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EDUCATION

MENTAL WELLBEING PROVISION IN WESTERN AUSTRALIAN SPORT

DR JUSTEN O'CONNOR
ASSOCIATE PROFESSOR RUTH JEANES
DR CHRISTINE GROVE
DR KAREN LAMBERT
NADIA BEVAN
HAYLEY TRUSKEWYCZ

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TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF TABLES

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EXECUTIVE SUMMARY

INTRODUCTION

Sport offers an opportunity through which individuals can engage within society as participants undertaking a meaningful pursuit, increasing self-mastery, enhancing social support and decreasing social isolation (Giles-Corti, et al., 2004). Consequently, sport can play an important role in sustaining wellbeing and in particular mental health (Asztalos et al., 2009; Hajkowicz, et al., 2013). Sport, as a connected social network, can also play a role in reducing stigma associated with mental illness and build stronger connections to health resources. Yet, according to Liddle et al., (2017), sporting organisations are not doing all that they can to promote and resource positive mental health. There is an apparent lack of coordinated support for clubs, and this is needed to develop the confidence and capacity to support the mental wellbeing of their members (Mazzer & Rickwood, 2015). Sporting contexts have a role to play in proactively promoting mental health and wellbeing as part of primary prevention, but greater support and a more strategic approach is needed.

In July 2020, Healthway in partnership with SportWest, commissioned researchers at Monash University to build on key findings from their Mental Wellbeing in Victorian Sport project with the intent to help inform the development of a framework to guide and strengthen mental health prevention initiatives across community sport in Western Australia. With input from sporting organisations across the State at both an association and grassroots level the aim of this research is to generate a more comprehensive understanding of the work being undertaken to support positive mental health in community sports contexts across Western Australia. Through a comprehensive mapping of existing support resources and end-user needs, the research will inform future strategies aimed at promoting mental health across the community sport sector and support sporting associations and community sport clubs to access the types of initiatives and programs most relevant to their needs.

METHODOLOGY

The scope of this project was centred around the provision of Mental Health and Wellbeing (MHW) programs within the state of Western Australia targeting community sporting clubs. It involved the following research methods:

- A rapid review of literature related to the provision of MHW initiatives for remote and Aboriginal communities was used to add to the 'best practice' criteria for mental health provision in community sport clubs
- A market analysis to ascertain MHW initiatives and programs active in Western Australia.
- 12 semi-structured interviews with providers from which detailed notes and transcripts were used to understand the sector.
- Digital surveys were sent via Healthway and SportWest contacts to representatives from state sporting associations and community sporting club participants within Western Australia. The survey captured data on user needs, reach and quality of providers.
- Data from interviews was used to conduct an analysis of selected MHW initiatives against the criteria.

FINDINGS

PHASE 1) ADDITION OF CRITERIA FOR REMOTE AND ABORIGINAL COMMUNITIES

A rapid review of literature was conducted to ascertain criteria that providers of mental wellbeing programs should be meeting when delivering to remote, rural and Aboriginal communities. This criteria can be added to criteria for quality provision of mental health programs in sport already developed from a rapid review of literature (O'Connor, et al., 2020). When compared to city locations, rural and remote communities are at greater risk of severe negative impacts from

mental health disorders, this includes Aboriginal and/or Torres Strait Islander communities. There are several challenges in rural and remote mental health programs/services for Aboriginal people, including the accessibility and the quality of mental health programs and their appropriateness for the cultural and social context.

A number of health care professionals and organisations have requested specific and tailored mental health frameworks, interventions and programs for Aboriginal people and remote communities (Rural Doctors Association of Australia, 2016; Bishop, Ransom, Laverty, & Gale, 2017; Hazell, Dalton, Caton, Perkins, 2017; Rural Doctors Association of Australia, 2018; National Rural Health Alliance, 2016; Pierce, & Brewer, 2012; Centre for Rural and Remote Mental Health, 2017; Vines 2011). To address the needs and challenges for and with Aboriginal and remote communities, mental health and wellbeing programs and their frameworks need to consider the following:

- Given the biggest challenges in rural and remote areas is lack of available workers and the distances to travel to provide programs and interventions, the literature suggests the following as useful:
    - technology to build or grow programs into online formats to enable a reach that is wide and far;
    - programs to be embedded with local GPs and community centres in conjunction with integrated service models in rural and remote communities;
    - reviews into current programs available to rural and remote areas to see if they do meet the mental health and wellbeing criteria of best practices.
- The inclusion of Aboriginal health representatives to tailor frameworks and intervention implementation to ensure accessibility, appropriateness and suitability for use in remote communities;
- Drawing upon both female and male (diverse) Aboriginal health representatives to adapt the criteria and content to appropriately support Aboriginal people and remote communities' mental health and wellbeing;
- Partnering with Aboriginal health representatives to attain advice on adapting current or creating new mental health frameworks and programs that acknowledge, understand and respect the:
    - interconnectedness of kinship, culture, law, land and spirituality;
    - effects of invasion, colonisation and ongoing cultural stress, and;
    - stigma toward Aboriginal and Torres Strait Islander people with mental illness, which can be inadvertently enforced by health care providers who don't speak the Aboriginal language and use short-hand forms of verbal and non-verbal communication.

These findings generated the following criteria that were modified/added to those developed by (O'Connor et al., 2020).

For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and this is integrated into delivery approaches and content.

NOTE: This current project has not sought confirmation or feedback on these guidelines from Aboriginal health representatives, which ideally would be the next step to ensure these guidelines are appropriate for Aboriginal communities.

Phase 2) Market Analysis - Scoping of Initiatives Impacting the State of Western Australia

Key providers offering mental health service to community sports clubs in Western Australia

The search of providers identified 13 key providers offering support services to community sporting clubs operating within the state of Western Australia, which are detailed in the full report. These providers were all active in working in the community sport sector and offered a range of resources and support to community clubs. We additionally identified organisations offering advice and guidance on mental health issues to the community sport sectors. These agencies

were not included in the more detailed analysis of providers documented above. An additional 32 providers were identified as supporting MHW and could be linked to sporting contexts. We identified 45 providers operating in the mental health promotion space that could be in some way connected to sport.

PHASE 3) SPORT ORGANISATION SURVEY

A survey was sent to all state sporting association representatives and distributed widely via SportWest and SSA mailing lists to reach sporting club members from a range of sports (n = 76) within Western Australia. Representatives from community sporting clubs (*n* = 111) and employees of State Sporting Associations (SSAs) (*n* = 42) responded to the survey.

When asked the question '*How much of a priority is supporting mental health and wellbeing within your sporting association?*' 20% of SSAs suggested it was not a priority at all or a low priority. The majority felt it was a moderate priority (46%) whilst 34% felt it was a high priority. This indicates that the majority of SSAs felt mental wellbeing promotion was of importance to their organisation. Sporting club participants were asked to consider priorities for a range of things that happen in a sporting club. Highest priority tasks were unsurprisingly implementing COVID-19 protocols (m=3.60, SD = 1.4), followed by improving facilities and equipment (m = 3.35, SD = 1.2). Supporting the mental health and wellbeing of members was the second lowest priority on the list when comparing mean rankings (m = 2.94, SD = 1.25) just in front of 'providing resources to achieve on field success (m = 2.86, SD = 1.10). Whilst supporting mental health and wellbeing was still a high rating priority, when compared to other tasks, it sits slightly lower in the pecking order. This is an important understanding given these are predominantly time-poor volunteer participants.

Ninety-one club participants felt moderately confident in their capacity to support mental health and wellbeing in their club. 38% of respondents felt not at all confident or only slightly confident in supporting mental health and wellbeing, suggesting there is room for support, particularly given the significant leadership roles many of these respondents held. 23% felt very confident meaning some clubs may be better positioned to extend their capacity for provision. That 77% of the group were not at all to moderately confident in supporting mental health, suggests a role for external providers to support clubs.

Participants were asked to identify from a large list of providers, the ones they were familiar with. The most popular response was 'none of these', particularly from community sporting club members. This suggests many of the programs are not known to many club representatives (leadership represents 61% of the sample). As noted in the interviews with providers, MHW provision was left largely to the clubs to negotiate with minimal coordinated support coming from the lead organisation. Most of the programs had reach in the metropolitan areas with less visibility in rural and remote communities. Representatives from primarily team sports were most likely to recognise one or more of the programs on offer. Fewer programs had been utilised by SSAs and community sporting clubs in this sample. Most participants felt they did not know enough about the programs to be able to rate them. This suggests that there is a disconnect between providers and clubs. Clubs indicated they needed support to unpack the services on offer in this space. Some mentioned looking centrally for advice and guidance from SSAs or above.

Combined, both SSA representatives and community sport club representatives felt a one-off guest speaker (an ex-athlete) who had worked through a mental health challenge/issue was the most preferred format for supporting the provision of mental health and wellbeing in sporting clubs. Community sport club representatives had a clearer preference for this format. They least preferred a series of scheduled events with a qualified facilitator, reflecting the findings of the providers who found the market was mostly only receptive to one off engagements. Of note, club representatives were slightly more receptive to a comprehensive whole of club strategy in comparison to other formats and both SSAs and club representatives were receptive to get help with suggested policies and strategies that they could use in relation to changing club culture.

PHASE 4) SUMMARY OF INTERVIEWS WITH PROVIDERS

Interviews with key providers

Key representatives of 12 MHW programs that deliver into community sporting clubs were interviewed. A summary of the findings highlights the following:

- A number of new (e.g. 6 -18-month-old) organisations have entered the market in WA offering mental health support to the community sport sector. The majority of the providers had developed face to face and online educative workshops/sessions and materials, some of these organisations were however focused solely on awareness raising and resource provision without workshops.
- Providers pointed to the need for regulation and guidelines in this space suggesting that the quality of providers varied significantly, but clubs were often unaware of how to determine which providers they should be working with and the quality/suitability of the product they were offering.
- The majority of providers felt there was a need for regulation and guidelines in this space. It was noted how easy it is to establish a product in this sector without any real scrutiny or quality, suitability or value.
- All providers acknowledged the challenges of working within the voluntary sport sector and recognised that they could often only start a dialogue, raise awareness and provide some basic information to clubs in the time that they had to work with volunteers, coaches and members. Many indicated that they would like to deliver more comprehensive education programs and felt this was essential to drive significant changes in culture. The ability to do this currently was limited.
- Many providers acknowledge that work needs to be undertaken to address the exclusionary nature of sport, as a key aspect of promoting positive mental health within community sports club settings. However, most providers feel unable to undertake education and work that begins to address broader aspects of exclusion in club settings. Instead the focus is on basic mental health first aid and awareness raising of mental health issues across a number of their programs.
- Whilst acknowledging the limitations of what they could do with community sport participants, most providers were in agreement that offering one or two education sessions to community clubs and then exiting was ineffective. Providers needed to offer ongoing support, refresher sessions and continuing training for positive mental health practices to become embedded within the club.
- Most providers understand the importance of providing ongoing support, however they had limited capacity to do more than one session per year. A significant focus was on awareness raising and creating conversations in the community space, with the aim of empowering club members and leaders to converse on topics of mental health. Linking to local mental health referral services was a key component of most programs as this enabled community members to be aware of the local mental health support services.
- A significant challenge for the organisations who worked in remote and regional WA was the vast geographical spread of WA, especially in relation to resource allocation. With limited resources, providers who worked in regional and remote WA found it difficult to provide ongoing support and were mindful not to create more mental health issues within the population groups they worked with, especially when they were going to leave the community after a short period of time (e.g. 1-3 days).
- Organisations who worked in regional and remote WA detailed the importance of and need for working in these communities. However, they also identified multiple limiting factors associated with this, including the challenges related to reporting KPI focused outcomes and the complexities of new providers working in small communities.
- Only a few providers articulated how they made cultural adjustments to their programs with three discussing the adaptation of resources and education for Aboriginal participants. One provider specifically tailored and designed their offerings in consultation with the local Aboriginal community. Several providers mentioned that they tailored their content based on the club or community they worked with; however, they did not detail the specifics of how this is done or in consultation with whom.

- Beyond three of the programs, evaluation of initiatives is limited, making it difficult to make informed judgements regarding the impact of programs on the community sport sector. Effective evaluation is considered a key criteria of quality programs. Providers suggested evaluation in this space can be difficult.
- The majority of providers work with AFL clubs and nearly all tend to engage with team sports. There were limited providers working with individual sports despite acknowledging that there can often be significant mental health issues associated with some individual sports. Most providers stated that they would assist any sporting club who asked for assistance but there was a dominant focus on team sports.
- Most acknowledged the gendered dimensions of mental health, which is important to consider in the design and delivery of programs.
- Programs have different capacities and reach. Some chose to focus on a narrow area of work in this space but still provide valuable services.
- There is limited collaboration between different organisations or sharing of resources/expertise. There is a feeling of competitiveness within the marketplace with different organisation seeking to stake their claim for market share. However, many providers expressed that they wanted greater collaboration between providers and particularly to work more with higher level structures in sport such as leagues and associations to develop a more coherent and strategic approach to raising awareness of mental health. A collaborative approach was seen as a valuable way to distribute consistent messaging and awareness of mental health and wellbeing in the community sport sector.
- Structurally there seems a considerable disconnect within this space between the mental health providers, sporting associations, leagues and the clubs. Providers tend to work directly with clubs and rely on word of mouth referrals from other clubs, direct approaches and marketing directly to clubs themselves. Some providers work with schools to gain further promotion of the organisation. Some have sought to work through leagues and associations at a local level where possible but have found that leagues often want payment to promote their services to their club members. Few work through the State Sporting and Recreation Associations, which potentially limits the opportunity for coordination, regulation and more effective promotion to clubs.
- The pairing of the lived experience message from an ex-athlete from within the sporting community, and with the knowledge and evidence of a psychologist was considered an effective approach to reach a wider audience. In this, and several other providers' approaches, they detailed the quality and significance of the messages they are providing, remarking that how the content is delivered is of the utmost importance, especially due to the sensitive nature of mental health and wellbeing.
- Most providers discussed the importance of coaches being trained in first aid mental health at a minimum level standard so that they can assist in mental health awareness and supporting their clubs' members. One provider targets coaches through a mental health topic in the AFL - Level One coaching accreditation process. Other sports do not appear to have an accreditation process and providers thought this a key area of concern and requires addressing.
- Providers were seeking support from organisations like Healthway, SportWest and in some cases SSAs in the form of advocacy, advice and guidance for the sport sector, endorsement, lobbying for funding, supporting greater collaboration across the sector, assisting organisations in understanding cultural considerations of mental health and wellbeing in Aboriginal populations, development of shared resources/tools, advocate coaches to be trained in mental health first aid and establish a steering group.

