in wellbeing for secondary schools’. These organisations work together to provide schools with various programs and curriculum resources for mental health and wellbeing (beyondblue, 2013b). For instance, the ReachOut Teachers Network, as part of the Inspire Foundation, provides online training activities, webinars and resources regarding mental health and wellbeing for teachers and others working with young people. HeadStrong is another free, easily accessible, downloadable resource on mood disorders, mental health and resilience designed for teaching within the curriculum of secondary schools. In addition to MindMatters, beyondblue offers the secondary schools program—a curriculum resource for years 8 to 10 to
increase protective factors against mental health problems and help students develop skills that will assist them to cope with life’s challenges—and SenseAbility—a strengths-based resilience program designed for those working with young Australians aged 12–18 in the classroom.

9.3.6 Integrating mental health teaching and learning within the school

Supporting young people’s mental health and wellbeing is now a fundamental part of the teacher’s role. Assisting them to carry out promotion, prevention and early intervention behaviour increases young people’s access to mental health support and will help to reduce the burden of mental health problems among young people. The main issue with the mental health training and resources currently available to teachers, and a likely factor contributing to teachers’ continued lack of confidence and ability to support young people’s mental health, is that they are provided on ad hoc basis and/or tend to require a significant time commitment adding to teachers’ already demanding workloads and crowded curriculum (Askell-Williams et al., 2007).

In order to increase teachers’ skills, confidence and subsequent effectiveness of school-based mental health practices, it is vital that mental health training is integrated into formal training protocols, including pre-service training and continuing professional development. Mental health literacy assists teachers to confidently promote mental health and wellbeing, identify emerging mental health problems, and know how to facilitate access or guide young people to more specialist support or intervention where required (Trudgen & Lawn, 2011). It should be part of every teacher’s core skill set and must be a routine component of teacher training (Graham et al., 2011; see section 9.5.3 for further discussion of mental health literacy training).

To counter any views of mental health work as an extra burden for teachers on top of their existing duties, teacher education and development should be transmitted through the
existing systems of staff support, networking, and mentoring, to ensure that it feels part of the regular workload (Weare, 2010). Notably, MindMatters has made advances in this area and has demonstrated, to some extent, how to align mental health training with teachers’ current professional practices and systemic pressures (Weare & Markham, 2005). An important feature of the redeveloped MindMatters initiative, which will commence in 2014, is that it will provide free programs and training through structured professional development for teachers, as well as for students and parents (beyondblue, 2013a). Greater focus on professional learning and teacher efficacy in Australian schools is required (Rowling, 2009) and the resourcing and provision of initial teacher training and on-going professional development in the area of mental health must remain a priority (Graham et al., 2011). The necessity for integration into the school system applies not only for teacher training, but should extend to all mental health practices and procedures within the school environment (Askell-Williams et al., 2007). In order to maximise the effectiveness of school-based mental health, key policies and strategies must be pursued that sustain mental health initiatives at a national level (CASEL, 2013).

For students, mental health literacy and learning should be integrated into the national curriculum and across the school setting, not seen as a separate add-on issue or subject (Askell-Williams et al., 2007; Weare, 2010). The national Australian curriculum, being developed by the Australian Curriculum and Assessment Reporting Authority (ACARA) in consultation with state and territory education authorities, sets out the core knowledge, learning areas, and general capabilities all Australian students should learn as they progress through schooling (ACARA, 2013). SEL, or personal and social capability as it is termed in the Australian curriculum, is now one of seven general capabilities included in the national curriculum. In line with the need to integrate mental health teaching and learning into regular school procedures, ACARA intends for
personal and social capability to be addressed across the whole curriculum, in all learning areas, and at every stage of a student’s schooling. However, in practice, teachers may most explicitly address the development of social and emotional capabilities—including knowledge, skills, behaviours and dispositions that are protective and supportive of young people’s mental health—within the specific learning area of Health and Physical Education (ACARA, 2013).

Further efforts must be made to integrate both teacher training and practices of supporting student mental health more concretely into the schools’ systems as routine components of teaching and learning. The current study suggests that including tasks involving actions that are supportive of young people’s mental health into key performance indicators, performance and development reviews, and formal job descriptions would further encourage teachers’ involvement in such behaviour, and reward them for performing these activities. Likewise, increasing or reinforcing teachers’ awareness of the impact that PPEI behaviours have in leading to desired and rewarding outcomes, such as improved mental health and wellbeing for young people, and the positive contribution that even relatively small actions can have for a young person’s mental health, may increase teachers’ perceived value of performing such actions and motivate increased PPEI involvement.

9.4 Role of Coaches

In contrast to the large body of research focusing on the role of teachers in young people’s mental health, the opportunity for youth sports coaches to positively impact mental health is considerably less well recognised. Given the prominence of sport among Australian young people, coaches have great potential to contribute to PPEI for mental health and there is growing acceptance for this role among coaches. The current research highlighted that while
coaches did not perceive a large amount of external pressure, they did feel that expectations for them to be involved and supportive of young people’s mental health and wellbeing had increased in recent years. Furthermore, many coaches recognised the negative impact mental health problems can have on performance and learning, and held personal values or expectations of themselves to take action to support young people’s wellbeing. These were promising findings, as coaches are increasingly being recognised as sources of support contributing to young people’s mental health, with campaigns such as the ‘silence is deadly’ campaign from Menslink—a Canberra-based charity that supports young men through mentoring and counseling services—who have teamed up with local professional athletes, the Canberra Raiders, to reduce the stigma associated with seeking help among men by raising awareness of coaches as trusted supports for help-seeking (Menslink, 2013). PPEI may be an area of future growth for the role of a youth sports coach.

### 9.4.1 Mental health promotion

Mental health promotion aligns particularly well with the core aims of the coach’s role in health promotion and performance (Kokko, Kannas, Villberg, & Ormshaw, 2011). As a result, in contrast to the wide breadth of the teacher’s role in mental health spread across PPEI, the current level of involvement of coaches in supporting mental health tends to be more heavily centered on mental health promotion. Exercise and health are key motivations for participation and performance in sport and, consequently, a key aspect of a coach's role in mental health promotion occurs naturally through endorsing a healthy lifestyle. Coaches are also uniquely valuable in promoting participation in sports, which in itself has many mental health benefits (Malcolm, Evans-Lacko, Little, Henderson, & Thornicroft, 2013). Coaches identified providing a positive and safe environment as another action they frequently perform that contributes to
mental health promotion, as caring climates in sport foster positive emotional regulation and mental wellbeing in young people (Fry et al., 2012).

9.4.2 Prevention

The sporting environment is a particularly valuable setting for accessing and supporting vulnerable young people, as vulnerable or at risk young people that may not access other supports or services do tend to participate in sports (Lubans et al., 2012). While coaches in the current research reported greater involvement in promotion behaviour, they also have an important role in the prevention of mental health problems. They reported regular involvement in reducing risk factors for mental health problems by identifying and stopping bullying, and enhancing protective factors through developing young people’s life skills. In fact, coaches viewed teaching life skills and values to young people through sport participation as one of the main contributions they can make to young people’s development and mental health. Gould et al. (2006) similarly found that coaches considered teaching personal and social skills that enhance young people’s resilience and ability to cope with life’s challenges as one of the most important objectives of their role. Furthermore, as a result of this type of recognition, targeted sports and social inclusion programs (e.g. Midnight basketball) have been developed in Australia to enhance both life and sport skills for at-risk young people (Danish & Nellen, 1997; Midnight Basketball Australia, 2011). Skill development in this manner acts towards both the promotion of wellbeing and prevention of mental health problems.

9.4.3 Early intervention

Coaches described that it was increasingly common for them to become aware of young people’s mental health concerns, but that they were rarely involved in early intervention for mental health. This may be due to not knowing what to do or how to help when faced with a
young person needing support for a mental health problem or disorder. Bapat et al. (2009) suggested that coaches lack the necessary skills and knowledge to effectively influence young people’s mental health and wellbeing. The current research supported this finding, with coaches perceiving they had limited skills and confidence in supporting young people’s mental health needs and feared doing harm by saying or doing the ‘wrong’ thing.

Another factor that likely contributes to coaches’ lack of early intervention behaviour is that they are often left to work alone in isolation (Gilbert & Trudel, 2005). Therefore, they tend to have a great deal of discretion as to the approach, actions, and decisions they make within the coaching role. As reported in the current research, this can result in a great deal of variance in individual coaches’ attitudes, knowledge, and style of coaching, some of which are more supportive of young people’s mental health than others. Additionally, the majority of coaches are community coaches and volunteer workers, with other careers, dedicating their precious and limited personal time to coaching. They often learn to coach through experience and by engaging with other coaches, rather than through formal training and, consequently, are not likely to be experts in the field of coaching (Cushion et al., 2010; Cushion, Armour, & Jones, 2003; Lemyre, Trudel, & Durand-Bush, 2007).