Phase 5) Analysis of Initiatives against Criteria

As part of the review process, interview data, the range of resources shared with the research team and publicly available resources were used to score a select number of providers on the criteria developed from the rapid review. There was significant variation across programs on the criteria, this often reflected the fact that many of the programs had been purposely tailored to fit a niche or nuanced foci. Key points of difference between providers involved links to a clear strategic framework and theories of MHW promotion, delivery modes to suit a range of participant needs, quality evaluation and sustained impact.

CONCLUSIONS

Findings support the notion that sport, through the provision of a trusting social community network, lends itself to supporting a focus on mental wellbeing. The social relationships and social integration that occurs in and through sport was documented by club representatives, and this can offer important protective factors for mental health. Currently, work in the community sporting space is geared to provide promotion through awareness raising and reducing stigma attached to help seeking. This remains in and of itself incredibly important work and fits within State Governments promotion plans. However, if the full potential of sport in this space is to be realised, then how it can progress to sit alongside the best of other Domain 2 sites (workplaces, schools) that offer promotion and prevention strategies, needs greater attention. There is potential to tackle head on potential risk factors tied to health equity and problematic sport culture, whilst leveraging the protective social physical health, social connectedness and identity building that sport does well. This evaluation highlighted limitations in the capacity for providers to move beyond awareness raising, given the already high demands placed on volunteer community clubs.

The potential of the community sport sector to contribute even more than it currently does to mental health and wellbeing is reflected in the significant growth of programs aiming to work in this space, albeit in a largely unregulated environment. We identified 45 different programs with some links to mental health and sport. Survey data highlighted the lack of awareness amongst sporting clubs and organisations about who these providers were and what they offered. Limited information about quality and value are available for decision making. Providers were generally supportive of the idea for more oversight and quality regulation in the sector. There is an agreement that a more regulated process would be welcomed to ensure the precious and limited time/people/financial resources clubs invest in facilitating such programs gain maximum benefit. This suggests a greater role for more central organising bodies to coordinate and support a more strategic and integrated approach to MHW provision in the community sport sector. This particularly speaks to the need for resourcing only evidence-based and evidence-informed programs through quality evaluation. With a greater demonstration of impact, clubs and SSAs may be more willing to invest precious time and resources in extending beyond awareness raising.

Programs that score highly against the ‘best practice’ criteria could clearly articulate a strategic alignment to a mental wellbeing framework underpinned by clear models or theory for MHW promotion; offered a variety of high-impact delivery methods and modalities to suit a range of participant needs; had a detailed understanding of the sport settings in which they were operating; utilised valid and reliable measures to ascertain their impact against clearly stated program goals and; had a documented strategy for achieving ongoing impacts for individual club members while supporting the development of capacity and capability within clubs to impact its culture. That is not to say there is no role for more niche programs that offered one or two things extremely well. There is a need for support for organisations to better understand cultural considerations of mental health and wellbeing in Aboriginal and remote communities. Support is also needed for the logistics of regional and remote delivery and the possibilities for working with or alongside existing health service providers in a coordinated way.

Sport offers both protection and risk when it comes to mental health, being able to increase protective factors whilst diminishing risk in and through sport is an attractive proposition that is yet to be fully realised. The sector is growing, government is investing in it, COVID-19 has impacted people’s health and the timing is right to consider more strategically the role of sport in mental health promotion. The establishment of a steering group comprising representation from MHW experts, providers of MHW programs and sporting club participants could work towards achieving a range of recommendations outlined in the report.

INTRODUCTION

Substantive opportunities exist in sport to positively impact a range of protective factors known to support mental health. Sport can play an important role in sustaining wellbeing and in particular mental health (Asztalos et al., 2009; Hajkowicz, et al., 2013). Together with promoting physical health, sport can elicit feelings of social connectedness, strong personal relationships and a sense of belonging to a community which are vital to maintaining mental health. Sport offers an opportunity through which individuals can engage within society as participants in a meaningful pursuit, increasing self-mastery, enhancing social support and decreasing social isolation (Giles-Corti, et al., 2004). Sport, as a connected social network, can also play a role in reducing stigma associated with mental illness and build stronger connections to health resources. Yet, according to Liddle et al., (2017), sporting organisations are not doing all that they can to promote and resource positive mental health. There is an apparent lack of coordinated support for clubs, and this is needed to develop the confidence and capacity to support the mental wellbeing of their members (Mazzer & Rickwood, 2015). Sporting contexts have a role to play in proactively promoting mental health and wellbeing as part of primary prevention, but greater support and a more strategic approach is needed.

Informed by the principles of the World Health Organization's (1986) Ottawa Charter for Health Promotion, Healthway aims to promote and facilitate good health and activities that encourage healthy lifestyles for Western Australians. Improving mental health is one of five strategic goals for the organisation. In July 2020, Healthway in partnership with SportWest, commissioned researchers at Monash University to build on key findings from their Mental Wellbeing in Victorian Sport project, with the intent to help inform the development of a framework to guide and strengthen mental health prevention initiatives across community sport in Western Australia (WA). With input from sporting organisations across the State of WA, at both an association and grassroots level, the aim of this research was to generate a more comprehensive understanding of the work being undertaken to support positive mental health in community sports contexts. Through a comprehensive mapping of existing support resources and end-user needs, the research will inform future strategies aimed at promoting mental health across the community sport sector. It will also serve to support sporting associations and community sport clubs to access the types of initiatives and programs most relevant to their needs.

This report is structured to respond to the following:

1. Conduct a market analysis of mental wellbeing initiatives and resources to ascertain:
    a. An overall summary of initiatives;
    b. delivery mediums;
    c. target audience;
    d. cost to clubs;
    e. time commitment required and;
    f. initiatives or programs endorsed by State Sporting Associations and community sporting club representatives.
2. Adapt and deploy a set of 'best practice' criteria to ascertain impact, feasibility/usability and quality around provision of a selected set of mental wellbeing initiatives and resources within WA.
3. Understand the perspectives of both providers and end-users in supporting mental health and wellbeing in community sport.

Following a review of the literature, this report outlines the two-part method used to analyse the provision of mental wellbeing across the Western Australian sporting sector. It presents the findings from this analysis and synthesises a set of recommendations that peak bodies, like Healthway and SportWest, can draw upon to guide sporting associations and clubs in the provision of mental health promotion.

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LITERATURE REVIEW

Mental health is commonly presented as a broad continuum from positive health functioning at one end through to severe conditions that significantly impact on the activities of living at the other. Mental health consequently is not fixed or static. How a person moves back and forth along the mental health continuum over time can be impacted by their mental health literacy (Jorm, 2012) and a host of socio-ecological factors. The World Health Organisation (WHO, last update 2014) define mental health as:

> *A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*

Globally, mental health problems contribute substantially to the overall disease burden, with major depression linked to disability, suicide and heart disease (Whiteford et al., 2013). According to the WHO (2014) depression and anxiety cost the global economy US$ 1 trillion each year. Mental health impacts substantially on many aspects of life, including school, work, relationships and the everyday capacity to participate in community life (WHO, 2014). The Australian Department of Health (Dec 2015) suggests that each year:

> *16.8% of the population (3.7 million Australians) experience symptoms of a mental illness sufficient to warrant a diagnosis…A further 23.1% (5.2 million) will have symptoms that fall short of a formal diagnosis but have other indicators of need for mental health assistance. About half will have had a previous mental illness and may require help to prevent relapse. The remainder may require early intervention to prevent development of a full-scale illness.*

Twenty per cent of Australian adults will experience a mental illness in any year (AIHW 2018). Within Western Australia, one in five people will experience mental health problems each year and almost half of the population, within their lifetime, will experience a mental health problem (Mental Health Commission, 2011). Western Australia's suicide rate was approximately 20% higher than the national average in 2016 and has been consistently higher than the national average since 2007 (Mental Health Commission, 2018). As noted by the Mental Health Commission (2011), all Western Australians will be affected by poor mental health in some way at a personal level.

According to Whiteford et al., (2010), all age groups are impacted by common mental health problems with depression and anxiety rising abruptly in childhood (ages1–10 years) and peaking in adolescence and early to middle-age (ages 10–29 years). An estimated 1 in 4 of all adolescents experience a mental health disorder in any given year with approximately half these disorders beginning to manifest before the age of 14 years (Kessler et al., 2005; World Health Organization, 2012). Half of all mental illnesses emerge before the age of 14 years (Mental Health Commission, 2018).

Childhood represents an ideal time for intervention because childhood experiences lay the foundation for future mental health (Giles-Corti, et al., 2004). Within Australia, 14% of children and adolescents scored in a clinical range, suggesting concerns with mental health (Australian Institute of Health and Welfare, 2020). There are significant cost and health implications for late detection or non-treatment (Breslin, Haughey, Donnelly, Kearney, & Prentice, 2017). Research suggests an accumulative effect occurs as a result of exposure to stressors across the life course and this contributes to inequitable mental health outcomes (Allen, Balfour, Bell, & Marmot, 2014; Kessler et al., 2010). Failure to address adolescent mental health conditions, has implications for adulthood with impaired physical and mental health limiting opportunities for fulfilment (World Health Organization, 2012).

In the United Kingdom, an estimated 17% of adults had experienced a 'common mental disorder' like depression or anxiety in the past week (Baker, 2020). Generalised anxiety disorder was amongst the most commonly identified mental

disorders followed by depressive episodes (Baker, 2020). Within the United States, one out of five adults in 2010 aged 18 or older had a mental illness (Robert Wood Johnson Foundation, 2013). Contrary to the popular perception that the prevalence of common mental disorders over the past three decades is rising, Baxter et al. (2014) suggest numbers have remained relatively stable. Within Australasia, they report figures of 7.1% for females and 3.7% for males on anxiety disorders in 2010, and 4.2% (female) and 2.5% (male) for major depressive disorders (Baxter et al., 2014). Harvey et al. (2017) reported stable figures for mental disorders in Australia between 2001 and 2014. There is some modelling to suggest that mental health problems may increase in Australia as a result of COVID-19 and could remain higher some-time after the pandemic (AMA, 2020; Fisher et al., 2020, Preprint).

Those in lower socioeconomic groups have poorer health than other Australians regardless of how socio-economic status is measured (by income, education, the socio-economic status of place of residence, occupation) (Giles-Corti, et al., 2004). Whilst the middle classes are affected, the poor and disadvantaged are disproportionately impacted by common mental disorders and their negative consequences (Allen et al., 2014; WHO, 2004). Low educational attainment, material disadvantage, unemployment and social isolation, particularly for older people, are significant factors (Allen et al., 2014).

According to the WHO (2004), both risk and protective factors are multi-layered consisting of environmental, economic, family-related, or individual factors. They suggest that:

> *Mostly, it is the cumulative effect of the presence of multiple risk factors, the lack of protective factors and the interplay of risk and protective situations that predisposes individuals to move from a mentally healthy condition to increased vulnerability, then to a mental problem and finally to a full-blown disorder (p. 20).*

The National Mental Health Commission's review of mental health programs and services within Australia, highlighted how a 'person-centred mental health system would feature more clearly defined pathways between health and mental health. It would recognise the importance of non-health supports such as housing, justice, employment and education, and emphasise cost-effective, community-based care' (Department of Health, Dec 2015, p. 7). This approach is reflective of an ecological perspective that emphasises interaction between, and interdependence of, a host of factors within and across all layers of health (Rimer and Glanz, 2005). Through consideration of people's interactions with their physical and sociocultural environments, we can understand how behavior both affects, and is affected by multiple levels of influence whilst shaping, and being shaped by the social environment, what Rimer and Glanz (2005) refer to as reciprocal causation.

Because of variation in personal, social, cultural and policy level factors, certain individuals are more at risk of experiencing mental health challenges and mental illness, mediated across multiple axes of diversity. Newly arrived communities, particularly those who have experienced forced migration can experience significant anxiety, depression and other mental health challenges in the early years of settlement due to significant disruption, trauma, loss of identity within their new country and challenges adjusting to new cultural practices, language and systems (Ellis et al., 2019).

The LGBTQ+ community have more recently been identified as at risk of poor mental health as a result of ongoing stigma, homophobic and transphobic bullying. LGBTQ+ young people are more likely to have contemplated or attempted suicide than their heterosexual peers (Byron et al., 2017). Women also tend to have higher levels of common mental disorders compared to men at every level (Allen et al., 2014; WHO, 2004).

Whilst higher numbers of women report experiencing mental health challenges, suicide rates are higher amongst men and are particularly high in rural/regional areas. Suicide within Australia is, by some way, the leading cause of death for young men, accounting for 24.4% of all deaths of young people aged 15–24 years (Rice, Purcell & McGorry, 2018). Problematic notions of masculinity, the association of mental illness with weakness and negative behaviour associated

with socially desirable forms of masculinity (such as heavy alcohol consumption, violence and aggression), can result in men experiencing conflict within their identity construction. This can lead to, or exacerbate, mental illness and also result in men being less willing to acknowledge they are experiencing mental health difficulties or seek help (McCusker & Galupo, 2011). Dominant and unhealthy forms of masculinity are also connected to the high rates of gender-based violence witnessed within Australian society (Kuskoff & Parsell, 2020). Young Australian men, with higher levels of conformity to traditional notions of masculinity, reported being twice as likely to experience thoughts of suicide at some point in the last two weeks (Men's Project & Flood, 2018). Gender based violence has significant implications for the mental health of men, women and young people, with those experiencing violence more likely to suffer from anxiety, depression, panic disorders and post-traumatic stress disorder that can continue within generations for many years (Howard, Trevillion & Agnew-Davies, 2010).

Social relationships and social integration offer important protection against increased risk of distress (anxiety, depression), suicidal ideation, health behaviour and seeking health care (Beutel et al., 2017). A sense of belonging is attained through social connectednesss, with positive outcomes for mental health behaviour coming from increased social ties (Burns, Evans, Jancey, Portsmouth, & Maycock, 2020). Volunteers within clubs for example, report higher levels of social connectedness, wellbeing and self-esteem than non-volunteers (Burns et al., 2020).