Unlike teachers, coaches do not appear to be guided by any procedural or structural guidelines regarding early intervention and connecting young people to appropriate supports. Coaches in the current research reported a total lack of guidelines or assistance from any form of ‘pastoral care-type’ system. Some expressed concerns and challenges in decisions around confidentiality and the difficulty of balancing privacy of information versus communicating necessary information between other parties, such as parents. Similarly, Bapat et al. (2009) found coaches raised concerns in managing potential conflicts between developing a trusting and
confidential relationship with a young person versus informing parents, family members, and other professionals about any issues or concerns. Consequently, most coaches indicated that when concerned for a young person’s mental health they would primarily communicate directly with the young person.

9.4.4 Other challenges to address

The lack of systemic support for coaches in mental health also leaves them, and young people, vulnerable to increased risks. A coach may contribute to a young person’s positive experiences of sport, or have the opposite effect (Williams et al., 2003). There have been cases of coaches harmfully exploiting their position and relationship with young people in sport, resulting in child abuse and sexual exploitation (Bringer, Brackenridge, & Johnston, 2006). Bringer et al. (2006) suggested that in light of increased public awareness and concern of sexual exploitation in sport, coaches may be hesitant to offer personal support to young people due to their perceived risk of being viewed as being too close to their athletes and accused of abuse or exploitation. Consistent with this, a number of coaches in the current study described a need to act with caution and consideration when engaging in tasks to support young people’s mental health, and acknowledged that concern for self-protection (protection of themselves, their position and their reputation) can create apprehension. It is, therefore, important that coaches are aware of how to, and are able to, appropriately and effectively assist young people with their mental health.

9.4.5 Need for training and systemic support for coaches in mental health

Coaches need to receive clear guidance and education to support them in their developing role in PPEI. It is important they have access to and obtain training and advice on how they can appropriately utilise their potential to support young people’s mental health, to recognise where
the boundaries of such support lie, and what referral pathways are available to assist young people in need of further intervention.

As was the case with teachers, the current research suggests coaches would welcome and value further training and support to improve their skills, confidence and knowledge of care pathways. Voight (2005) add that even coaches who are skeptical or reluctant to support young people’s mental health may become more open minded through increased awareness and realisation that the actions they already perform also act toward PPEI and are beneficial to young people’s overall mental health. Making mental health training more available to sports coaches would boost their ability to assist confidently and effectively, and may be valuable in reducing barriers to mental health care, leading to improved outcomes for young people’s mental health and wellbeing.

Formal training for coaches, however, is limited due to the lack of an overarching structure and issues concerning volunteerism. More specifically, given most community coaches of youth sports are volunteers, expectations for additional training and commitment of time needs to be carefully considered (Cushion et al., 2010). Online information and training regarding mental health is becoming increasingly more available. Perhaps given the limitations to providing formal face-to-face training, online education may be a more appropriate way of providing brief training as it is easily accessible, flexible, convenient, and less time intensive. As an example, coaches can seek guidance from the ‘Play by the rules’ initiative, which provides online information for clubs and coaches on how to help someone in crisis or whose mental health they are concerned for (Sporting Pulse, 2013). Additionally, Mental Health First Aid is an internationally recognised program of mental health education which offers an eLearning version
that coaches could utilise (Mental Health First Aid, 2013; see section 9.5.3.1 for further information on MHFA).

Coaches also need to be supported systemically in their emerging role in PPEI for mental health. The sports clubs and organisations that coaches work within must support coaches by modelling values and attitudes that promote mental health and wellbeing and destigmatise help-seeking behaviour. In line with this, Lemyre et al. (2007) argue that youth sport coaches should be working together, with their associated sports clubs and volunteers within their sporting community and with parents, to provide young people with a sporting environment that is values-based and oriented to youth development. Establishing a culture creates a platform from which coaches are better able to take action in PPEI for mental health as it appears congruent with the environment the young people are familiar with. Kokko et al. (2011) in a study of youth sports clubs in Finland, found that there was large variation in the extent to which sports clubs actively practiced or delivered health promotion (through topics such as injury prevention, sleep and rest, nutrition, and substance use) and identified a need for clubs to provide more active guidance to coaches on health promotion. Current research indicates this need also extends to enhancing guidance from sports clubs to coaches regarding mental health promotion. Moreover, assisting coaches to integrate PPEI activities into their everyday practices may help to remove barriers to young people’s service use (Reinke et al., 2011).

9.5 Implications for Other Community-Based Adults

The shift toward a positive model of mental health is helping to ensure that mental health is seen as ‘everyone’s business’ (Parham, 2007). This investigation of teachers and sports coaches, whose opportunity to contribute to this area is less well recognised, should extend the
awareness and knowledge of the variety of settings and people that are influential and have potential to benefit young people’s mental health. A number of implications can be drawn from the current research pertinent not only for teachers and coaches but able to be applied to the roles of many other community-based adults in young people’s lives.

9.5.1 Other community-based roles in PPEI

The impact of promotion, prevention and early intervention can be strengthened by community involvement and many adults in community-based settings have potential to assist in similar ways to teachers and coaches. For instance, church-associated organisations and clergy members are ideal sources to promote young people’s mental health by encouraging community involvement and positive behaviour, as well as fostering a culture of acceptance and inclusion. Clergy members are also involved in youth outreach programs which aid in prevention of mental health problems by targeting mental health risk factors such as substance abuse and high-risk behaviour (Hopkins et al., 2007). Similarly, youth workers have been identified as having an influential role in early intervention and pathways to mental health care, particularly for vulnerable or marginalised young people (Rickwood & Mazzer, 2012).

As suggested for coaches, supporting mental health may be an area of future growth for many community-based adults who are familiar with and involved in young people’s lives, including clergy members, youth workers, and social or leisure activity leaders (CoA, 2004; Rickwood et al., 2005). These adults should be encouraged to promote positive mental health and well-being, advocate for the prevention of mental health problems, and intervene early in the development of mental health problems. Community groups and organisations that regularly come into contact with young people need to be supported, educated and utilised in PPEI programs (Hampshire & Nicola, 2011).
9.5.2 Clear expectations and boundaries

It is imperative that community-based adults have clear expectations and guidance on how they can appropriately assist young people’s mental health. These adults must understand the professional boundaries of their roles and expertise when supporting young people with their mental health. Acting beyond these boundaries can lead to negative professional consequences and may also adversely impact the young person involved. The current study confirmed that both teachers and coaches recognised that providing any form of treatment, or counselling, as outside the scope of their role. This understanding is essential; while community-based adults can make valuable contributions to PPEI, they are not experts in mental health and should not be acting as such. As highlighted by participants of the current study, health care professionals who specialise in mental health are the ones equipped and appropriately qualified to assist with mental health concerns. It is, therefore, imperative that community-based adults are aware of and have confidence in the pathways to refer young people to mental health professionals, and that such community pathways to appropriate care are in place.

9.5.3 Training in mental health literacy

Community-based adults need to receive more training in mental health to increase their confidence and ability to effectively and appropriately support young people’s mental health. Increasing adults’ mental health literacy, which is ‘knowledge and beliefs about mental disorders which aid their recognition, management, or prevention’ (Jorm et al., 1997, p. 182), empowers communities to take action for better mental health (Jorm, 2012). Mental health literacy interventions provide education on the biological, psychological, and social aspects of mental health, and discuss the signs and symptoms of mental illness, as well as what types of help and services are available and how to access help (Jorm et al., 1997; Kutcher & Wei, 2012). Such
programs are effective in increasing community knowledge of mental health, reducing stigma, promoting positive attitudes towards help-seeking, and facilitating early intervention for mental health problems (Gulliver, Griffiths, Christensen, & Brewer, 2012; Kelly, Jorm, & Wright, 2007; Kutcher & Wei, 2012; Reavley & Jorm, 2012). Improving the mental health literacy of community-based adults may lead to better outcomes for young people with mental health problems by enhancing their ability to identify the early signs of mental health problems and facilitate appropriate and timely help (Kelly et al., 2007).

**9.5.3.1 Mental Health First Aid (MHFA)**

One of the leading programs that addresses adults’ mental health literacy is Mental Health First Aid (MHFA). First developed in Australia, MHFA has grown and now operates as a not-for-profit organisation, with a strong international presence, providing structured training to assist adults to respond to mental health concerns and crises. A range of tailored MHFA programs have been developed that deliver relevant and specific knowledge to targeted populations. For instance, youth MHFA is a 14 hour course aimed at adults working or living with young people. The third edition of this specialised program was released in 2013 and is appropriate for adults in community-based roles. Moreover, youth MHFA has been delivered to both teaching and coaching samples and has been effective in improving participants’ confidence and ability to recognise and help someone with a mental health problem or disorder (Jorm et al., 2010; Pierce et al., 2010). Continuing to expand the distribution of such training to community-based adults would be beneficial for young people’s mental health and wellbeing.

Other specialised MHFA courses have been developed for teens assisting their peers, supporting older persons, and assisting people who are Aboriginal and Torres Strait Islander. Additionally, MHFA courses for frontline community workers such as medical and nursing, as
well as financial counselors, are currently being offered, free of cost, as part of an initiative funded by the Australian Government Department of Health and Ageing aiming to train frontline community workers to better identify and respond to the needs of people at risk of suicide (Mental Health First Aid, 2013).

### 9.5.4 Community-based adults in suicide prevention

The Australian government has had a particular focus on suicide, as it is the leading cause of death among Australian young people (ABS, 2013a). Consequently, suicide prevention campaigns are one of the key initiatives strongly advocating for the involvement of community-based adults (Cross et al., 2011; Isaac et al., 2009; National Mental Health Commission, 2013). Given their established relationships and regular contact with young people, such adults are in valuable positions to provide essential initial intervention when a mental health crisis or emergency occurs. Moreover, when a mental health crisis, such as suicide, occurs it affects not only the individual and their family, but also the surrounding community (National Mental Health Commission, 2013). In times of crises, community-based adults may be able to step-up and provide valuable support to assist the range of affected community members in responding to and recovering from such events.

The current research, however, found that both teachers and coaches were least involved in talking with young people about suicide risk in comparison to the other measured PPEI behaviours. In line with these findings, King, Price, Telljohann, and Wahl (1999) in a study of over 200 health teachers, found that the majority believed it was an appropriate component of their role to identify young people at risk for suicide, and that by doing so they could potentially avert a tragedy. However, the majority of these teachers did not believe they had sufficient knowledge and skills to recognise individuals at-risk.
Suicide prevention training

Training for gatekeepers and community-based adults is a key component of suicide prevention campaigns (Cross et al., 2011; Isaac et al., 2009). The USA seems to be leading the charge with a number of large-scale, developed suicide prevention training programs for gatekeepers including: Question, Persuade and Respond (QPR; Quinnett, 2007); the Applied Suicide Intervention Skills [ASIST] program (LivingWorks, 2010); and the LINK model, which describes Looking for possible concerns, Inquire about concerns, Note level of risk, and Know referral resources and strategies. These types of training programs teach gatekeepers how to identify people at increased risk for suicide and refer those people for treatment (Isaac et al., 2009).

Gatekeeper training has been implemented in many target population groups, including school settings (and also for military personnel, public school staff, peer helpers, clinicians, and those working with Aboriginal and Torres Strait Islander people) and has been shown to be successful at enhancing knowledge, building skills, and molding the attitudes of gatekeepers regarding suicide prevention (Cross et al., 2011; Isaac et al., 2009; Katz et al., 2013; Tompkins & Witt, 2009). Notably, current findings indicate efforts to educate and assist community-based adults to identify and respond to young people at risk of suicide must continue as these adults are not yet comfortable engaging in suicide prevention behaviour. Wyman et al. (2008) in a randomised trial of QPR gatekeeper training on 249 staff of 32 schools recommended that in addition to educational gatekeeper training, teachers and other ‘natural gatekeepers’ need skills training that employs active learning strategies as well as interventions that modify young people’s help-seeking behaviour in order to increase suicide identification behaviour. For instance, Sources of Strength program (SoS; LoMurry, 2005) aims to increase young people’s...
connectedness with adults by engaging diverse adolescent peer leaders to help change student norms regarding the acceptability of suicide, help-seeking, and communication between young people and adults. Wyman et al. (2010) found the SoS program to positively impact school-wide norms about help-seeking and suicidal behavior. Cross et al. (2011) in a randomised control trial found behavioural rehearsal and role play practice positively impacted gatekeeper suicide prevention skills. Such studies show that gatekeepers require a reasonably high level of training that is both in-depth and interactive in order to be confident and effective.

9.6 Implications for Mental Health Clinicians

There are implications of the current findings relevant for mental health clinicians and services, as well as for the teachers, coaches, and other community-based adults who can help promote and intervene to support young people’s mental health. The efforts of community-based adults in identifying and providing initial support to young people experiencing mental health concerns should be complemented by a subsequent effective clinical response in order to best meet young people’s mental health needs. There is a wide range of different clinical and service responses to mental health problems in Australia, including school-based services, general practice, child and adolescent mental health services, and the specific youth mental health service initiative of headspace, which is increasingly being rolled out across Australia. It is important that these providers understand the roles and value of community-based adults facilitating young people’s pathway to mental health care and in providing on-going support. Moreover, the care and support that young people receive for their mental health may be enhanced by effective cooperation and communication between mental health clinicians and
community-based adults. These professional relationships may be particularly important for school-based mental health.

9.6.1 Clinicians in school-based mental health

All Australian schools have pastoral care systems—although the nature of the systems can vary—and access to school-based mental health clinicians, such as counsellors, and psychologists (Cardoso et al., 2012). These clinicians operate within the educational system to provide a source of mental health expertise within the school domain (Rowling, 2007b). As the school specialists in mental health, school-based clinicians must support early intervention by assisting to identify, manage and respond promptly to young people experiencing mental health concerns. They also need to possess the knowledge and skills necessary to understand school mental health referral processes and protocols, and to establish resources that support learning and development. Moreover, it is crucial that these clinicians are both integrated and available within the school system in order for teachers to feel confident that their efforts in identifying and referring young people for mental health intervention will be followed through. It is particularly important that school-based clinicians are able to provide assistance and guidance to teachers when young people with more serious mental health problems or those at increased risk of suicide are identified. Additionally, it is imperative that school-based clinicians maintain awareness of the various interventions and services available both within and for the school community that are often changing, for example if a headspace centre becomes located in the community (Ball, Anderson-Butcher, Mellin, & Green, 2010; Michael, Owens, Albright, & Anderson-Butcher, 2014).
9.6.2 Facilitation of mental health education

The language of ‘mental health’ both in schools and within the community has traditionally been filtered through an illness lens, which is a perspective that aligns with the training and orientation of mental health clinicians who are knowledgeable in the treatment of mental health problems (Rowling, 2007b). However, school-based clinicians can also play a role in the shift towards positive paradigms of mental health and are valuable contributors to the implementation of school-based mental health and SEL initiatives (Michael et al., 2014; Zins & Elias, 2007). Furthermore, as they work within the school system, school-based clinicians are in valuable positions to extend knowledge to others within that system, including teachers and young people, to be more aware and effective in supporting mental health. School-based clinicians can provide information, deliver demonstrations and conduct educational activities to groups of teachers and/or young people to assist them in learning about mental health as a holistic concept, environmental factors that influence it, recognising when there is a need for support or intervention, and taking appropriate action. School-based clinicians can also reinforce the importance of teachers’ relationships with young people, and may be able to recommend engagement strategies for teachers to connect with young people, which is vital for facilitating help-seeking behaviour and early intervention.

9.6.3 Interdisciplinary collaboration in school-based mental health

School mental health relies on interdisciplinary systems and effective collaboration between school-based clinicians, teachers, and other school personnel (Michael et al., 2014; Weist et al., 2012; Wyn, 2007). Working within the educational setting, school-based clinicians are required to integrate their practices into an education context whereby they work in cooperation with the school community to address the mental health and academic needs of
young people (Mellin, Anderson-Butcher, & Bronstein, 2011; Michael et al., 2014). The partnership between school-based clinicians and teachers is vital for young people’s access to mental health care (Rowling, 2007a; Wyn, 2007). These professionals rely on reciprocal support from one another to best support young people with mental health concerns in the school setting. To illustrate, teachers in the current study reported that when concerned for a young person’s mental health they would utilise pastoral care pathways and systems to notify school-based clinicians and other specialised personnel within the school setting. In return, since school-based clinicians do not have the same level of regular contact with students, they largely rely on this recognition and referral from teachers in order to identify those who may be in need of their services. Teachers further reported that with the exception of parents, they would rarely directly contact or refer to parties external to the school. Teachers described that rather than becoming involved in external referral processes, they would instead rely on school-based clinicians to make any necessary referrals to mental health or psychiatric services. School-based clinicians, therefore, help to provide clear pathways for young people to access mental health care and are an essential link between the school and community mental health services (Weist et al., 2012).

Given the reciprocal relationship between teachers and school-based mental health professionals, clearly defined roles and working relationships, as well as effective feedback between these parties is essential for young people’s mental health and wellbeing (Mellin et al., 2011).