Despite the existence of effective treatments, there is evidence that many people, especially younger people, do not gain access to the support they need (Breslin et al., 2017; Rothì & Leavey, 2006). Whilst primary care and school settings are considered key sites for prevention and referral, a range of factors including a lack of recognition by the person that they have a mental disorder (Jorm, 2012), stigma surrounding mental health, and mistrust of authority figures contribute to the failure of young people to seek help from these sources (Breslin et al., 2017; Leavey, Rothi, & Paul, 2011; Rothì & Leavey, 2006; Sawyer et al., 2001). Within Australia, Sawyer et al. (2001) found 'only a very small proportion of all children and adolescents with problems receive help from specialised mental health services'. Adolescents prefer informal settings to raise concerns about their mental health (Hurley, Swann, Allen, Okely, & Vella, 2017). Indeed, only 13% of young men aged 16–24 years experiencing a recent mental health problem will access mental health services (Rice, Purcell and McGorry, 2018). Consequently, it can take a long time to seek help (years) and adolescents are more likely to seek professional help through the support of influential others (Hurley et al., 2017; Jorm, 2012; Jorm, Kitchener, Kanowski, & Kelly, 2007).

Young people are particularly at risk because they haven't yet developed the capacity to recognise their feelings may be a consequence of being unwell. Jorm et al. (2007) highlights the important role members of the public play in supporting someone with a mental disorder. Jorm (2012) identified deficiencies in:

a) the public's knowledge of how to prevent mental disorders
b) recognition of when a disorder is developing
c) knowledge of help-seeking options and treatments available
d) knowledge of effective self-help strategies for milder problems, and
e) first aid skills to support others affected by mental health problems. (p. 1)

Deficiencies in mental health literacy within the Australian public and beyond, suggest a need for greater training within the community (Jorm, 2012; Jorm et al., 2007).

Rural and Remote Mental Health Including Aboriginal People

In rural and remote areas, a range of geographic, economic, social, cultural, demographic, and environmental factors exacerbate systemic shortcomings and impact the accessibility and quality of mental health frameworks, programs and interventions (Rural Doctors Association of Australia, 2018). The National Rural Health Alliance, suggests in rural and remote areas there is a:

> Greater prevalence of some chronic conditions and disability, and generally poorer health. Rates of smoking, risky drinking and illicit drug use are also higher. There are fewer employment opportunities leading to lower incomes and less financial security. There is greater exposure and vulnerability to natural disasters, while rates of overcrowding, housing stress, and homelessness are higher.

Consequentially, rates of mental health challenges are much higher than those in city areas around Australia. For example, in 2016, the number of suicides per 100,000 people in rural and remote Australia was 50% higher than in cities (Hazell, Dalton, Caton & Perkins, 2017). This rate gets higher and grows more rapidly as areas become more remote. The suicide rate for Aboriginal and Torres Strait Islander people is twice that for non-Indigenous people (Hazell et al., 2017). A barrier to engaging in mental health and wellbeing support is the associated stigma and a 'rural stoicism' towards living in remote areas. Stigma and 'rural stoicism' can in part be tackled through community services and sports centres improving attitudes towards mental health and encouraging positive help-seeking behaviour (Hoolahan, 2002).

The potential for Aboriginal People to experience mental health difficulties as a result of ongoing trauma from colonisation, cultural dislocation and poor access to appropriate services and support is well documented within existing literature (Jorm et al., 2012). There are specific needs and challenges with regard to the quality, consistency and support for the mental health and wellbeing within Aboriginal people and remote communities (Rural Doctors Association of Australia, 2018). Needs include understanding and respecting kinship, as well as consideration for the impact of invasion and stigma associated to mental health. Challenges include community and health care workers knowledge and responsiveness of the cultural and social context, the distances between communities and services, lack of programs and frameworks specific to the context, regular change of workers/community and lack of collaboration with Aboriginal health representative's and community (Hazell, Dalton, Caton, Perkins, 2017; Rural Doctors Association of Australia, 2018; National Rural Health Alliance, 2016).

The Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 seeks to ensure that the delivery of health and community services occurs within an approach that sensitively recognises and understands Aboriginal people's cultural rights, views and values, and access to culturally sensitive services – known as Cultural Security (Mental Health Commission, 2018). Cultural Security ensures all people are treated with regard to their specific cultural needs and differences. Specifically, recognising the centrality of culture to health and respecting Aboriginal people and cultures is necessary to enhance service access, equity and effectiveness. It is critical to reducing, and ultimately closing the gap in health outcomes in rural and remote regions (Northern Territory Health, 2016).

Cultural security also provides a commitment to the provision of mental health services offered by the health system that will not compromise cultural and human rights, values and expectations of Aboriginal people. Cultural security can be achieved by: "developing accessible and effective health care systems for Aboriginal people based on acknowledgement of Aboriginal peoples' right to self-determination, empowerment and healthcare and as such, an understanding and responsiveness to cultural views, beliefs and knowledge systems which play an integral role in adherence to health care services" (Northern Territory Health, 2016, p. 7).

Frameworks for the Provision of Mental Wellbeing

Sawyer et al., (2001, p.813) identified gaps in service provision and a pressing need to 'identify the optimal mix of promotion, prevention, consultation and treatment interventions that provide cost-effective help for young people and their families in Australia'. The Australian Government's Department of Health, recognised in 2015 that the mental health system comprised a 'collection of often uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice' (Department of Health, Dec 2015, p. 5). The report also suggested that policy and program design was not being guided by a 'consistent and consolidated framework, with decisions not coordinated across governments'.

Recommendations included a stepped care model that addressed the full range of needs in the population, with a particular emphasis for the well population and at-risk groups for early intervention, self-care and greater integration between service providers across service levels. In particular, greater access to lower cost, evidence-based alternatives to face-to-face psychological therapy sessions are considered important elements in at-risk groups. For individuals and families, access to self-help and publicly available digital resources is considered important. As an example of implementation of policy changes, the federal government has taken steps to centralise digital resources as part of its Head to Health initiative (https://headtohealth.gov.au/).

Within Western Australia, the Mental Health Commission reports to the Minister for mental health. The Commission provides and partners in the delivery of prevention, promotion and early intervention programs; treatment, services and supports; and research, policy and system improvements (Mental Health Commission, 2018). The Commission's role, among other things, is to support public awareness education, build community capacity to develop, implement and evaluate mental health promotion activities and promote community connectedness. The Mental Health Commission (2019) signalled a need to significantly increase investment in mental health promotion and prevention services, currently forecasted to meet 28% of optimal levels by 2025. Organisations and agencies funded to provide promotion and prevention programs are to implement **evidence-based** and **evidence-informed** promotion and prevention initiatives in line with the Prevention Plan. As part of primary prevention, the framework for mental health promotion sits within the Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2015-2025 (Mental Health Commission, 2018). The plan outlines the following principles:

- Programs and initiatives exist across the life course.
- A combination of whole-of-population, localised, and targeted programs exist.
- Evidence-based (or evidence-informed) programs and initiatives are adopted.
- Multiple strategies are supported across local, state and national levels.
- Innovation is supported by robust evaluation.
- Partnerships, collaboration and co-design are a central feature.
- Valuing diversity, equity, cultural inclusivity and human rights is fundamental to the plan.

Alongside workplaces the prevention plan identifies sport as sitting within Domain 2: Creating and maintaining supportive environments (Mental Health Commission, 2018, p. 25). Sporting clubs were named as a setting where mental prevention initiatives can be implemented to promote optimal mental health and reduce alcohol and other drug use and related harm. The strategies relating to mental health for Domain 2 across the life-course are as follows:

- Develop and/or implement whole-of-population prevention initiatives that: Promote participation in local community activities; increase the sense of belonging within a community; provide appropriate mental health and alcohol and other drug information; encourage commitment by community organisations to participate in prevention activities; and *build capacity of organisations to plan and implement their own prevention activities*.
- Expand existing and develop new interventions that promote social inclusion and reduce the stigma associated with mental and/or alcohol and other drug-related issues.

For children and young people (4-17 years), the strategy with links to sport, is to 'encourage local communities to provide appropriate community initiatives that support mental health and wellbeing, and prevent alcohol and other drug-related issues amongst children and young people (for example, alcohol-free community events, sporting and cultural programs)' (p. 35). Of relevance, is the strategy to 'Deliver whole-of-school and community-based multi-faceted programs that promote optimal mental health, wellbeing and resilience of young people' (p. 36).

Donovan and Anwar-McHenry (2016) outline a distinction between mental health promotion and mental illness prevention and early intervention. According to these researchers, mental health promotion can be defined as:

> interventions designed to maximize mental health and well-being by increasing the coping capacity of communities and individuals and by improving environments that affect mental health. Mental health promotion aims to improve the well-being of all people regardless of whether or not they have a mental illness (p.193).

Prevention on the other hand refers to attempts to prevent disorders developing by targeting known risk factors whilst early intervention involves actions that specifically target people displaying the signs and symptoms of a mental disorder. As noted in the strategic framework for Domain 2 above, programs in the workplace, education settings or indeed the sport sector, sit within population wide mental health promotion frameworks. WA's *Act Belong Commit* for example, can be readily adapted to sporting contexts. Yet according to the Mental Health Commission (2018), these programs can stretch beyond social connection, awareness raising and information sharing to '*participate in prevention activities*' (i.e. improve mental health literacy, reduce mental health issues, promote social inclusion, shift attitudes) (p. 29). Consequently, community sport settings in policy documents appear to straddle local health promotion **and** prevention categories. It is also possible that community sporting clubs and mental health providers they work with, are called upon in times of local crisis (such as following a suicide in a community club), to participate in intervention. Consequently, Domain 2 organisations like workplaces, schools and even sporting clubs, can serve a range of promotion, prevention and possibly intervention functions.

The structured and regulated nature of many workplaces and nearly all schools, means they have tools and resources to develop strategic approaches to support mental wellbeing promotion and prevention. Beyond Blue provides an example of what might form part of an integrated strategic framework approach within these more structured settings (Beyond Blue, accessed, June 2020). These integrated approaches address a wide range of factors that may impact mental wellbeing across layers of an organisation. They draw on features of **protection** through risk reduction and increasing protective factors, **promotion** of mental health and wellbeing by developing strengths and capabilities and **intervention** where any difficulties are addressed.

These approaches are undertaken through a shared, collaborative approach where promoting mental wellbeing is viewed as everyone's business. This shared responsibility encapsulates all layers of an organisation, whereby mental wellbeing becomes an objective of the organisation and is integrated into policies, procedures and is appropriately resourced. Integrated approaches also modify both the risk and the protective factors. Reducing exposure to stressors and emphasising protective factors like positive social connection and a supportive workplace culture. Integrated approaches aim to impact cultural practices to build organisational resilience and reinforce a strengths-based approach. The benefits of a mentally healthy organisation are made clear and illustrated through a commitment from leadership. This in-turn contributes to the production of a strong culture that values everyone (listened to, respected), especially the most vulnerable (Beyond Blue, accessed, June 2020).

Rather than a top-down 'expert' delivery model, approaches should consider involving people in co-designing integrated approaches to leverage self-determination and perceived control over mental health outcomes. To reduce the impact of stigma and support change, a focus on actions likely to benefit an individual (self or others) is important (Breslin et al., 2017; Jorm, 2012). Approaches should take a broad focus and be ongoing in both participation and communication. Clear goals are important, covering areas such as improving understandings, addressing risks, fostering an anti-bullying culture, combating stigma, promoting positive wellbeing, providing support and enacting prevention. Strategies should be evaluated against baseline measures and the stated goals to better understand what is working and what needs to be adjusted.

MENTAL HEALTH PROVISION IN SPORT

Like workplaces and schools, community sport is increasingly being viewed as a site to promote public mental wellbeing and potentially play a role in prevention and even intervention. Indeed, sport provides a trusting social community network that lends itself to supporting a focus on mental wellbeing (Breslin et al., 2017). Community sport however poses a unique set of challenges. Community sport is not as readily regulated as workplaces or schools and its transient volunteer staff and participant base makes it difficult for them to prioritise resources away from the day to day running of competitive sport. Despite this, there has been a significant proliferation in the number of public mental health programs associated with community and elite sport.

In addition to potential structural and resource limitations, there are concerns with the capacity of sport settings to promote mental wellbeing given the potential for mixed messages. Sporting culture frequently celebrates ritualised combat, mental toughness and disapproval of weakness disclosure (Bauman, 2016; Breslin et al., 2017; Connell, 2005; King et al., 2020). Within Australia, displays of hetero-masculinity are commonly found in sport settings (Connell, 2005; King et al., 2020). Additionally, sport settings can foster a social pressure on youth to show toughness with the denial of pain potentially contributing to under-use of primary health care later in life (Connell, 2005). Despite evidence that suggests young Australian men are becoming more progressive on many elements of masculinity, ideals of remaining strong, being the breadwinner and fighting back when challenged persist (The Men's Project and Flood, 2018; King et al., 2020). According to The Men's Project and Flood (2018), sporting cultures play a particular role in shaping the lives of boys and men where they will either conform, resist or fail dominant expectations. They suggest:

> 'boys and men learn to be 'proper' men, for example through parental socialisation, peer groups, schools and universities and other institutions, sports, communities, and media and popular culture…[Within these spaces,] 'particular ways of being a boy and man are dominant, while others are stigmatised, punished, or silenced' (p. 46).

They argue that among other groups, some sporting codes and clubs within Australia make particularly energetic efforts to promote or defend traditional, patriarchal ideals of masculinity with negative consequences for mental health.

Yet even though there are apparent contradictions in sporting contexts, Breslin et al. (2017) suggest mental health awareness programs in sport contexts can be effective. The Men's Project & Flood (2018), point out that working with, and sometimes against the views of these institutions is a good place to continue to erode outdated and harmful norms of masculinity. They recommend engaging with young people in settings like community sporting clubs, to provide activities/interventions that support positive alternatives to harmful norms. Specifically, in relation to masculinity and its impact on mental health, an approach to 'meet men and boys where they are' should be 'tailored to their specific contexts and could form part of current place-based approaches' (The Men's Project and Flood, 2020, p. 34). The range of communities in Western Australia, including sporting communities, are considered important in providing broader informal supports. Sporting clubs are attractive because 'programs that are easily accessible, based in the community with strong links to existing universal services are likely to be the most acceptable, effective and least stigmatising' (Mental Health Commission, 2011).

Breslin et al. (2019) identified a need for guidelines for the implementation and evaluation of mental health programs in non-elite sporting contexts, because they impact a significant number of people worldwide. In developing consensus statements to support mental wellbeing in sport, they identified the growing number of health awareness programs emerging within the sporting landscape. These programs varied considerably in content, design, theory and evaluation with a degree of uncertainty about the outcomes or their effectiveness. There was a lack of agreement on minimal training requirements for supporting content development and provision and they recognised a greater need for evidence-based recommendations within the sector.