9.6.4 Referral feedback and communication with relevant adults

The current research has demonstrated the important roles and influence that many adults have in young people’s mental health. Many community-based adults, such as teachers and coaches, have knowledge that mental health professionals can draw upon to enhance their practice (Rowling et al., 2002). It is important for clinicians to communicate with these other
parties in order to best support young people across the many different domains of their lives. Clinicians may also be effective in facilitating conversations between community-based adults and parents, and assist community-based adults to discuss mental health issues with parents.

Clinicians must support teachers and other community-based adults in their efforts to identify and refer young people with mental health concerns. Clinicians should be mindful that other adults in young people’s lives, including teachers, coaches, parents, and other community-based adults, do not have their level of expertise or knowledge of mental health. As highlighted in the current study, teachers and coaches feel they lack mental health related skills and knowledge, and can find it challenging to differentiate what is ‘normal teenage behaviour’ and what is symptomatic of a mental health problem that may require further support. Clinicians can assist to improve these adults’ mental health literacy and understanding of when referral to a mental health professional is indicated by obtaining consent and providing feedback regarding individual cases in which they have been part of the young person’s pathway to care. Making it part of clinicians’ practice to provide such referral feedback, and being supportive of teachers when they approach with concerns regarding a young person’s mental health, should also act to positively reinforce future help-seeking behaviour among teachers and young people.

Additionally, feedback between clinicians and community-based adults can directly benefit young people’s treatment for mental health problems (Ball et al., 2010). Often strategies derived or discussed in therapy need to be implemented in the young person’s everyday life, and informing relevant adults may assist in this application. For instance, effectively intervening in young people’s mental health at school may involve school-based clinicians and teachers flexibly negotiating an integrated treatment plan in which certain strategies may be applied within the
classroom to meet the unique mental health and education needs of a young person (Michael et al., 2014).

9.7 Conceptual Contributions

9.7.1 PPEI framework

This thesis has contributed significant new conceptual knowledge to the rapidly developing field of PPEI, which is the fundamental framework underpinning current government mental health strategies in Australia and internationally. In particular, the current research addressed a major conceptual gap by identifying and defining actions that distinctively characterise promotion, prevention and early intervention as separate constructs as they relate to community-based professional roles.

The Mrazek and Haggerty (1994) spectrum of mental health interventions emphasises the importance of promotion, prevention and early intervention as well as continuing care and recovery and relapse prevention. The spectrum further illustrates that the influence of many actions overlap across promotion, prevention and early intervention, and that a number of interventions or initiatives combine or include elements from each intervention domain. While acknowledging this overlap, the conceptual clarity this research has provided by identifying and categorising specific activities that distinctively represent promotion, prevention, or early intervention is considerable and provides evidence that these domains can be viewed as distinct foci within the spectrum of interventions. This will contribute to the advancement of the PPEI field and highlight practical activities that can be encouraged and incorporated into interventions or initiatives aiming to benefit young people’s mental health and wellbeing through PPEI.
9.7.2 Important roles in PPEI for adults outside the field of mental health

Promotion, prevention and early intervention can lead to substantial benefits for young people’s mental health and wellbeing as well as reduce the prevalence and burden of mental health problems and mental disorders (AIHW, 2011; CDHAC, 2000b). In line with a number of Australian government frameworks, which recognise the value of community involvement in PPEI for young people’s mental health (e.g., CDHAC, 2000a; CoA, 2004, 2009; National Advisory Council on Mental Health, 2011), the current research has confirmed the significant roles that people outside of traditional mental health services have in contributing to PPEI. Given young people’s preference to seek help from people they know, and the range of PPEI activities that adults within the community can perform, there is a need to incorporate mental health into the routine practice of community-based adults working with young people (Finney, 2006). Adults, like teachers and coaches, who interact with young people in community-based settings should be a focus of strategies designed to promote mental health, prevent mental health problems, and intervene early in mental illness for young people. This research informs specific ways forward to achieve these aims.

9.7.3 Role-related perceptions

This research has also advanced knowledge regarding the influence and importance of individuals’ professional role identity. This identity is built on individuals’ perceptions of their working role, and strongly affects their willingness to perform and accept responsibility for specific tasks and behaviours (Parker, 2007; Siebert & Siebert, 2007). Subsequently, addressing individuals’ role-related perceptions may be effective in enhancing motivation and willingness to engage in new or desired behaviours within their roles. Whereas previous studies have tended to focus on just one type of role perception, most commonly role breadth, or have combined and
confounded facets of role perceptions, the current findings support McAllister et al. (2007) who stress the importance of measuring role breadth, role efficacy, role instrumentality, and role discretion as distinct perceptions. Furthermore, this research highlighted that the extent to which each of these perceptions influences behaviour varies across different contexts. For example, role breadth and efficacy were found to have the greatest influence on promotion and prevention behaviour, whereas role instrumentality most strongly influenced early intervention behaviour. One explanation for the increased influence of instrumentality on early intervention behaviour may be that additional motivation could be required for teachers and coaches to carry out behaviours for which they have reduced confidence in their ability, as was the case with early intervention behaviour; the link between behaviour and rewarding outcomes may provide the additional motivation required to perform these actions. It is therefore important to consider and understand individuals’ views of their role by applying frameworks that account for multiple facets of role perceptions.

9.8 Strengths and Limitations

The present research comprised many strengths as well as a number of limitations. A major strength of this research was the integration of qualitative and quantitative methods, which facilitated the exploratory and developmental nature of the research. The aims of this thesis were achieved by effectively adopting a qualitative methodology in phase I, which allowed for an in-depth exploration and understanding of teachers’ and coaches’ roles and involvement in supporting young people’s mental health and produced a solid foundation to inform the development of the PPEI measure in phase II, the inclusion of role perceptions in phase III of the research, and assisted in the interpretation of findings in phase III. The use of quantitative
methods in phase III enabled predictive analyses to be conducted, which enhanced understanding of the influence that teachers’ and coaches’ perceptions regarding their roles have on their involvement in supporting young people’s mental health. As demonstrated throughout this chapter, results of each complementary phase of research were compared and contrasted in order to make stronger inferences relating to teachers’ and coaches’ roles in supporting young people’s mental health (Tashakkori & Teddlie, 2010).

Another strength of this research was the simultaneous investigation and comparison of teachers’ and coaches’ views of their roles and involvement in PPEI to support young people’s mental health. Highlighting the similarities and differences between these two distinct groups has provided valuable information as to how to target and encourage different groups of people to assist young people with their mental health. In particular, finding that the extent to which individuals felt competent to perform PPEI behaviours, perceived PPEI behaviours as an expected part of their role, and linked engaging in such behaviours with rewarding outcomes, similarly influenced both teachers’ and coaches’ behaviour enhances the generalisability of the current findings. These role-related perceptions are also likely to influence the helping behaviour of other community-based roles interacting with young people, such as clergy members, youth workers, social or leisure activity leaders, and adult family friends.

This research adopted a novel approach to explore an emerging research area. As there was no previously available measure, the development of a measure of PPEI was a key strength of this research. In addition to providing a brief means of measuring specific involvement in promotion, prevention and early intervention behaviour, the development of a measure specifically for use in the current research also had a number of other benefits. The set of activities listed in the PPEI tool were derived directly from discussions with teachers and
coaches. While the PPEI tool has extended value in measuring other adults’ PPEI behaviour who work with young people, this allowed the measure to be directly relevant for the current research by specifically targeting teachers and coaches as the populations of interest, as well as addressing the specific PPEI behaviours being investigated in this research. Additionally, the 15-item measure developed within this research is the first instrument that enables quantitative measurement and recording of involvement in promotion, prevention and early intervention behaviours as distinct categories. This is a significant contribution as it was previously difficult to determine an individual’s involvement across these intervention domains.

Although a notable strength of this research, use of the PPEI measure developed in phase II also has limitations. Firstly, as it is a new measure it has not been subjected to psychometric testing and external validation. Additionally, as a consequence of the aim to create a set of activities which distinctively characterised promotion, prevention and early intervention as separate domains, the PPEI measure did not capture behaviours that support young people’s mental health across more than one of the intervention domains. Such behaviours were unable to be classified into a sole category and were excluded from the measure in order to enable greater discriminant validity of the behaviour categories in this measure. While not appropriate for this measure, behaviours that benefit mental health across multiple domains of the PPEI spectrum are important actions to be considered in initiatives and interventions that aim to improve young people’s mental health. Furthermore, the instrument measured only five activities within each category of promotion, prevention and early intervention. Efforts were made to ensure these activities were appropriately representative of the range and diversity of actions that lie within each category for both teachers and coaches. This allowed for exploration of the boundaries of
activities that are within and beyond the scope of teachers and coaches roles; however, it is likely that the inclusion of different or additional activities would produce different findings.