To assist sporting clubs in the sustainable promotion of mental wellbeing as part of a coordinated primary prevention approach, this report provides an application of 'best practice' criteria for the quality provision of mental health support in sporting clubs, with additions for remote and Aboriginal communities. It also provides an examination of a range of mental wellbeing initiatives and resources against the developed criteria. Finally, the report synthesises a set of recommendations from the analysis, to offer clear direction to stakeholders looking to engage in mental wellbeing initiatives through sport. An analysis of findings is presented following an outline of the approach to data collection.

Best Practice Criteria for Mental Health Provision in Sport Clubs

A rapid review process conducted by O'Connor et al., (2020) was undertaken to determine a set of criteria to establish 'best-practice' mental health provision in sport. These are summarised under four broad areas: i) A systemic framework for mental wellbeing provision; ii) clear strategies to guide mental wellbeing promotion; iii) evaluation and efficacy and; iv) sustainability of the program. The rapid review found that effective programs are programs that sit within and operate as part of an overarching systematic and strategic framework for mental wellbeing provision. Mental health promotion messages work best when they are consistently and persistently applied across multiple contexts (i.e. schooling, workplace, media, sport, etc.) and at multiple levels (policy, leadership, participant).

The scoping review also revealed that successful MHW programs in sport have a clear focus that is tailored for varying levels. This focus is complimented by the formation of strong partnerships and collaborations that strengthen social and economic outcomes. In particular programs:

- have targeted foci;
- align these foci to audience needs; and
- extend and amplify the foci through the formation of collaborative partnerships.

Programs should also demonstrate they make a measurable and meaningful impact on outcomes they claim to target, through the implementation of carefully planned and executed evaluation. Demonstrating the meeting of outcomes through robust evaluation is the best indicator of program quality and impact. Programs delivering mental wellbeing initiatives to sporting clubs, should demonstrate institutional and program sustainability. Consequently, mental wellbeing promotion as part of primary care should not be considered a one-off event so that core outcomes of the program endure even after an intensive focus has passed.

Collectively, these criteria (detailed in the methodology) inform best practice for the provision of mental wellbeing programs in sporting clubs. Given the context of this initial review was within the state of Victoria Australia, it was recognised that in order to be applicable to Western Australia, a greater focus on remote, rural and Aboriginal populations was needed. The next section outlines the methods undertaken to adapt these criteria for WA, generate a market analysis of market of providers impacting the state of Western Australia and capture a response from a sample of sporting organisations and club participants about the state of play for mental wellbeing promotion in sporting clubs.

METHODOLOGY

This section outlines the methodology undertaken to ultimately produce a set of recommendations for support agencies looking to progress mental wellbeing primary prevention initiatives via sporting clubs. The approach encompassed five phases: 1) The addition of criteria for remote and Aboriginal communities, 2) A market analysis to scope the providers/programs operating within WA; 3) A survey to gain insights from State Sporting Associations and community club participants about their needs with regard to mental health provision and their thoughts on interactions with existing providers; 4) A select number of interviews with MHW providers to community clubs were conducted to gain insights into their operations linked to the set of criteria developed by O'Connor, et al., (2020) and; 5) provider interview data were used to evaluate providers against the quality criteria to give insight into the breadth of provision within the sector. Each of these phases are explained in detail below.

PHASE 1) THE ADDITION OF ABORIGINAL PEOPLE AND REMOTE COMMUNITY CRITERIA

It was recognised that additional criteria were needed to explore the Western Australian context, specifically in relation to the needs of Aboriginal peoples and communities. To do this, literature review searches, analysis and reporting followed the Joanna Briggs Institute manual (Aromataris & Munn, 2020). Electronic databases that were utilised, included Scopus, Psychinfo and Google Scholar. Search terms were: rural and remote mental health; Aboriginal people and remote communities' health; Aboriginal people's mental health; quality of mental health programs for Aboriginal people and remote communities; quality mental health programs in rural and remote Australia; Aboriginal peoples' mental health; programs for Aboriginal peoples' mental health. A number of 'grey' literature and a smaller number of research articles were generated from the searches (see Table 1). National, Government and service organisation reports were included in the analysis. The reports were analysed to provide a summary overview of rural and remote mental health including Aboriginal people / remote communities. From the summary, a set of criteria were extracted. These were considered to be pertinent to the provision of mental wellbeing in remote and Aboriginal communities.

TABLE 1: SOURCES FOR THE DEVELOPMENT OF CRITERIA - REMOTE AND ABORIGINAL COMMUNITIES

Author/s and Year	Title
The Australian Government Department of Health (2006)	Pathways of recovery: Preventing further episodes of mental illness: Aboriginal peoples and Torres Strait Islanders
Bishop, L., Ransom, A., Laverty, M., & Gale, L., (2017)	Mental health in remote and rural communities.
Centre for rural and remote mental health (2020)	Centre for rural and remote mental health
Dudgeon, P., Walker, R., Scrine, C., Shepherd, C., Calma, T., & Ring, I. (2014)	Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people
Hazell, T., Dalton, H., Caton, T., & Perkins. D., (2017)	Rural Suicide and its Prevention.
Hoolahan, B., (2002)	'The Tyranny of Distance'. Issues that impact on mental health care in rural NSW.
Rural Doctors Association of Australia, (2016)	Mental health care in rural Australia: A RDAA background paper.
Rural Doctors Association of Australia, (2018)	Submission to the Senate Community Affairs References Committee Inquiry into the Accessibility and quality of mental health services in rural and remote Australia.
Rural and Remote Mental Health (2019)	Rural and Remote Mental Health 2019 Annual Report
National Rural Health Alliance, (2016)	Mental health in rural and remote Australia.
Pierce, D., & Brewer, C., (2012)	Factors Promoting Use of Mental Health Services in a Rural Area of Australia.
Centre for Rural and Remote Mental Health, (2017)	Rural Suicide and its Prevention: a CRRMH Prevention Paper – Summary
Vines, R., (2011)	Equity in health and wellbeing: Why does regional, rural and remote Australia matter?

PHASE 2) MARKET ANALYSIS - SCOPING OF INITIATIVES IMPACTING THE STATE OF WESTERN AUSTRALIA

This part of project was focused on conducting a market analysis of mental wellbeing initiatives and resources aimed at sporting clubs and with reach into the state of Western Australia, Australia. The intent was to capture the range of initiatives on offer that targeted mental wellbeing through the sport sector and provide information on target audience, delivery medium, evidence of impact, end-users, foci and cost/commitment requirements for clubs. Initiatives sat at the primary prevention level only. Programs with a core focus in another area (i.e. inclusion) but with clear links to mental wellbeing were also considered within the market analysis. This section provides an overview of the method used to capture information on initiatives.

The market analysis review was undertaken using a variety of methods. Initially, information was collated drawing on knowledge within the research team and through discussions with Healthway, and the previous work conducted with VicHealth. This informal approach was coupled with more systematic methods that included a comprehensive digital search of organisations. To complete this, online searches using keywords such as 'mental health,' 'sport,' 'mental wellbeing,' 'social connection', 'mental ill health', 'stigma', 'inclusion', diversity and 'Western Australia' were conducted and results entered into a summary table. Additional information to inform the analysis findings was gathered from website material, apps and other available resources. Interviews and discussions revealed additional initiatives that if appropriate were added to the table.

Phase 3) Survey of SSA and Community Sport Participants

A survey of State Sport Associations and community sport club members was conducted to ascertain what needs SSAs and community sporting clubs have in relation to mental wellbeing provision and the extent to which providers are recognised and utilised in sport. A digital survey was distributed to all state sporting associations and via Healthway and SportWest networks to sporting club members. The survey was open for a period of 15 days and garnered 175 responses.

Phase 4) Interviews With Providers

Finally, to contribute information to the market analysis and to better understand how initiatives matched criteria for quality provision (see Phase 3 below), a series of interviews were conducted with mental health and wellbeing (MHW) providers who agreed to participate. All providers were invited via personalized email to participate in a phone interview to discuss elements of their initiatives. Of the 14 providers sent an email, 12 providers agreed to participate in interviews. Two researchers conducted the guided interviews, one leading the conversation and the other taking comprehensive notes. Interview notes were used to help complete the Market Analysis table and matched to Phase 3 criteria. Programs were de-identified for reporting purposes to maintain confidentiality. A summary table for the Market Analysis is provided in the findings section.

Phase 5) Analysis of Initiatives Against Criteria

A combination of gathered resources, survey data and interview data were collated to review initiatives. Where available, data from these multiple sources were used to score the initiative against the modified criteria. In applying the criteria, consensus was sought between at least two researchers who conducted the interviews. Not all programs provided information needed to undertake the analysis. Summary data was de-identified for reporting to maintain confidentiality. A summary of initiatives against the criteria is provided in the findings section.

FINDINGS

The findings are presented in four sections. First, criteria relating to remote and Aboriginal people were added to the best-practice criteria for mental wellbeing interventions in the sport sector. Second, the findings from the market analysis of initiatives that deliver into Western Australia are presented. Third, the results of the survey are summarised. Fourth, interview data with providers is summarised and finally, initiatives are analysed against the criteria.

PHASE 1) ADDITION OF CRITERIA FOR REMOTE AND ABORIGINAL COMMUNITIES

A review of literature was conducted to ascertain criteria that providers of mental wellbeing programs should be meeting when delivering to remote, rural and Aboriginal communities (see Methods). A summary of the review is provided here, followed by the addition of 'best practice' criteria for the provision of mental wellbeing in sporting clubs.

Mental health programs in remote and rural areas and for Aboriginal people must be tailored to support the specific needs of these communities. When compared to city locations, rural and remote communities are at greater risk of severe negative impacts from mental health disorders, this includes Aboriginal and/or Torres Strait Islander communities. There are several challenges in rural and remote mental health programs/services for Aboriginal people, including the accessibility and the quality of mental health programs and their appropriateness for the cultural and social context.

Next steps to support mental health and wellbeing in rural and remote areas

A proactive rural and remote mental health strategic framework is needed to address the particular mental health needs in these communities. In rural and remote areas, a framework would be ideally grounded through:

- A holistic approach which centralises awareness of the impact that social, economic, cultural and environmental determinants of mental health have in this context, particularly where suicide clusters have occurred;
- service provision supported by all levels of governments;
- greater collaboration with community services, such as sports and outreach centres;
- communication and collaboration between mental health and health services with other health, social and community services including GP clinics, psychology/social work/counselling support and outreach services;
- opportunities to upscale mental health and wellbeing programs for online technology options with adaptations for rural and remote areas;
- provisions for regular and ongoing telehealth consultations and;
- investing in training for other mental health workforces and social and community sector workforces to improve the quality of mental health care and integration of services in rural and remote areas.

Intervention guidelines for rural and remote areas

Given the biggest challenges in rural and remote areas is lack of available workers and the distances to travel to provide programs and interventions, the literature suggests the following as useful:

- technology to build or grow programs into online formats to enable a reach that is wide and far;
- programs to be embedded with local GPs and community centres in conjunction with integrated service models in rural and remote communities;
- reviews into current programs available to rural and remote areas to see if they do meet the mental health and wellbeing criteria of best practices.

Quality of and support for mental health for Aboriginal people / within remote communities

Aboriginal people have specific needs when it comes to support for mental health and wellbeing (Rural Doctors Association of Australia, 2018). Quality and consistent support needs to respect notions of kinship, the levels of stigma associated with mental health and a sensitivity to the impact of invasion. Community and healthcare workers need to both understand and respond to the unique set of challenges that exist within these communities. These challenges include the cultural and social context, the distances between communities and services, lack of programs and frameworks specific to the context, regular change of workers/community and lack of collaboration with Aboriginal health representatives and community (Hazell, Dalton, Caton, Perkins, 2017; Rural Doctors Association of Australia, 2018; National Rural Health Alliance, 2016).

Intervention guidelines for Aboriginal people / remote communities

A number of health care professionals and organisations have requested specific and tailored mental health frameworks, interventions and programs for Aboriginal people and remote communities (Rural Doctors Association of Australia, 2016; Bishop, Ransom, Laverty, & Gale, 2017; Hazell, Dalton, Caton, Perkins, 2017; Rural Doctors Association of Australia, 2018; National Rural Health Alliance, 2016; Pierce, & Brewer, 2012; Centre for Rural and Remote Mental Health, 2017; Vines 2011). To address the needs and challenges for and with Aboriginal and remote communities, mental health and wellbeing programs and their frameworks need to specifically:

- Include Aboriginal health representatives to tailor frameworks and intervention implementation to ensure accessibility, appropriateness and suitability for use in remote communities;
- draw upon both female and male (diverse) Aboriginal health representatives to adapt the criteria and content to appropriately support Aboriginal people and remote communities' mental health and wellbeing;
- partner with Aboriginal health representatives to attain advice on adapting current or creating new mental health frameworks and programs that acknowledge, understand and respect the:
    - interconnectedness of kinship, culture, law, land and spirituality;
    - effects of invasion, colonisation and ongoing cultural stress, and;
    - stigma toward Aboriginal and Torres Strait Islander people with mental illness, which can be inadvertently enforced by health care providers who don't speak the Aboriginal language and use short-hand forms of verbal and non-verbal communication.

NOTE: This current project has not sought confirmation or feedback on these guidelines from Aboriginal health representatives, which ideally would be the next step to ensure these guidelines are appropriate for Aboriginal communities.

Best practice criteria for the implementation of mental wellbeing in WA sporting clubs

A set of 'best-practice' criteria was formed from a rapid review of the literature (O'Connor et al., 2020). Following an additional review of literature, criteria were added to provide a greater focus on Aboriginal people and remote communities, these appear in bold below. The full set of criteria can be found in Table 2.

TABLE 2: CRITERIA FOR MENTAL HEALTH AND WELLBEING PROVISION IN COMMUNITY SPORT

Strategic framework
Initiative has explicit ties with an established overarching mental wellbeing framework.
Initiative uses language and approaches consistent with established MHW promotion frameworks.
Initiative is underpinned by well-established models/theories of MHW promotion.

Initiative targets the individual (i.e. awareness raising, help-seeking strategies), social (i.e. masculine norms, social climate), media (i.e. awareness raising via social media) and policy layers (i.e. policy against the use of harmful language).

Initiative utilises well-resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.

For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people

For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.

Initiative voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).

Initiative helps clubs establish community support for the need to focus on mental wellbeing (establish the business case / authorizing environment).

Intervention format

The intervention offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).

Program is targeting different cohorts both within and beyond sport clubs.

Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.

Intervention components

Intervention has clearly stated outcomes and content is consistent with them.

Provides appropriate ways to raise awareness of and promote mental wellbeing.

Intervention reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues)

Intervention consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.

The intervention draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language)

The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and this is integrated into delivery approaches and content.

Intervention links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.