Findings may have been impacted by the volunteer or self-selected nature of the samples in phases I and III. This may have attracted participants who were more interested and committed to mental health than other adults in community-based roles. Less interested participants may have revealed less willingness to adopt such roles and provided more information on barriers to engaging in PPEI. Additionally, the research was based on a local urban sample as participants were recruited solely from one medium sized Australian city. Notably, efforts were made to counter the impact of the local self-selected samples and to extend the generalisability of findings by targeting a range of schools and sports clubs, varying in demographics. This captured a diverse range of participants across ages, experience, subjects taught, and sports coached. However, communities vary and results may differ in rural or other communities.

This research also relied on self-report methods, which gives rise to some inherent limitations. Self-report measures are dependent on participants’ recall and accuracy of relaying information, and are vulnerable to social desirability biases. As such, participant responses may have reflected an overestimation in the extent to which their actual behaviour is supportive of mental health and the frequency of which they engage in PPEI behaviour. Notably, steps were taken to minimise the potential impact of social desirability on responses by conducting individual interviews with each participant, rather than a collective focus group in phase I, and by utilising an online format for the survey in phase III to increase participants feeling of anonymity. Nevertheless, a more accurate representation of teachers’ and coaches’ behaviour would be achieved by incorporating an observational measure of their actual behaviour.
9.9 Future Research Directions

The current investigation is among the first to emphasise the significant role coaches can play in supporting young people’s mental health through PPEI. Future research should continue to explore this emerging role for coaches as valued sources of support for young people’s mental health and wellbeing. Coaches’ unique opportunity to carry out PPEI for mental health within an environment that strongly promotes team-based culture and cooperation within the group to achieve mutual goals, as in team sports, could be an interesting dynamic to explore. The value of PPEI behaviour may be increased in such an environment where young people are able to learn and develop skills to improve mental health with and from each other, facilitated by the coach, as they do for sport-related activities.

The introduction of a brief measure for promotion, prevention and early intervention behaviour facilitated this investigation of teachers’ and coaches’ involvement and role in supporting mental health in this research. In future, this measure could be used more broadly to assess PPEI behaviour across other adults in community-based roles working with young people. Additionally, future research should continue to explore and define the range of activities that community-based adults can perform in PPEI to support young people’s mental health. Further investigation of the type of competencies and skills community-based adults require to effectively carry out PPEI actions, as well as the formulation of methods for these adults to attain such skills, is also required.

Future research could also investigate mental health clinicians views on what they believe the roles of community-based adults are in relation to mental health, where the boundaries and limits of their involvement should lie, and how they can best work together to support young people. This would be valuable as clinicians could provide a unique perspective from within the
mental health system that may draw attention to vastly different benefits and concerns of community-based adults’ involvement, than were highlighted in the current study by adults working outside of clinical services.

Finally, and particularly importantly, seeking the views of young people regarding the extent to which they perceive their teachers’ and coaches’ behaviour and approach to their roles as supportive of their mental health would also be a valuable addition to this field of research. Young people may have quite different perceptions regarding the influence teachers and coaches have on their mental health, how commonly they engage in the specific PPEI behaviours investigated in this research, and which of these actions young people find most helpful. While previous help-seeking literature suggests young people would be more willing to accept help from people they already know (Rickwood et al., 2005), it may also be important to specifically investigate young people’s willingness for teachers and coaches to be involved in supporting their mental health. This is particularly important in relation to early intervention as it requires providing individual support to a young person experiencing a mental health problem, whereas actions for promotion and prevention tend to be directed at groups of young people and can occur more covertly within the natural course of school or sporting activities.

9.10 Overall Contribution of the Thesis and Conclusions

This thesis by published works has provided a unique examination of teachers’ and coaches’ views of their roles and involvement in supporting young people’s mental health through promotion, prevention and early intervention. Significant new conceptual knowledge was contributed by defining specific activities that characterise promotion, prevention and early intervention for mental health and creating an instrument to measure these constructs. This thesis
has provided vital insight into the specific actions that community-based adults perform to support young people’s mental health and has advanced the understanding of the influence that role-related perceptions have on these adults’ engagement in such behaviours. Investigating sports coaches’ influence in this context was particularly novel and has revealed that coaches, along with teachers, are valuable groups to target in emerging programs intending to improve the mental health and wellbeing of Australian young people. Supporting mental health through PPEI may be an area of future growth for the role of a youth sports coach and other community-based adults. If mental health is ‘everybody’s business’, then everybody needs to be aware, confident and competent in their relevant role.

This research has shown that teachers and coaches recognise the importance, and are accepting, of supporting young people’s mental health within their roles. Both teachers and coaches are making valuable contributions to young people’s mental health by taking action in promotion, prevention and early intervention. Additional training and support in mental health related areas is required to enhance their ability to assist confidently and effectively. Encouraging and assisting adults in community-based roles to engage in promotion, prevention and early intervention behaviour will strengthen and diversify young people’s access to mental health support, as well as help to reduce the burden of mental health problems, and improve the mental health and wellbeing of Australian young people.
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Are you a sports coach, teacher, or youth worker of young people aged 12 – 18? **Have your say.**

Research Project:
**What is the role of sports coaches, teachers, and youth workers in young peoples’ mental health?**

A study looking into the influence of adults (who work with young people in the ACT) in the promotion, prevention, and early intervention of young peoples’ mental health care.

Participate in a brief (20-30 minute) interview regarding your views on the influence your field has on young peoples’ mental health.

For more information or to participate in the project contact Kelly Mazzer, University of Canberra, [Kelly.Mazzer@canberra.edu.au](mailto:Kelly.Mazzer@canberra.edu.au)
Hi all

As part of my PhD in Clinical Psychology I am conducting a research project looking into the roles of sports coaches, teachers and youth workers in young peoples’ mental health. I am currently seeking high school or college teachers within the ACT to participate in the project. Participation will involve meeting with myself for a short 20-30 minute interview regarding the influence that the field of teaching or coaching has on young peoples’ mental health.

If you are a teacher or coach, and are interested in participating in the project or would like more information please send your contact details to kelly.mazzer@canberra.edu.au.

If you know of any teachers or coaches who may wish to contribute, please help to spread the word by distributing the attached flyer or forwarding this email. The more the merrier!

Thank you for your support.

Kelly Mazzer
PhD (Clinical Psychology) Candidate
University of Canberra
Participant Information

Project Title

The role of sports coaches, teachers, and youth workers in young peoples’ mental health

Researcher

Kelly Mazzer
PhD (Clinical Psychology) Candidate
Psychology, Faculty of Health
University of Canberra ACT 2601
Ph: 6201 2653
Email: kelly.mazzer@canberra.edu.au

Supervisors

Professor Debra Rickwood
Psychology, Faculty of Health
University of Canberra ACT 2601
Ph: 6201 2701
Email: debra.rickwood@canberra.edu.au

Dr Thea Vanags
Psychology, Faculty of Health
University of Canberra ACT 2601
Ph: 6201 2569
Email: thea.vanags@canberra.edu.au

Project Aim

The aim of this research is to explore gatekeeper’s views of their role in promoting young people’s mental health. This study aims to investigate whether sports coaches, teachers and youth workers perceive themselves to be, or have capacity to be, effective in the promotion, prevention and/or early intervention in young people’s mental health.

Benefits of the Project

Participants may benefit from this research through increased awareness of mental health and mental health problems in young people, and the current or potential impact they, as gatekeepers, have in this area. The information gained from the research will also be used to inform the wider community regarding the ability of adults to assist young people with mental health care.

General Outline of the Project and Participant Involvement

Sports coaches, teachers and youth workers, within the ACT, who are in regular contact with young people aged 12-18 will be sought to participate in a brief interview regarding their role as a coach, teacher or youth worker. The interview will ask the coach, teacher or youth worker about their
perceptions of their role and how they believe it to be relevant to promoting young peoples’ mental health. Individuals who agree to participate in the research will be asked to participate in an individual interview with the researcher at a time and place that is convenient and agreed to by the participant. The interview will take about 20 – 30 minutes and be audio-taped and transcribed with participants’ permission. A transcript of the interview may be requested for checking.

Participation in the research is completely voluntary. Individuals may, without any penalty, decline to take part or withdraw at any time without providing an explanation, or refuse to answer a question.

The information obtained from the interviews will be analysed to identify common themes. While direct quotes may be used to illustrate the common themes, care will be taken to ensure that these do not identify any individual.

There is little anticipated risk to participants involved in this study. However, should individuals find any of the questions distressing, please contact Lifeline on 13 11 14. Lifeline is a free and confidential service.