Evaluation and Efficacy

Measures are clearly aligned with stated program outcomes and program content.

The program has utilized valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.

What works is known, how it works is known, and repeatability is universal.

Measures have established impact across different settings, sustained over time.

Evidence collected is publicly available and open to external scrutiny (i.e. on website).

Sustainability of program

The community and a range of stakeholders have a vested interest in the program.

The program is financially self-sufficient and not dependent upon grants.

The host organization is “mature” (stable, resourceful).

The value and mission of the program fit well with the broader community.

The program meets legal and compliance responsibilities.

The program represents 'good value for money' for the club.

Sustainability of impact

The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.

The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.

The program a clear strategy for supporting positive culture change within community clubs.

PHASE 2) MARKET ANALYSIS - SCOPING OF INITIATIVES IMPACTING THE STATE OF WESTERN AUSTRALIA

Key providers offering mental health service to community sports clubs in Western Australia

The search of providers identified thirteen key providers offering support services operating within the state of Western Australia which are documented in Table 3. An additional 32 providers were found to be supporting MHW more broadly and are listed in Table 4. These providers were all active in working in the community sport sector and offered a range of resources and supports to clubs. Table 3 provides a brief overview of the services key providers offer and their areas of focus.

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TABLE 3: OVERVIEW OF KEY PROVIDERS OFFERING MENTAL HEALTH SUPPORT TO COMMUNITY SPORTS CLUBS

ORGANISATION	WEBSITE	INTERVIEW	AREA OF FOCUS	SERVICES OFFERED	COST TO CLUBS
Outside the Locker Room	https://otlr.org.au	Y	All community clubs, all ages, players, parents, coaches and volunteers. Awareness raising, education and referral pathways.	Deliver a mental health education and welfare support program for community sporting clubs across Australia, in all sporting codes. Program includes: • Education workshops; two face to face visits and online follow up. • First session covers broad aspects of mental health, clubs chose the focus of second session. • An App provides support and referral pathways. All who attend workshops are encouraged to register via the app, those requiring additional support are then referred to other support services. • Toolkits and resources including toolkit to support clubs dealing with the aftermath of suicide. • Awareness raising via social media.	Yes
Tackle Your Feelings	https://www.tackleyourfeelings.org.au	Y	AFL focused, targets coaches and volunteers to raise their knowledge of mental health issues and how to support/refer participants, tailored for junior, youth and adult awareness raising, education and accreditation of clubs.	Focus on ensuring coaches feel able to respond to mental health challenges amongst participants and create environments that support positive mental health. • Offer 1 hour face to face training and 3 online modules. • Participation leads to club accreditation • Videos and articles available via website. • Champions profiled. • Awareness raising via social media.	Free

Orygen	https://www.orygen.org.au	Y	Mental health organisation offering some support to sports clubs, focus on developing supportive cultures in clubs.	Sport specific search found a web based toolkit at https://www.orygen.org.au/Training/Resources/Physical-and-sexual-health/Toolkits/Supporting-mental-wellbeing-in-community-sport • Ran small scale pilot program in WA providing face to face education. Intending to extend this. • Online webinars. • Generic mental health research and policy support; referral service; training.	Free
Good Sports	https://goodsports.com.au/this-is-good-sports/	Y	Aim is to reduce harm and positively influence health behaviours, funded by Australian Drug Foundation. Work with sports clubs to prevent and minimise the harm cause by alcohol and other drugs.	Overall works on changing club cultures to create positive club culture. • Primary focus is drugs and alcohol, however a specific program on mental wellbeing called 'Healthy Minds' at https://goodsports.com.au/programs/healthy-minds/ • Program can be face-to-face or online deliver • Works with leadership (e.g. committee and influencers of the club), however also works with whole of clubs and associations/leagues. • Accreditation process and ongoing, continued support from Good Sports. • Programs support and reinforce each other. • COVID-19 support at https://goodsports.com.au/safely-restarting/	Free

Bouncing Back (Richmond Wellbeing)	https://www.rw.org.au/bouncing-back-program/	Y	The Bouncing Back program is designed to equip coaches, captains, administrators, parents and young adults with the skills to offer support to club members who experience mental health challenges. Focussed on men aged 18-45 years.	Addresses men's mental health through creating conversations, support and providing avenues of assistance. ● Face-to-face mental health awareness training sessions. Breaks down mental health issues and how to start a conversation about mental health for men ● Webinar during COVID-19	Free
Good Chat Foundation (in partnership with Youth Focus, a WA youth mental health provider)	https://www.thegoodchatfoundation.com/	Y	An individual program that works with mental health practitioners (e.g. counsellor/psychologists) to find appropriate sports environments to get young people active in a supportive environment to develop protective factors and find a sense of belonging and community.	A collaborative, yet individual approach to creating positive culture within sporting environments. Targets low SES youth who are in therapy to find suitable sporting environments with support from mental health practitioner, family and sporting environment (e.g. coach, teammates). • Sporting club - provide support to committee and leadership in guiding your culture and messaging around mental health. • Apparel, corporate (sponsorships), fundraising, donation, partnerships, social media • Clinical referral login online portal • Provide post intervention assistance	Free or subsidised (dependent on funding to support this)
Stitch in Time Project	https://stitchintime.org.au/	Y	Youth focussed to support and develop mental wellbeing through sessions, programs and mentoring initiatives in schools with Basketball WA, National Basketball League & sporting organisation and clubs. Provide youth (and others e.g. parents, volunteers) with the tools to self-	Co-facilitation of programs with a psychologist and lived experience in metropolitan and regional WA. Three-year partnership approach with schools, communities, corporate and sporting organisations. Main programs provide practical approaches to empower and create connections within the community to seek help and support.	Free

			care and support each other for mental health and wellbeing.	• Partnering with local schools to implement a leadership/mentoring program through a four-week workshop. • Sport leadership program includes mentoring aspects and leadership tools to provide a holistic approach to positive mental and physical health. • E-learning as a continued resource to support the workshops	
Fair Game	https://www.fairgame.org.au/what-we-do/	Y	Fair Game uses a holistic approach which combines health education, fitness programs and recycled sports equipment, to reduce the risk of lifestyle related disease, build social cohesion and improve mental well-being. Serving remote and under-serviced communities around Australia including Aboriginal and Torres Strait Islanders and CALD communities.	Four main programs - two that include movement and mental health. • Game On - Fair Gamers are trained to provide a variety of programs based on the unique requirements of each community. These include basketball and AFL based games, dance as well as the NAPCAN award-winning *Wellness Walkabout yoga program,* a culturally appropriate yoga program published in highly endangered Indigenous languages. • Healthy Communities • Recycle and donate • Fair Game academy - unique mix of formal and informal training and development opportunities in Fair Game's sport, fitness, wellness and sports equipment recycling programs. The Academy's program focuses on several key areas including leadership development, communication, teamwork, information technology skills	Free

				and cultural awareness.	
Zero2Hero	https://www .zero2hero.com.au/camp-hero-sports/	Y	Dedicated to increasing the understanding of mental health issues and the awareness of mental health services among children and young people through innovative programs, events, and education. Lived experience underpins all programs, however each session is tailored to the group.	Multiple programs across different sectors such as schools, camps, adventure activities, parents and staff, and annual youth mental health forum. • Workshops in sporting clubs • Sport-specific 3-day and 5-day camp for youth. The camps are designed to increase young athletes (including beginners) health and wellbeing, improve mental and physical strength and develop their leadership skills. • Webinars through COVID-19 on topics driven by youth (e.g. the immune system, staying motivated)	Yes, various depending upon program
Hey Sport, R U OK?	https://www.ruok.org.au/sport	Y	Hey Sport, R U OK? is a campaign to benefit all participants, officials, administrators and supporters across the grassroots sporting community. The first phase of the campaign provides resources and tips for coaches to help them build an R U OK? Target culture to support coaches, athletes and players.	Easy-to-use resources to support clubs to change club culture and create conversations for early intervention. All about supporting each other. Everyone should be a club champion. • Coaches primary focus to start with, resources include a coaches Toolkit and Host a Round resources, plus promotional material • Next stages likely to be directed at other leaders in clubs, such as officials, referees, club managers	Free
WA regional football league (in collaboration	http://wacfl.com.au/programs/sponsored-rounds/think-mental-health-round	Y	Promoting and educating in regional men's senior football clubs on creating sense of belonging and community and creating conversations to build	Currently in its second year and building on the first year of promotion and brand awareness. • Tailored to the community and currently building educative components	Free

with Think Mental Health)			connections for suicide prevention. Main aims are to build capacity of the people in the club and community and for them to reach out to support services when required.	• Acts as a conduit to referral services	
Act, Belong, Commit	https://www.actbelongcommit.org.au/about-us/what-is-act-belong-commit	Y	Promotes simplistic messaging for holistic mental health and wellbeing.	Promotion and partnerships with different sectors, e.g. schools, local governments and community groups. Create partnerships with sporting clubs which includes: • Strategies to promote mental wellbeing • Webinars • Online community • Online resources and some physical resources (e.g. promotional materials such as drink bottles, stickers etc) • Networking and personal development sessions • COVID-19 - blog posts	Free
Men's Outreach Service Aboriginal Corporation (MOSAC) Alive & Kicking Goals	https://mensoutreach.org.au/ https://mensoutreach.org.au/alive-kicking-goals/	N	Provides a range of support services to men, their families and communities in the Kimberley region of Western Australia. Focus on areas of youth suicide prevention (life promotion), family and domestic violence, men's health and wellbeing and a child and youth bike engagement program	Four key MOSAC programs: • Change Em Ways - an Indigenous men's behaviour change family violence program • Men's Health and Wellbeing Program - delivers a range of programs to support men and their families • LifeCycle Youth Connect - operates mobile bicycle repair sessions for young people in targeted communities across the West Kimberley	Unknown

			ALIVE & Kicking Goals! is a multi-award-winning youth suicide prevention project that promotes strong and healthy living. AKG is based in the Kimberley, Western Australia. It aims to reduce the high suicide rate among Aboriginal and Torres Strait Islander youth in and around Broome through peer education workshops, one-on-one mentoring, and counselling. The project is initiated, managed, and led by Aboriginal people in the Kimberley.	• Alive & Kicking Goals Alive & Kicking Goals programs: • Life Promotion Program – an educational DVD developed by local Indigenous women who are now known as the Women's Reference Group. • Alcohol, drugs and tobacco awareness workshops • Men's suicide prevention and awareness – a DVD workshop has 3 main speakers featured in the film, who talk about their experiences with depression, suicide, help seeking and how they dealt with it. • Living Deadly Program – workshops exploring the cycle of grief that is experienced in the Kimberley region, and strategies including goal setting, communication, anger management and emotional intelligence.	

The key themes emerging from interviews with these providers have been collated in relation to each category of the framework (see Phase 4). A summary of findings from interviews is also presented in Phase 4 Findings. In undertaking the market analysis, we additionally identified organisations offering advice and guidance on mental health issues to the community sport sectors. These agencies were identified as only offering this support so were not included in the more detailed analysis of providers documented above. Table 4 provides an overview of these organisations and links to their resources.

TABLE 4: OTHER RELEVANT PROVIDERS OFFERING INDIRECT SPORT SERVICES/PRODUCTS (WA & AUSTRALIA)

NAME	URL	AREA OF FOCUS/SERVICES OFFERED
AFL (various resources, programs, initiatives and projects)	Example: AFL mental health education https://www.afl.com.au/afl-education/mental-health Example: AFL junior mental health program https://www.afl.com.au/news/441504/afl-beefs-up-junior-mental-health-programs	The AFL is committed to ensuring a safe, welcoming and inclusive environment for all people involved in Australian football. To achieve this the AFL will promote the importance of mental health and wellbeing of those within the AFL industry via education resources. Partnership with headspace, education program particularly targeting young players moving towards the professional game, support the next generation of talent. The programs will be tailored to 16 to 18-year-old boys and girls in the NAB AFL Academy, state academy programs and multicultural and Indigenous talents.
AFL Kickstart Indigenous Programs	https://healthinfonet.ecu.edu.au/key-resources/programs-and-projects/1662/	About 90,000 Aboriginal and Torres Strait Islanders participate in Australian football. The Australian Football League (AFL) seeks to use Australian football as the vehicle to improve the quality of life in Indigenous communities, not only in sport, but in the areas of employment, education and health outcomes.
Australian Institute of Sport (AIS)	https://ais.gov.au/health-wellbeing	Dedicated landing page with click through articles, blogs and support. Links to a variety of projects involving elite athletes in community sport: Lifeline Community Custodians at https://ais.gov.au/custodians Bite Back Mental Fitness Training at https://www.ais.gov.au/bite-back Mental health Referral Network (mainly targeting high performance athletes) at https://www.ais.gov.au/mhrn COVID-19 AIS framework for rebooting sport is a three-step plan is a positive step towards the reintroduction of sport and recreation at https://www.ais.gov.au/health-wellbeing/covid-19#ais_framework_for_rebooting_sport
Australian Sports Commission (SportAus)	https://www.sportaus.gov.au	Sport Australia has developed a 'Return to Sport Toolkit' that includes a suite of resources to help sporting organisations get ready to recommence training, competitions and programs in a safe, responsible and low risk manner post COVID-19. Available here https://www.sportaus.gov.au/return-to-sport Also see 'Safe and Inclusive Sport' at https://www.sportaus.gov.au/integrity_in_sport
Better Out than In	http://betteroutthanin.com.au	Developed by the AFL Players' Association, in partnership with its Alumni services, the AFL Coaches Association, MATES in Construction, La Trobe University and Cummins & Partners as part of Beyond Blue's STRIDE Project with donations from the Movember Foundation. Website that includes stories, individual support/advice referrals, actions to support others. Uses sports analogies and set up through sport organisations. Based in Victoria, Australia reach

		through partners.
Beyond Blue mental health sports rounds (e.g. AFL, NRL)	https://www.beyondblue.org.au/get-involved/rugby-league-beyond-blue-round https://www.beyondblue.org.au/get-involved/afl-victoria-i-beyondblue-i-round	Through community partnerships with elite sporting clubs and high-profile events around the country, Beyond Blue is able to deliver its mental health messages to large and diverse populations. Dedicated sports round for mental health awareness raising.
Black Dog Institute hub FFA in partnership with Black Dog	https://www.ffa.com.au/news/introducing-black-dog-institute-hub https://www.ffa.com.au/black-dog-institute	Providing mental health education and support to grassroots football (FFA) community and employees, national team players, directors and stuff by partnering with Black Dog Institute. Utilises Black Dog Institutes resources across digital properties. Uses online resources, tools and apps.
Clearinghouse for Sport	https://www.clearinghouseforsport.gov.au/knowledge_base/high_performance_sport/performance_preparation/athlete_mental_health	Sport and Mental Health online information and facts, includes web links to services for athletes and coaches. High performance athlete focus (knowledge base for performance preparation.
Community street soccer (Big Issue soccer program)	https://www.thebigissue.org.au/community-street-soccer/about/	The heart of Street Soccer is weekly training sessions held across Australia. Participants get together in a safe and non-threatening environment, allowing them to get fit, make new friends and seek support and advice. Support staff also work closely with players, linking them to services that address issues including homelessness, substance abuse, family breakdown and mental illness. For Perth location go here https://www.thebigissue.org.au/community-street-soccer/where-we-play/
Curtin Stadium, Youth Mental Health Program	https://stadium.curtin.edu.au/health-rehabilitation/youth-mental-health/	The program involves a series of one-hour gym-based individualised exercise programs, combining both aerobic, resistance, stretching and relaxation. It's ideal for 17-25 years old with mental health issues, who have a level of readiness to participate in a supervised exercise program.
Department of Local Government, Sport and Cultural Industries	https://www.dlgsc.wa.gov.au/department Sport and Recreation at https://www.dlgsc.wa.gov.au/sport-and-recreation	Promoting participation and achievement in sport and recreation to support a healthy lifestyle for all Western Australians through physical activity. 'Mental health' search yielded some links. COVID-19 support available here https://www.wa.gov.au/government/covid-19-coronavirus
Football West, Aboriginal Soccer Community Program	https://footballwest.com.au	Football West had lots of initiatives and projects, worth further investigation. Old article here https://footballwest.com.au/29873-2/
Game Plan (Australian Cricket Association)	https://auscricket.com.au/gameplan/	GamePlan is the Australian Cricketers' Association's wellbeing and education program. This provides support to members, professional contract holders, ex-players and some others.