The results of the research will be written up as part of a PhD thesis and may be used in publications and conference presentations. A summary of the results will be available from the researcher on request.

Confidentiality

Participation in this research is confidential. All information collected from participants will be stored securely and only the researcher will have access to the individual information provided by participants. Individual responses will be grouped together with all other responses. No one person’s responses will be identifiable.

Anonymity

Anonymity and confidentiality of responses will be assured by reporting only general themes from the interview and using only non-identifying quotes.

Data Storage

The information collected will be stored securely on a password protected computer throughout the project and then stored at the University of Canberra for the required five year period after which it will be destroyed according to university protocols.

Ethics Committee Clearance

The project has been approved by the Committee for Ethics in Human Research of the University.

Queries and Concerns

Queries or concerns regarding the research can be directed to the researcher, Kelly Mazzer, whose contact details are at the top of this form.
Appendix D: Phase I Participant Consent Form

Participant Consent Form

Project Title

The role of sports coaches, teachers, and youth workers in young peoples’ mental health

Consent Statement

I have read and understood the information about the research. I am not aware of any condition that would prevent my participation, and I agree to participate in this project. I have had the opportunity to ask questions about my participation in the research. All questions I have asked have been answered to my satisfaction.

(Please tick)

☐ I agree to audio recording of the interview.

Name..............................................................................................................................

Signature......................................................................................................................

Date ............................................

A summary of the research report can be forwarded to you when published. If you would like to receive a copy of the report, please include your email address below.

Name..............................................................................................................................

Email..............................................................................................................................
Below is a list of behaviours that may be performed by adults in professional or semi-professional roles in young people’s lives, such as teachers and coaches, that can affect young people’s mental health. For each item please indicate whether you think the behaviour is best categorised as:

- the **promotion** of mental health,
- the **prevention** of mental health problems,
- **early intervention** in mental health,
- or whether a category for this behaviour is **unclear**; or the behaviour is not represented by any of these categories (**none**).

Please select your response by clicking inside **one (or more*)** box for each behaviour.

*Please aim to select only one category that the behaviour most applies to. However, multiple categories may be selected if the behaviour is better represented by more than one category.

<table>
<thead>
<tr>
<th></th>
<th>Promotion</th>
<th>Prevention</th>
<th>Early Intervention</th>
<th>None/Unclear</th>
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</thead>
<tbody>
<tr>
<td>1. Facilitate the development of young people’s general living skills</td>
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<td>2. Make an appointment for a young person to see a professional</td>
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<td>3. Identify warning signs and behaviour change in a young person</td>
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<td>4. Help young people to feel comfortable talking about mental health and illness</td>
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<td>5. Ask a young person checking questions, such as ‘Are you okay?’</td>
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<td>6. Develop young people’s problem solving skills</td>
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<td>7. Provide a positive, safe, friendly environment</td>
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<tr>
<td>8. Talk about early warning signs of mental illness</td>
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<td>9. Help young people with personal relationship issues</td>
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<tr>
<td>10. Attend a Doctor’s appointment with a young person</td>
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<tr>
<td></td>
<td>Promotion</td>
<td>Prevention</td>
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<tr>
<td>11. Identify and intervene in bullying</td>
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<td>12. Encourage young people to build positive attitudes towards people with mental illness</td>
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<td>13. Provide guidance to a young person about where to seek further help</td>
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<td>14. Personally contact the parents of a young person whose mental health you are concerned about</td>
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<td>15. Diagnose a young person with a mental health problem</td>
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<td>16. Have an ‘open door’ approach for young people to speak with you</td>
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<td>17. Ask a young person about suicide risk</td>
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<td>18. Promote healthy lifestyle and exercise</td>
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<td>19. Listen to a young person’s personal concerns</td>
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<tr>
<td>20. Offer advice to a young person about their mental health concerns</td>
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<td>21. Refer a young person to other sources of help (eg GP, psychologist, counselor)</td>
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<td>22. Help young people develop an optimistic approach to life</td>
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<td>23. Make recommendations about medication to a young person</td>
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<td>24. Encourage setting of realistic goals and goal achievement</td>
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<td>25. Facilitate young people’s connections with peers</td>
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<td></td>
<td>Promotion</td>
<td>Prevention</td>
<td>Early Intervention</td>
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<td>26.</td>
<td>Contact the police about a young person’s mental health</td>
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<td>27.</td>
<td>Assist in building young people’s confidence and self-esteem</td>
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<td>28.</td>
<td>Encourage young people to participate in their community</td>
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<td>29.</td>
<td>Contact a mental health crisis team about a young person’s mental health</td>
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<td>30.</td>
<td>Notify and consult colleagues about concerns you have for a young person’s mental health</td>
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<td>31.</td>
<td>Provide opportunities for young people to build resilience</td>
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<td>32.</td>
<td>Encourage inclusivity and participation of all young people in activities</td>
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<td>33.</td>
<td>Assist young people in learning how to manage stress</td>
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<td>34.</td>
<td>Tell a young person to ‘wake up to themselves’</td>
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<td>35.</td>
<td>Encourage a young person to talk to their parents about their personal problems</td>
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<td>36.</td>
<td>Use behaviour management strategies to assist young people to reduce or prevent behaviour problems</td>
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<td>37.</td>
<td>Educate young people on mental health and illness</td>
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<td>38.</td>
<td>Actively advocate for young people’s voice in policies</td>
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<td>39.</td>
<td>Help young people to develop time management and organization skills</td>
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<td>40.</td>
<td>Be aware of any young person who is vulnerable or having concerns and monitor them</td>
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Appendix F: Phase II Expert Recruitment Email

Hi Everyone,

I am writing to ask if you would help out one of my PhD students by doing a quick exercise for her. She needs to get a short list of behaviors and activities that are clearly promotion, prevention or early intervention for mental health - as per the Institute of Medicine Mrazek and Haggerty type spectrum of interventions.

So, I am asking some of my learned colleagues to have a look at a longer list of items and indicate what categories of mental health promotion, prevention of mental illness, or early intervention for mental illness they think they fall into. This just needs to be your first impressions (no need to revise the spectrum or anything like that!). It should only take a few minutes.

So, to help out, all you need to do is open the attached document and categorise the items. Kelly has formatted the attachment so that you just need to click on the boxes you want to choose. You will then need to save the attachment and return it via email to Kelly.Mazzer@canberra.edu.au.

If you prefer you can email it to me or return by snail mail if that suits you better (to my UC address below).

Her project has HREC approval.

Thank heaps. I appreciate your help.

Debra Rickwood PhD FAPS

Professor of Psychology
Faculty of Health, University of Canberra ACT 2601
E: <Debra.Rickwood@canberra.edu.au>
P: 61 2 6201 2701

Head, Clinical Leadership and Research headspace National Youth Mental Health Foundation
47-51 Chetwynd St, North Melbourne VIC
E: <DRickwood@headspace.org.au>
P: 61 3 9027 0139
Hi (insert name)

I am a PhD candidate at the University of Canberra conducting a research project on the role of coaches in young people’s mental health. I am contacting you as I am currently seeking sports coaches of 12-18 year olds to take part in the research by completing a short online survey. I would be grateful for your clubs participation. Everyone who completes this survey will go into the draw to win an Apple iPad. Please see below for further details of the research.

I would appreciate you forwarding the below information (shaded area) onto the coaches of your club (junior teams), with a cc to me to assist my records. Coaches are then able to complete the survey via the link provided.

Please don’t hesitate to reply to Kelly.Mazzer@canberra.edu.au if you have any further questions.

*Note: If your club is not willing to be involved in this research please reply to notify me, to ensure you do not receive any further emails regarding the project.

Thank you for your support.

---

Dear Coach,

You are invited to take part in a short online survey about the role of coaches in young people’s mental health. **Everyone who completes this survey will go into the draw to win an Apple iPad.**

**Survey Background**
I am a PhD candidate in Clinical Psychology at the University of Canberra. I am conducting a survey investigating coaches’ views of their role and involvement in supporting young people’s mental health.

The survey can be completed online via computer or smart phone. It should take around 10-20 minutes to complete. The survey is anonymous, you will not be identified by your responses.

**Why do this survey?**
As a coach of 12-18 year olds, your input would be a valuable contribution to this research. The information gained from the research will be used to inform participants and the wider community regarding the ability of adults to assist young people with mental health care.

**Getting Started**
For more information or to complete the survey [please click ONE of the links below](http://canberrahealth.qualtrics.com/SE/?SID=SV_eRoU1hfdDqLLrcE).
Coach survey (smart phone version):
http://canberrahealth.qualtrics.com/SE/?SID=SV_0PanaQ8w838VcPi

I would be grateful if you could complete the survey within 3 weeks from you receiving this email.