Happiness Co.	https://www.happinessco.org	Pre-emptive mental health programs, focused on finding happiness and run in schools, communities and organisations, including sporting organisations, groups and clubs (as workplaces). Offers: 21day Happiness Challenge, motivational/key note speaking, Workplace Happiness program, 1 on 1 Coaching, 10week Happiness Mentorship program, Ambassador Program, Happiness Co Squad - "committed to kindness". Western Australia based.
Headspace Head Coach	https://headspace.org.au/headcoach/	Some of Australia's best athletes share how they train their minds – what are the little or everyday things they do to reach their potential and live fun and fulfilling lives. Old link to WA activity here https://headspace.org.au/headspace-centres/geraldton/are-you-a-coach-or-club-representive-working-with-12-to-25-year-olds/
Institute of Indigenous Wellbeing and Sport	http://www.iiwswa.org.au https://www.facebook.com/InstituteofIndigenousWellbeinganfSports/	The Institute responsibility is to develop partnerships that maximise opportunities for Aboriginal Australians living within Western Australia to participate in sport and recreation in order to produce health, education, social and cultural benefits for individuals and their respective communities.
iNSPIRE Sport (App)	https://www.inspiresportonline.com	iNSPIRE Sport Online provides athletes with the perfect tool to be the best version of themselves. The app gives athletes access to engaging content, that encourages and supports their learnings on topics such as mental and physical health, nutrition, sleep and fatigue, recovery, movement and more.
Mental health charter (sport: Volleyball WA)	https://www.volleyballwa.com.au/uncategorised/volleyball-wa-develop-mental-health-charter/	Incorporating key information as well as signs and symptoms of poor mental health, the charter aims to develop 'an engaged workforce that is mentally and physically safe and healthy.'
Mind Max (App)	https://mindmax.com.au/#home	MindMax is an app to maximise wellbeing and resilience and create a community of fit minds. Funded by Movember Foundation and made in collaboration with AFL players, this free and accessible app empowers you to build, strengthen and maintain a fit mind.
Nyoongar Wellbeing and Sport	https://www.nyoongarsports.com.au	NWS aims do develop partnerships that maximise opportunities for Aboriginal Australians residing in Nyoongar country, to participate in sport and recreation in order to produce health, education, social and cultural benefits for individuals and their respective communities.
Reboot Sport	https://rebootsport.com.au	Website and consultancy service with guides to supporting mental health in sport post COVID-19. Some mention of health and inclusion. Support packages for sale ranging in cost and inclusions. Also offers: writing for grants, links to other organisations, blogs/news – see '4 steps to reboot mental health through sport'.
Movember	https://au.movember.com/	Men's mental health charity that offers a broad range of resources and support. Mental health focus at https://au.movember.com/about/mental-health

Play by the Rules	https://www.playbytherules.net.au	Play by the Rules provides information, resources, tools and free online training to increase the capacity and capability of administrators, coaches, officials, players, parents and spectators to assist them in preventing and dealing with discrimination, harassment, child safety, inclusion and integrity issues in sport. Webinars, blogs, articles, news and other resources to support mental health and wellbeing found at https://www.playbytherules.net.au/search?q=mental+health
Pride Cup	https://pridecup.org.au	Offers education programs and events targeting LGBT+ inclusion in sport. Including: education programs for players, coaches and officials (30- or 90-minute sessions and custom sessions (for varying settings); coordinate events; online information/blogs/posts. Based in Victoria, Australia reach; pride rounds occur in many states including WA.
Pride in Diversity	http://www.prideinclusionprograms.com.au	Pride in Sport is the only sporting inclusion program specifically designed to assist National and State sporting organisations and clubs with the inclusion of LGBTQ employees, players, coaches, volunteers and spectators. Provide face to face education, expert advice with a number of Pride Inclusion programs (e.g. Pride in Health and Wellbeing). Website includes: the world-first Pride in Sport Index (PSI) benchmarks and assesses the inclusion of LGBTQ people across all sporting contexts; membership program; Australian Pride in Sport Awards.
Pukaup	https://www.pukaup.com/pukaup	Collation of mental health provider support website links, offers talks/speaker, podcast, online shop. Based in Victoria, Australia reach.
Shooting Stars (governing body Netball WA) Seven Sisters program*	http://shootingstars.com.au/# http://shootingstars.com.au/shooting-stars-launches-holistic-wellbeing-program/	Shooting Stars is an educational program that uses netball and other vehicles to drive its primary vision of increasing school attendance rates for young Aboriginal and Torres Strait Islander (ATSI) girls living in remote communities and regional towns to 80-90%. Shooting Stars has launched its Seven Sisters program which provides Aboriginal girls and women with opportunities to develop positive social and emotional wellbeing skills and preventative mental health strategies. The ten-week program uses netball as a space to teach participants emotional regulation strategies. The program has been developed in line with Aboriginal concepts of health, which applies a holistic model of connection to seven different spheres of life: culture, land, physical self, mental self, community, family/kinship and ancestors/spirituality.
Smiling Mind	https://www.smilingmind.com.au/smiling-mind-app	A mindfulness app. Also includes: training courses/PD (target teachers, workplace, made to order); resources/resource hub; stories; blogs. In 2012, Smiling Mind and Cricket Australia's Sport Psychology Team partnered to create a specific sports-based meditation program. The program can be found on the Smiling Mind app under programs at https://www.smilingmind.com.au/cricket-australia

State of Mind (NRL)	https://www.nrl.com/community/state-of-mind/	Flagship program 'The State of Mind' Grassroots Program is a four-step recognition process that has been developed in consultation with expert partners.
The Resilience Project	https://theresilienceproject.com.au/sports-clubs/	Broader project but started working with elite level sports clubs including training with players, coaches and admin staff. Offer programs that typically includes presentations for the players, the coaches, administration staff and the player's partners. May have elite focus.
True Sport	https://truesport.com.au	True Sport supports your club to build a happy, healthy and respectful culture by sharing 8 values that should be lived by on and off the field. The resources provided help teams, participants, officials and spectators embrace the values of True Sport to create fun, fair and safe sporting environments for everyone (inclusion and safety focus).
Western Australia Government, Department of Sport and Recreation	https://www.wa.gov.au/service/sport-and-recreation	Participating in sport and recreation activities including camping and caravan services, community recreation facilities and park and reserve permits. Search for 'Mental health + sport' also revealed a number of relevant articles, grants and projects.
Western Australia Institutes of Sport (WAIS), Athlete Wellbeing and Engagement	http://wais.org.au/athlete-wellbeing-and-engagement	WAIS will make decisions and take actions that are at all times considerate of athlete mental and physical wellbeing and safety.

* Identified too late to be included in more detailed analysis of Table 3 programs.

PHASE 3) SURVEY OF SSAS AND SPORTING CLUB PARTICIPANTS

As per details outlined in the method, a survey was sent to all state sporting association representatives and distributed widely via SportWest and SSA mailing lists to reach sporting club members from a range of sports (n = 76) within Western Australia. Representatives from community sporting clubs (*n* = 111) and employees of State Sporting Associations (SSAs) (*n* = 42) commenced the survey (see Figure 1). Of the major participation sports there was no representation amongst SSAs for Cycling or Athletics and there was significant representation from tennis, basketball and rugby league (see Figure 2). Overall the data set represents the voices of a wide spread of SSAs. Amongst community sport participants, athletics, golf, gymnastics, cycling, swimming, triathlon and volleyball were some of the more significant sports not to have member input into the survey (see Figure 3). Baseball and tennis had significant representation from community sport participants and their voice is consequently louder in the findings. Amongst many reasons why people might not respond to a survey, the COVID-19 shutdown may have played a role in response rates. Response numbers may also suggest that for some sporting groups, mental wellbeing provision may not constitute a significant enough priority to warrant input into the survey.