Thank you for your contribution.

Kind regards

Kelly Mazzer

PhD (Clinical Psychology) Candidate
University of Canberra

Email: Kelly.Mazzer@canberra.edu.au
Dear Principal (insert name)

I am a PhD candidate at the University of Canberra conducting a research project on the role of teachers in young people’s mental health. I am contacting you to request permission for this research to be carried out in within your school. Involvement in the project will be quick and simple, for both principals (forward this email to teachers) and teachers (10 – 20 minutes to complete a short online survey).

I am currently seeking teachers of grades 7 - 12 from selected schools across the ACT to participate in the research by completing a short online survey (paper version also available – please contact me if your school would prefer this method). The questionnaire asks about teachers’ views of their role in supporting young people’s mental health. It should take around 10-20 minutes to complete. Please note this research will not involve the students of your school. Everyone who completes this survey will go into the draw to win an Apple iPad.

The research has been approved by the Committee for Human Research Ethics at the University of Canberra, the Education and Training Directorate, and the Catholic Education Office (see attached research approval letter). For more information about the research please see the attached Participant Information Form.

**Principals are asked to please forward the below information (shaded area) onto teachers of grades 7 – 12 at your school, with a cc to me to assist my records. Teachers are then able to complete the survey via the link provided.**

I would appreciate your schools involvement. Please respond to Kelly.Mazzer@canberra.edu.au to notify me whether this research can proceed in your school.

Thank you for your consideration.

---

Dear Teacher,

You have been selected to take part in a short online survey about the role of teachers in young people’s mental health. **Everyone who completes this survey will go into the draw to win an Apple iPad.**

**Survey Background**

I am a PhD candidate in Clinical Psychology at the University of Canberra. I am conducting a survey investigating teachers’ views of their role and involvement in supporting young people’s mental health.

The survey can be completed online via computer or smart phone. It should take around 10-20 minutes to complete. The survey is anonymous, you will not be identified by your responses.
Why do this survey?
As a teacher, your input would be a valuable contribution to this research. The information gained from the research will be used to inform participants and the wider community regarding the ability of adults to assist young people with mental health care.

Getting Started
For more information or to complete the survey please click ONE of the links below.

Teacher survey (computer version):
http://canberrahealth.qualtrics.com/SE/?SID=SV_1ZbVBMgLo9Aobq

Teacher survey (smart phone version):
http://canberrahealth.qualtrics.com/SE/?SID=SV_eWeqVWU61uMHLCs

I would be grateful if you could complete the survey within 3 weeks from you receiving this email.

Thank you for your contribution.

Kind regards

Kelly Mazzer

PhD (Clinical Psychology) Candidate
University of Canberra

Email: Kelly.Mazzer@canberra.edu.au
**Project Title**

*The roles of teachers and coaches in young people's mental health*

---

**Researcher**

Kelly Mazzer  
PhD (Clinical Psychology) Candidate  
Psychology, Faculty of Health  
University of Canberra ACT 2601  
Ph: 6201 2653  
Email: Kelly.Mazzer@canberra.edu.au

**Supervisor**

Professor Debra Rickwood  
Psychology, Faculty of Health  
University of Canberra ACT 2601  
Ph: 6201 2701  
Email: Debra.Rickwood@canberra.edu.au

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**Project Aim**

This aim of this research is to examine teachers' and coaches' perceptions of their roles in young people's mental health. This research aims to investigate teachers' and coaches' involvement in, and acceptance of, supporting young people's mental health through promotion, prevention, and/or early intervention within their professional or semi-professional roles.

---

**Benefits of the Project**

Participants may benefit from this research through increased awareness of mental health and mental health problems in young people, and the current or potential impact they, as gatekeepers, have in this area. The information gained from the research will also be used to inform the wider community regarding the ability of adults to assist young people with mental health care.

---

**General Outline of the Project and Participant Involvement**

Teachers and sports coaches (aged 18 or over) within the ACT, who are in regular contact with young people aged 12-18 will be sought to participate in the research. Individuals who agree to participate will be asked to complete a written questionnaire at a time and place coordinated through their school or sporting organisation that is convenient and agreed to by the participant. The questionnaire will ask the coach or teacher about their view of their role in supporting young people’s mental health. The questionnaire is expected to take about 10 – 20 minutes to complete. **All participants will go into the draw to win an Apple iPad.**

Participation in the research is completely voluntary. Individuals may, without any penalty, decline to take part or withdraw at any time without providing an explanation, or refuse to answer a question. This study poses low risk to participants. However, should individuals find any of the questions distressing, please contact Lifeline on 13 11 14.

Lifeline is a free and confidential service. The results of the research will be written up as part of a PhD thesis and may be used in publications and conference presentations. A summary of the results will be available from the researcher on request.

---

**Confidentiality**

Participation in this research is confidential. All information collected from participants will be stored securely and only the researcher will have access to the individual information provided by participants. Individual responses will be grouped together with all other responses. No one person’s responses will be identifiable.

---

**Ethics Committee Clearance**

The project has been approved by the Committee for Human Research Ethics at the University of Canberra, the Education and Training Directorate, and the Catholic Education Office.

---

**Queries and Concerns**

Queries or concerns regarding the research can be directed to the researcher, Kelly Mazzer, whose contact details are at the top of this form.
The role of teachers in young people’s mental health

**Complete this questionnaire to enter the draw to win an Apple iPad**

This questionnaire asks for your views about supporting young people’s mental health through your role as a teacher. It should take about 10 – 20 minutes to complete.

To complete this questionnaire, read each question then select the response you think is most representative of your opinion. Please read all instructions carefully, and answer the questions as accurately as you can.

Please consider your role as a teacher when responding to each question.

The questionnaire is anonymous, you will not be identified by your responses.

Please download and read the Participant Information Form before continuing.

Thank you for your time.

- I have read the Participant Information Form and wish to participate in this research.
- I do not wish to participate in this research.
Faculty of Health

Gender
- Male
- Female

Age
- [ ] (years)

How long have you been a teacher?
- [ ] (years)

What year grades do you teach?
- 

What subjects do you teach?
- 

Please list any additional roles you occupy within the school (eg Pastoral Care Advisor, Year Coordinator).
- 

The school I currently teach at is
- [ ] Private
- [ ] Public
- [ ] Other
- [ ] Single Sex
- [ ] Coeducational
Listed below are 15 behaviours that may be performed by adults in professional or semi-professional roles in young people’s lives which may affect young people’s mental health.

Please indicate the extent to which you engage in each behaviour in your role as a teacher.

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Please again consider your role as a teacher. This time, for each of the 15 behaviours please indicate the extent to which you agree or disagree with the following 4 statements.

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Thank you

We thank you for your time spent taking this survey.
Your response has been recorded.

If you would like to enter the draw to win an Apple iPad please follow this link http://canberrahealth.qualtrics.com/SE/?SID=SV_0Pcbhrxm0RuAgjU

If you have any further queries or concerns about this research please see the Contacts and Complaints Procedure.
Appendix K: Phase III Survey (Coach Version)

The role of coaches in young people’s mental health

**Complete this questionnaire to enter the draw to win an Apple iPad**

This questionnaire asks for your views about supporting young people’s mental health through your role as a coach. It should take about 10 – 20 minutes to complete.

To complete this questionnaire, read each question then select the response you think is most representative of your opinion. Please read all instructions carefully, and answer the questions as accurately as you can.

Please consider your role as a coach when responding to each question.

The questionnaire is anonymous, you will not be identified by your responses.

Please download and read the Participant Information Form before continuing.

*You must be aged 16 or above to participate. Please do not complete this survey if you are under 16 years of age.

Thank you for your time.

☐ I have read the Participant Information Form and wish to participate in this research.

☐ I do not wish to participate in this research.
Faculty of Health

Gender
☑ Male ☐ Female

Age
☐ (years)

How long have you been a coach?
☐ (years)

Which sport(s) do you coach?

Please list any coaching qualifications you hold (e.g., completed coaching courses):

What level of competition do you coach?
(please select all that apply)
☐ Social ☐ Competitive ☐ Elite

Most of the young people I coach are
☑ Female ☐ Male ☐ Both
Listed below are 15 behaviours that may be performed by adults in professional or semi-professional roles in young people’s lives which may affect young people’s mental health.