FIGURE 1: SURVEY RESPONDENT BREAKDOWN

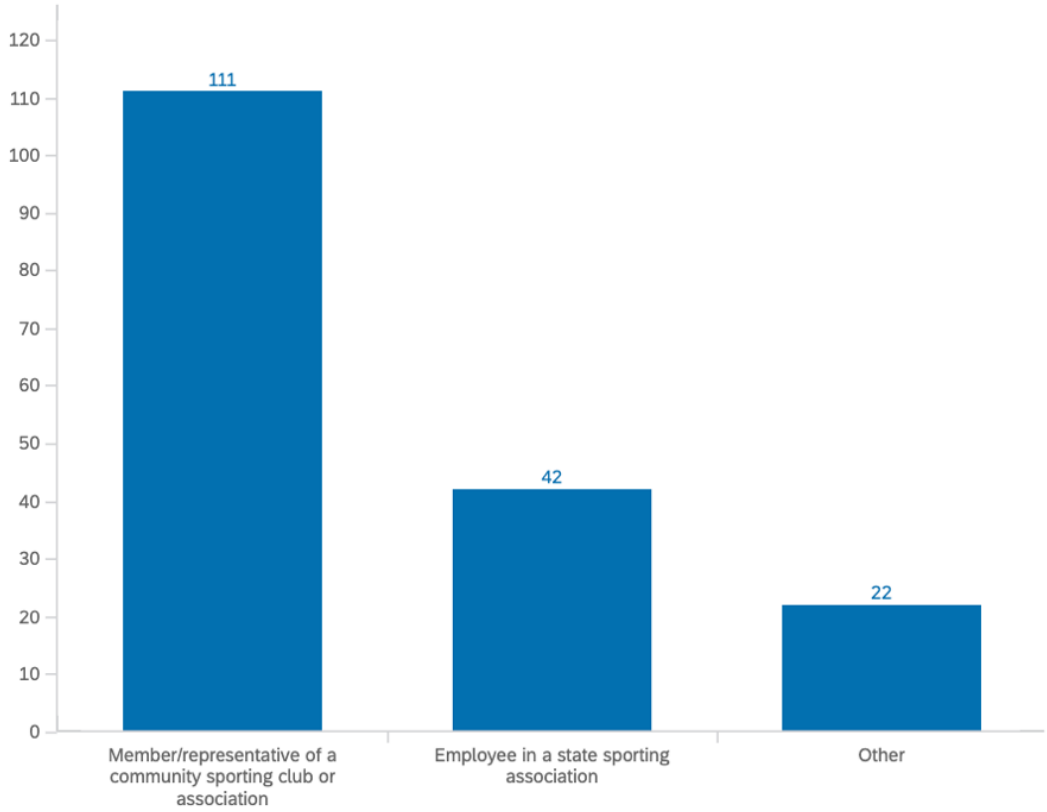


FIGURE 2: NUMBER OF STATE SPORTING ASSOCIATION RESPONDENTS BY SPORT

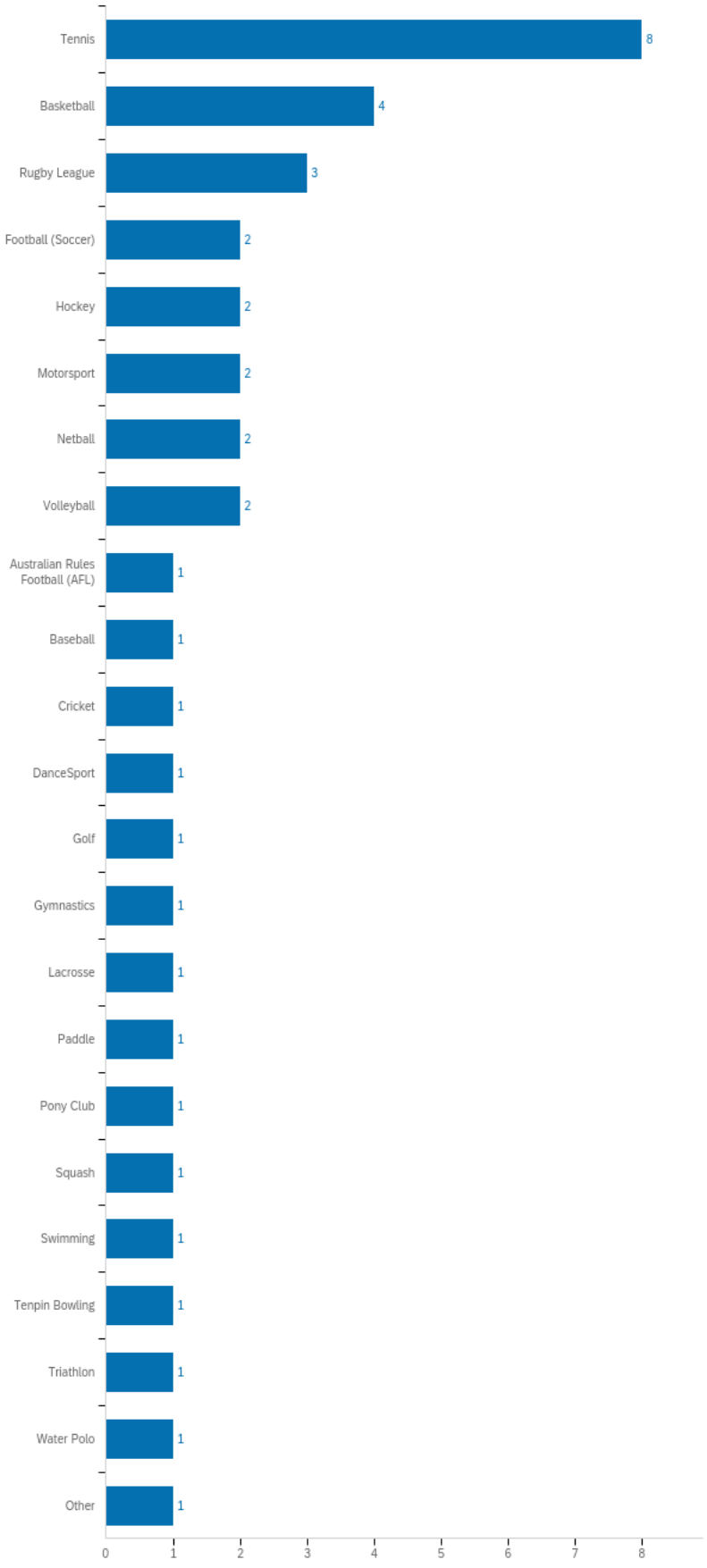
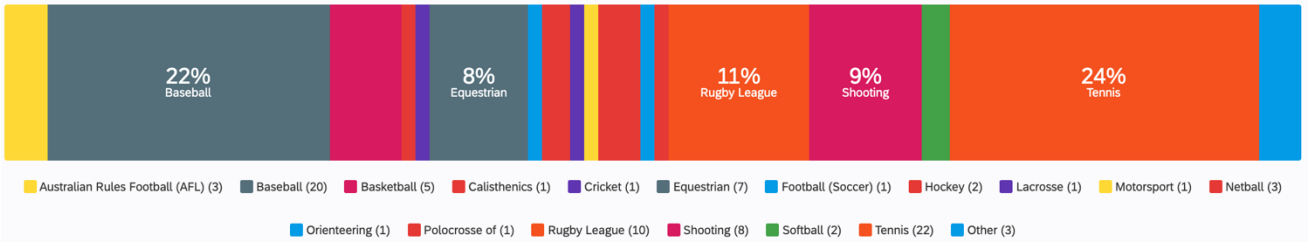


FIGURE 3: SPORTS REPRESENTED BY COMMUNITY SPORT MEMBER RESPONDENTS



SSA participant roles varied and included chief/executive officer/director (n = 12), general manager (n = 7), membership (n = 3), participation (n = 2), business development (n = 1) among other roles. The majority (n = 28) worked state-wide with sporting clubs and groups, some were focused on metro (n = 8), with two focused on regional and three in the 'other' category. Worth noting is that 37 percent of the SSAs who responded, felt their role was in no way connected to the provision of mental health and wellbeing in sporting clubs while 15% suggested it was directly connected.

When asked the question '*How much of a priority is supporting mental health and wellbeing within your sporting association?*', 20% of SSAs suggested it was not a priority at all or a low priority. The majority felt it was a moderate priority (46%) whilst 34% felt it was a high priority. This indicates that the majority of SSAs felt mental wellbeing promotion was of importance to their organisation.

When asked the question '*How important is it for State Sporting Associations to support clubs to promote mental health and wellbeing?*' 25% of the cohort felt it was moderately important whilst 73% felt it was very important with only one out of the 40 respondents suggesting it wasn't important at all. There was no meaningfully difference between those representing team sports (m = 3.84, SD = .38) and those from individual sports (m = 3.5, SD = .76) on level of importance.

An open question was asked about what the SSA did to support mental health and wellbeing in community sporting clubs. Responses are summarised in Table 5. Only 8 of the 42 respondents suggested they partnered with a program provider to deliver mental health and wellbeing programs in clubs. Others shared information, promoted awareness raising days and shared resources. Three suggested they were either embedding MHW into their strategic planning, developing a tailored program or had some sort of framework in place (see Appendix 1 for full responses)

TABLE 5: SUMMARY OF RESPONSES ABOUT WHAT SSAS DO TO SUPPORT MENTAL HEALTH IN SPORTING CLUBS

Response summary	Number of matching responses
Promote and support running sessions with a partner program.	8
Promote national initiatives like R U Ok Day.	5
Provide support on an as needed basis.	4
General sharing of information and resources.	4
Nothing.	3
Webinars, workshops, educational days.	3
Implementing a framework to provide awareness and resources to clubs.	1
Implement mental health within a comprehensive strategic plan.	1

Implement Safe Sport Framework.	1
Develop tailored program.	1
Fundraise for local MHW charities.	1
Respond to critical incidents.	1
Develop club policies.	1
Develop inclusive programs.	1

One hundred and five members or representatives of community sporting clubs were in a range of roles outlined in Table 6. Sixty-four respondents (61%) were in key decision-making leadership roles. Coaches only represented 6% of the sample. Ninety-one percent were volunteers (n = 96). They represented large clubs (n = 31, 30%), medium clubs (n = 50, 48%) and small clubs (n = 23, 22%). The vast majority were from metropolitan centres (n = 76, 73%), small regional centres contributed 13.5% with the remaining from large regional (7.7%) and remote communities (5.8%).

TABLE 6: MAJOR ROLE WITHIN THE COMMUNITY SPORTING CLUB/ASSOCIATION

Field	Choice Count	
President	19%	20
Vice President	4%	4
Secretary	17%	18
Treasurer	6%	6
Committee member	15%	16
Coach	6%	6
Player	14%	15
Parent of a player	6%	6
Other (please describe)	10%	10
Team manager/Administrator	4%	4
		105

Sporting club participants were asked to consider priorities for a range of things that happen in a sporting club on a 4-point scale of low priority, moderate priority, high priority to very high priority (see Table 7). Supporting the mental health and wellbeing of members was the second lowest priority on the list when comparing mean rankings (m = 2.94, SD = 1.25) just in front of 'providing resources to achieve on field success (m = 2.86, SD = 1.10). Importantly, this is still a high rating of priority, but when compared to other tasks, it provides some perspective about where this sits in the pecking order of priorities, particularly given these are predominantly time-poor volunteer participants. Of highest priority was unsurprisingly implementing COVID-19 protocols (m=3.60, SD = 1.4), followed by improving facilities and equipment (m = 3.35, SD = 1.2), recruitment and maintenance of the membership (m = 3.32, SD = 1.15), developing female participation in sport (m = 3.15, SD = 1.38), supporting diversity and inclusion (m = 3.12, SD = 1.34) and managing the scheduling of games (m = 3.07, SD = 1.16). The high priority given to supporting diversity and inclusion is worth noting as this is a protective factor for mental health. Also worth noting, is that promoting mental health and wellbeing is roughly equal to a focus on achieving on-field success. A high focus on performativity can in some instances

add a level of risk for mental health and wellbeing and this suggests people are looking for a balance, that is, they may not want to achieve on field success at the expense of mental health.

TABLE 7: PRIORITIES OF A RANGE OF TASKS WITHIN SPORTING CLUBS

Field	Low Priority	Moderate Priority	High Priority	Very High Priority	Total
Managing the scheduling of games for competition	5.26% 5	26.32% 25	46.32% 44	22.11% 21	95
Recruitment and maintenance of the membership	3.13% 3	17.71% 17	51.04% 49	28.13% 27	96
Implementing COVID 19 protocols	5.26% 5	20.00% 19	29.47% 28	45.26% 43	95
Improving facilities and equipment	3.13% 3	22.92% 22	41.67% 40	32.29% 31	96
Supporting the mental health and wellbeing of members	9.38% 9	31.25% 30	37.50% 36	21.88% 21	96
Developing female participation in sport	10.42% 10	27.08% 26	31.25% 30	31.25% 30	96
Providing resources to achieve on field success	4.17% 4	38.54% 37	40.63% 39	16.67% 16	96
Supporting diversity and inclusion	10.53% 10	24.21% 23	36.84% 35	28.42% 27	95

Sporting club members were asked what their club did to support mental health and wellbeing in an open question. Responses are summarised in Table 8. Popular responses related to providing a point of social contact (n = 29) and creating a welcoming and inclusive environment (n = 16) where they would support regular communication and 'check-in' on members. Nothing was also a common response (n = 17) Of the eight people that mentioned a particular program, the NRL's State of Mind program was mentioned 6 times. Outside of the NRL, there was little in the way of structured support or programs. Community clubs major contribution was to offer a point for social connectedness and belonging which is a strong protective factor for mental health.

TABLE 8: SUMMARY OF OPEN RESPONSES - WHAT MEMBERS DO TO SUPPORT MENTAL HEALTH IN SPORT

Response summary	Number of matching responses
Provide a point of social networking/contact/belonging	29
Nothing	17
Provide a friendly welcoming safe inclusive environment for all people	16
Support/utilise a particular program	8 (6 NRL)
Promotion of mental health days/rounds	6
Support anyone who wants to talk	4
Pass on information	3
Respond to individual need as required	3
Website/telehealth referral	2
Mental health assistance team or dedicated health officer	2
Pamphlets around club	1

When asked '*How confident do you feel about your capacity to support mental health and wellbeing in your club?*' 38.5% participants who responded felt moderately confident. 38.5% of respondents felt not at all confident or only

slightly confident in supporting mental health and wellbeing, suggesting there is room for support, particularly given the significant leadership roles many of these respondents have. 23% felt very confident meaning some clubs may be better positioned to extend their capacity for provision, perhaps beyond what is outlined in Table 8 above.

SSA respondents and sporting club members combined, felt that the most useful modes of delivery for mental health and wellbeing provision in sporting clubs was through a mixture of online and face to face content (m = 3.3, SD = .84), with purely online delivery rated the least preferred mode of delivery on a 4-point scale (M = 2.4. SD = 1.25). There was no real difference in the ordering of preferred modes between SSAs and club members/representatives, with the exception of face to face delivery and podcast/YouTube formats (see Table 9). Members were more likely to prefer face to face while SSAs had a preference for Podcasts and YouTube video content. Of interest was the receptiveness of clubs and members to get help with suggested policies and strategies that they could use in relation to club culture.

TABLE 9: DIFFERENT MODES OF DELIVERY TO SUPPORT MENTAL HEALTH AND WELLBEING (MEAN /4)

Field	State Sporting Association	Member of community sporting club
Mixture of online and face to face content	3.62	3.16
Suggested policies/strategies to impact club culture related to mental health and wellbeing.	3.26	3.06
Social media and web-based content	3.18	2.97
Only face to face content	2.81	2.84
Case-studies of scenarios and best practice responses	3.09	2.77
Hardcopy print resources and materials to distribute at clubs	2.85	2.61
Podcasts and YouTube video content	3.00	2.49
Other (please add anything else)	3.00	2.38
Only online content	2.59	2.30

Combined, both SSA representatives and community sport club representatives felt a one-off guest speaker (someone from sport) who had worked through a mental health challenge/issue was the most preferred format for supporting the provision of mental health and wellbeing in sporting clubs (M = 3.2, SD = 0.89) (see Table 10). The least preferred across both groups by mean score (4 – point scale) was a series of scheduled sessions with a qualified facilitator (M = 2.2, SD = 1.44). When looking at results for SSA representatives and community club representatives separately, we see that SSAs are generally favourable towards all formats (see Table 11). Community sport club representatives however have a clearer preference for the one-off guest speaker from the sporting sector who has worked through a mental health challenge/condition. Of note, was club representatives were slightly more receptive to a comprehensive whole of club strategy (M = 2.79, SD = 1.08) in comparison to other formats. They least preferred a series of scheduled events with a qualified facilitator (M = 2.57, SD = 0.99).

TABLE 10: USEFULNESS OF FORMAT FOR SUPPORTING MENTAL HEALTH AND WELLBEING IN SPORTING CLUBS

#	Field	Not useful	Slightly useful	Moderately useful	Very useful	Total
1	One-off guest speaker/s with expertise in mental health and wellbeing	4.51% 6	28.57% 38	34.59% 46	32.33% 43	133
2	One-off guest speaker/s from sporting sector who have worked through a mental health challenge or condition	5.26% 7	15.79% 21	32.33% 43	46.62% 62	133
3	A series of scheduled sessions with a qualified facilitator	12.03% 16	24.06% 32	33.08% 44	30.83% 41	133
4	A comprehensive whole of club inclusion and mental health strategy developed over 12 months.	12.03% 16	19.55% 26	30.08% 40	38.35% 51	133
5	Other (please add anything else)	55.56% 10	5.56% 1	0.00% 0	38.89% 7	18

TABLE 11: USEFULNESS OF FORMAT BY SSA AND COMMUNITY SPORT REPRESENTATIVES

Field	SSA Rep (mean)	Community Rep (mean)
One-off guest speaker/s from sporting sector who have worked through a mental health challenge or condition	3.47	3.12
A series of scheduled sessions with a qualified facilitator	3.44	2.57
One-off guest speaker/s with expertise in mental health and wellbeing	3.32	2.74
A comprehensive whole of club inclusion and mental health strategy developed over 12 months.	3.24	2.79

Reach and Evaluation of Providers

Participants were asked to identify from a list of providers the ones they were familiar with. More than one response was allowed (see Table 12). The most popular response was ‘none of these’, particularly from community sporting club members. This suggests many of the programs are not known to many club representatives (leadership represents 61% of the sample). The Good Sports program was recognised by 43 respondents. This program has a focus on changing club cultures with a primary focus on drugs and alcohol. They do have a specific program on mental wellbeing called ‘Healthy Minds’ and they work with club leadership and can provide be face-to-face or online delivery. Fair Game was recognised by 25 respondents and offers four core programs, two of which have a focus on mental health. Zero2Hero was recognised by 23 respondents and has a focus on increasing the understanding of mental health issues and awareness of mental health services among children and young people. Other programs that had modest reach were Stitch in Time and Outside the Locker room listed in Table 12.

The NRL’s State of Mind program was highly visible within NRL clubs, suggesting the NRL’s promotion/awareness strategy is effective (10 community respondents to the survey). When considering where community clubs are located, we can see that most of the programs had reach in the metropolitan areas with less visibility in rural and remote communities (see Table 13). Amongst SSAs, representatives from AFL, basketball, soccer, golf, hockey, netball, rugby, tennis, triathlon and volleyball were most likely able to recognise one or more of the programs on offer. Seven of the 10 of these are team-based sports. Community representatives from AFL, basketball, baseball, equestrian, hockey, netball, rugby and tennis had the highest awareness of programs, again mostly team-based sports. 10 of the presidents of clubs said they were not familiar with any of these programs.