**Please indicate the extent to which you engage in each behaviour in your role as a coach.**

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Please again consider your role as a coach. This time, for each of the 15 behaviours please indicate the extent to which you agree or disagree with the following statements.

a) This behaviour is an expected part of my job
b) I see a direct connection between whether I engage in this behaviour and my outcomes at work
c) I am completely confident in my capabilities when engaging in this behaviour
d) I have complete freedom to choose whether or not I engage in this behaviour

1. Encourage inclusivity and participation of all young people in activities

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2. Actively advocate for young people's voice in policies

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3. Refer a young person to other sources of help (e.g., GP, psychologist, counsellor)

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4. Talk about early warning signs of mental illness

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5. Promote healthy lifestyle and exercise

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6. Notify and consult colleagues about concerns you have for a young person’s mental health

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<th>Strongly Disagree</th>
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7. Encourage young people to build positive attitudes towards people with mental illness

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<th>Strongly Disagree</th>
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8. Offer advice to a young person about their mental health concerns

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13. Encourage young people to participate in their community

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14. Use behaviour management strategies to assist young people to reduce or prevent behaviour problems

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15. Ask a young person about suicide risk

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Thank you

We thank you for your time spent taking this survey. Your response has been recorded.

If you would like to enter the draw to win an Apple iPad, please follow this link http://canberrahealth.qualtrics.com/SE/?SID=SV_0Pcbrxm0RvAg1U

If you have any further queries or concerns about this research please see the Contacts and Complaints Procedure
Appendix L: Participant Prize Draw Entry

Win an Apple iPad

For your chance to win an Apple iPad please enter your contact details below.

All participants who completed the survey are eligible to enter the draw to win an Apple iPad. To be in the running all you need to do is enter your preferred contact details. One lucky winner will be drawn and contacted (via phone or email) by the researcher at the completion of this study.

* Your details will be stored separately from your survey and cannot be used to identify your responses.

The prize winner will be drawn and contacted at the completion of this study.

First Name:

Email Address:

Phone Number:

We thank you for your time spent taking this survey.
Your response has been recorded.
Appendix M: UC HREC Approval Letter

09/05/12

Ms. Kelly Mazzer
Faculty of Health
University of Canberra
BRUCE ACT 2617

Dear Kelly,

The Committee for Ethics in Human Research has considered your application to conduct research with human subjects for the project entitled *School teachers and sports coaches acceptance of their role in supporting young people’s mental health.*

Approval is granted until 01/03/13 the anticipated completion date stated in the application.

The following general conditions apply to your approval.

These requirements are determined by University policy and the *National Statement on Ethical Conduct in Research Involving Humans* (National Health and Medical Research Council, 2007).

<table>
<thead>
<tr>
<th>Monitoring:</th>
<th>You, in conjunction with your supervisor, must assist the Committee to monitor the conduct of approved research by completing and promptly returning project review forms, which will be sent to you at the end of your project and, in the case of extended research, at least annually during the approval period.</th>
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<tbody>
<tr>
<td>Discontinuation of research:</td>
<td>You, in conjunction with your supervisor, must inform the Committee, giving reasons, if the research is not conducted or is discontinued before the expected date of completion.</td>
</tr>
<tr>
<td>Extension of approval:</td>
<td>If your project will not be complete by the expiry date stated above, you must apply in writing for extension of approval. Application should be made before current approval expires; should specify a new completion date; should include reasons for your request.</td>
</tr>
<tr>
<td>Retention and storage of data:</td>
<td>University policy states that all research data must be stored securely, on University premises, for a minimum of five years. You and your supervisor must ensure that all records are transferred to the University when the project is complete.</td>
</tr>
<tr>
<td>Contact details and notification of changes:</td>
<td>All email contact should use the UC email address. You should advise the Committee of any change of address during or soon after the approval period including, if appropriate, email address(es).</td>
</tr>
</tbody>
</table>

Please add the Contact Complaints form (attached) for distribution with your project.

Yours sincerely
Human Research Ethics Committee

Charanel Slater
Ethics & Compliance Officer
Research Services Office
T (02) 6201 5870 F (02) 6201 5466
E Charanel.Slater@canberra.edu.au

HUMAN RESEARCH ETHICS COMMITTEE
APPROVED - Project number 12-05

www.canberra.edu.au

Postal Address:
University of Canberra ACT 2601 Australia
Location:
University Drive Bruce ACT

Australian Government Higher Education Registered Provider Number [CRICOS]: 00212K
Ms Kelly Mazzer  
31 William Hudson Crescent  
MONASH ACT 2904

Dear Ms Mazzer

Approval of research proposal

Thank you for your application to conduct the proposed research titled *School teachers' and sports coaches' acceptance of their role in supporting young people's mental health*. I am pleased to inform you that the Education and Training Directorate has approved your research.

Please note the following conditions regarding your proposed research project:
- research in the school(s) must be concluded by 1 March 2013
- provide a current certificate of public liability insurance on or before 1 November 2012 to continue research in schools beyond 31 October 2012
- any changes in the methodology, scope and timeframe of the project requires the approval from the Directorate
- provide names of schools that participated in the research project at the completion of research/data collection in schools
- within one month of completing your research, you are required to forward electronic and hard copies of your research (paper/report/thesis) electronically to det.research@act.gov.au and by mail to the following address:

Manager  
Reporting and Research  
Planning and Performance Branch  
Education and Training Directorate  
ACT Government  
GPO Box 158  
CANBERRA ACT 2601

- research reports received as per the preceding condition are placed in an online library accessible internally to all Directorate staff in order to inform policy and program development and evaluation through research in public schools.

The Directorate approves research in all public colleges, high and P-10 schools. You may now directly approach the principals of these schools and colleges, with a copy of this
approval letter, for permission to carry out your research. It will be at the discretion of the principal as to whether your research can proceed at their site.

You will need to contact non-government schools or their association directly for permission to conduct research in those schools.

If the principal assesses that the nature of the activity and/or the type of contact may place students at risk, the researcher will be required to undergo screening. The researcher or sponsoring organisation will have responsibility for arranging the screening and any associated costs.

A person entering a school to conduct research is a visitor to the school and must comply with the Visitors in Schools policy available at:

Any information that you obtain as part of research or data collection must be treated in accordance with the requirements of the Privacy Act 1988.

If you require any assistance please contact Ji-Hae Yun on (02) 6205 0970 or at Ji-Hae.Yun@act.gov.au

Best wishes for your research.

Yours sincerely

Tracy Stewart
Director
Planning and Performance

♀ June 2012
22 May 2012

Ms Kelly Mazzer
31 William Hudson Cres
MONASH ACT 2904

Dear Ms Mazzer,

I am writing in response to your request to undertake research titled "School teachers' and sports coaches' acceptance of their role in supporting young people's mental health" at St Clare's College, Griffith; and St Mary MacKillop College, Isabella Plains and Wanniassa in the Archdiocese of Canberra and Goulburn.

Your request has been approved subject to the following:

1. The Principal gives final permission for research to be carried out in his/her school. This letter of approval should accompany any approach to schools or teachers.
2. Researchers will not have any contact with school students. The research undertaken only requires the participation of teachers and those in sports coaches roles to complete an online or paper based survey. All of the research tasks will occur remotely with no direct contact with schools.
3. Mrs Dorrian is to be contacted immediately should your research differ in any way from that proposed.
4. Confidentiality of findings and anonymity of students is adhered to. The research must comply with the requirements of the Commonwealth Privacy Amendment (Private Sector) Act 2000.
5. That upon completion of your research a copy of your report is forwarded to me.

Please note that I am unable to approve your application to conduct research at St Edmund's College, Griffith; and Daramalan College, Dickson as these are Congregational schools. Please contact these schools directly regarding your research project.
Mrs Dorrian's contact details are:

Telephone: (02) 6234 5412
Fax: (02) 6234 5496
Email: mary.dorrian@cg.catholic.edu.au

Yours sincerely

[Signature]

Moira Najdecki
Director

“We plough the fields and scatter the good seed”
Appendix P: Paired Samples t-test of Teachers’ Role Breadth and Efficacy for PPEI

<table>
<thead>
<tr>
<th>Behaviour Category</th>
<th>Role breadth M (SD)</th>
<th>Role efficacy M (SD)</th>
<th>MD (SE)</th>
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<tr>
<td>Promotion</td>
<td>3.97 (.65)</td>
<td>3.89 (.64)</td>
<td>.09</td>
<td>[-.02, .19]</td>
<td>1.68</td>
<td>116</td>
<td>.12</td>
</tr>
<tr>
<td>Prevention</td>
<td>4.14 (.58)</td>
<td>3.87 (.62)</td>
<td>.27</td>
<td>[.16, .38]</td>
<td>4.98*</td>
<td>116</td>
<td>.90</td>
</tr>
<tr>
<td>Early Intervention</td>
<td>3.80 (.73)</td>
<td>3.48 (.83)</td>
<td>.31</td>
<td>[.20, .41]</td>
<td>5.81*</td>
<td>116</td>
<td>.41</td>
</tr>
</tbody>
</table>

Note. MD = mean difference; CI = confidence interval.
* p < .001