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TABLE 12: RECOGNISED PROVIDERS OF MENTAL HEALTH AND WELLBEING PROGRAMS

#	Field	State Sporting Association	Member of Community Sporting Club	Other	▲ Total
1	None of these	4	39	8	51
6	Good Sports	18	24	1	43
12	Fair Game	13	11	1	25
14	Zero2Hero	10	9	4	23
11	Stitch in Time Project	11	9	1	21
15	Outside the Locker Room	10	7	2	19
3	State of Mind (NRL)	4	11	1	16
8	Good Chat Foundation	9	3	2	14
18	Happiness Co.	7	2	2	11
17	Game Changers	6	3	1	10
7	Bouncing Back	5	3	1	9
23	Ahead of the Game	3	4	0	7
2	Tackle Your Feelings	3	3	0	6
16	Alive and Kicking Goals	2	4	0	6
22	Other	2	2	0	4
13	Sport and Life Training (SALT)	0	2	1	3
9	Orygen	0	0	1	1
24	Love Me Love You	0	1	0	1

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TABLE 13: RECOGNITION OF PROGRAMS BY LOCATION

#	Field	Metro	Large regional centre	Small regional centre	Remote
1	None of these	24	3	10	2
6	Good Sports	19	2	2	1
3	State of Mind (NRL)	11	0	0	0
12	Fair Game	8	1	2	0
14	Zero2Hero	8	0	1	0
11	Stitch in Time Project	8	1	0	0
15	Outside the Locker Room	5	1	1	0
16	Alive and Kicking Goals	3	1	0	0
23	Ahead of the Game	1	2	0	1
2	Tackle Your Feelings	3	0	0	0
8	Good Chat Foundation	2	0	1	0
17	Game Changers	2	0	1	0
7	Bouncing Back	3	0	0	0
22	Other	1	0	0	1
13	Sport and Life Training (SALT)	2	0	0	0
18	Happiness Co.	2	0	0	0
24	Love Me Love You	1	0	0	0
9	Orygen	0	0	0	0

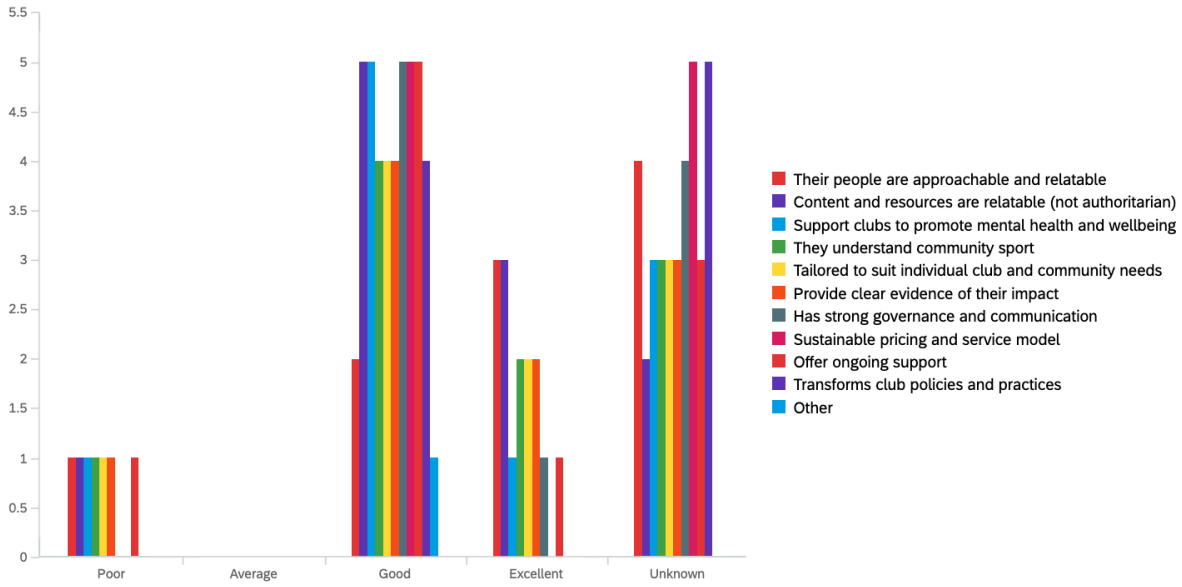
The question of which programs have been utilised by SSAs and community sporting clubs was answered. Again, 'none of these' was the top response (see Table 14). Twelve of the 16 programs presented to respondents had been utilised in some way or another by SSAs or clubs. Good Sports and the NRL program State of Mind and Fair Game seemed to have the biggest utilisation. State of Mind figures reflect the number of respondents from Rugby League, given State of Mind is single sport focused. The rest of the programs had single figure utilisation amongst SSAs and clubs.

TABLE 14: PROGRAMS THAT HAVE BEEN UTILISED BY SSAS OR SPORTING CLUBS

Field	State Sporting Association	Member Community Sporting Club	▲ Total
None of these	14	22	38
Good Sports	8	14	22
State of Mind (NRL)	3	10	14
Fair Game	2	4	6
Other	4	0	4
Outside the Locker Room	1	1	3
Good Chat Foundation	1	1	3
Zero2Hero	0	1	2
Stitch in Time Project	1	1	2
Tackle Your Feelings	1	0	1
Happiness Co.	1	0	1
Alive and Kicking Goals	0	1	1
Ahead of the Game	0	1	1
Sport and Life Training (SALT)	0	0	0
Orygen	0	0	0
Love Me Love You	0	0	0
Bouncing Back	0	0	0

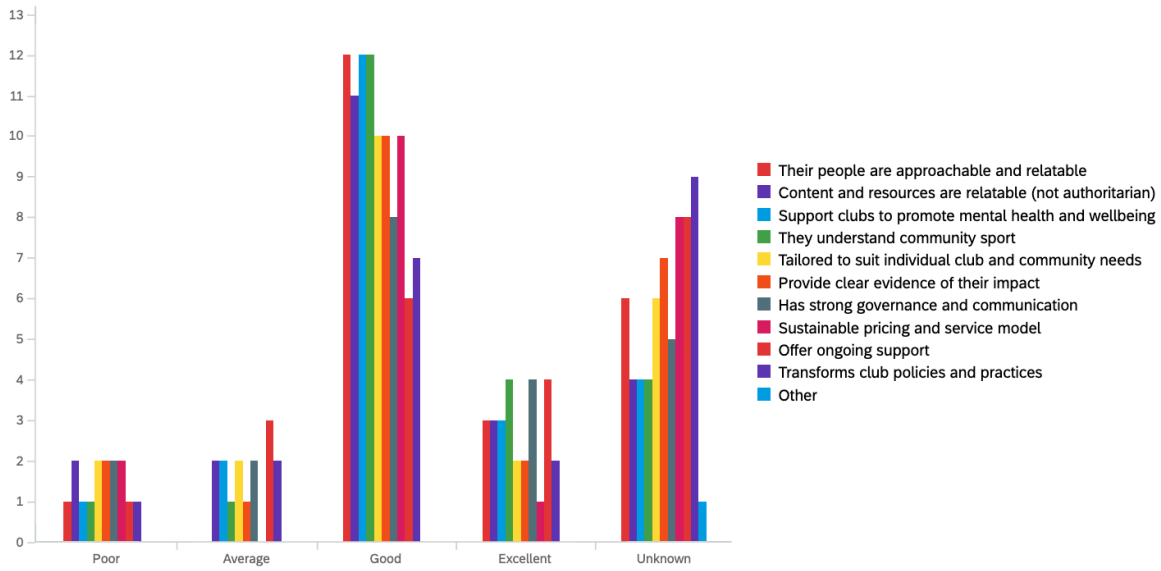
SSA employees, club participants and those who identified as ‘other’ (not shown in previous table) AND who had indicated they had utilised one or more of the listed programs, were asked to rate the quality of these programs against a range of criteria drawn from a set of ‘best practice’ criteria (O’Connor, et al., 2020). Most participants felt they did not know enough about the programs to be able to rate them on the criteria, with ‘unknown’ being the most or among the most popular response. Programs that had 4 or more responders review the program are presented here in tables 15, 16 and 17 (i.e. they had utilised the program and did not select ‘unknown’ as a response option). Only three providers were able to be reviewed, suggesting that for the majority who completed this survey, little is known about the details of what providers offer in relation to the criteria. Collectively, this data suggests the market is relatively naive to program providers and what they offer. For the three that were reviewed, SSAs and RSAs rated the provision by providers as Excellent or Good for the majority of the categories. Modest concerns centred around the tailoring of the program, the sustainability of the pricing and service model, ongoing support and the capacity of the initiative to develop sector skills and knowledge. The provider names have been replaced with randomly generated numbers to protect the identity of these providers.

TABLE 15: PROGRAM NO. 2



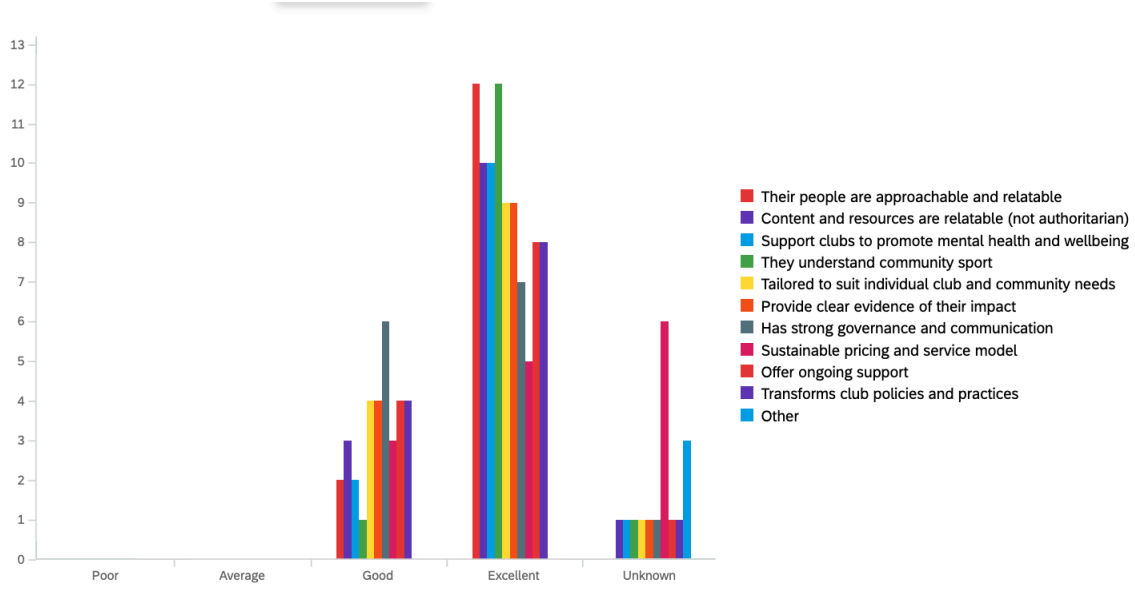
Field	Poor	Average	Good	Excellent	Unknown	Total
Their people are approachable and relatable	10.00% 1	0.00% 0	20.00% 2	30.00% 3	40.00% 4	10
Content and resources are relatable (not authoritarian)	9.09% 1	0.00% 0	45.45% 5	27.27% 3	18.18% 2	11
Support clubs to promote mental health and wellbeing	10.00% 1	0.00% 0	50.00% 5	10.00% 1	30.00% 3	10
They understand community sport	10.00% 1	0.00% 0	40.00% 4	20.00% 2	30.00% 3	10
Tailored to suit individual club and community needs	10.00% 1	0.00% 0	40.00% 4	20.00% 2	30.00% 3	10
Provide clear evidence of their impact	10.00% 1	0.00% 0	40.00% 4	20.00% 2	30.00% 3	10
Has strong governance and communication	0.00% 0	0.00% 0	50.00% 5	10.00% 1	40.00% 4	10
Sustainable pricing and service model	0.00% 0	0.00% 0	50.00% 5	0.00% 0	50.00% 5	10
Offer ongoing support	10.00% 1	0.00% 0	50.00% 5	10.00% 1	30.00% 3	10
Transforms club policies and practices	0.00% 0	0.00% 0	44.44% 4	0.00% 0	55.56% 5	9
Other	0.00% 0	0.00% 0	100.00% 1	0.00% 0	0.00% 0	1

TABLE 16: PROGRAM NO. 13



Field	Poor	Average	Good	Excellent	Unknown	Total
Their people are approachable and relatable	4.55% 1	0.00% 0	54.55% 12	13.64% 3	27.27% 6	22
Content and resources are relatable (not authoritarian)	9.09% 2	9.09% 2	50.00% 11	13.64% 3	18.18% 4	22
Support clubs to promote mental health and wellbeing	4.55% 1	9.09% 2	54.55% 12	13.64% 3	18.18% 4	22
They understand community sport	4.55% 1	4.55% 1	54.55% 12	18.18% 4	18.18% 4	22
Tailored to suit individual club and community needs	9.09% 2	9.09% 2	45.45% 10	9.09% 2	27.27% 6	22
Provide clear evidence of their impact	9.09% 2	4.55% 1	45.45% 10	9.09% 2	31.82% 7	22
Has strong governance and communication	9.52% 2	9.52% 2	38.10% 8	19.05% 4	23.81% 5	21
Sustainable pricing and service model	9.52% 2	0.00% 0	47.62% 10	4.76% 1	38.10% 8	21
Offer ongoing support	4.55% 1	13.64% 3	27.27% 6	18.18% 4	36.36% 8	22
Transforms club policies and practices	4.76% 1	9.52% 2	33.33% 7	9.52% 2	42.86% 9	21
Other	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 1	1

TABLE 17: PROGRAM NO. 14



Field	Poor	Average	Good	Excellent	Unknown	Total
Their people are approachable and relatable	0.00% 0	0.00% 0	14.29% 2	85.71% 12	0.00% 0	14
Content and resources are relatable (not authoritarian)	0.00% 0	0.00% 0	21.43% 3	71.43% 10	7.14% 1	14
Support clubs to promote mental health and wellbeing	0.00% 0	0.00% 0	15.38% 2	76.92% 10	7.69% 1	13
They understand community sport	0.00% 0	0.00% 0	7.14% 1	85.71% 12	7.14% 1	14
Tailored to suit individual club and community needs	0.00% 0	0.00% 0	28.57% 4	64.29% 9	7.14% 1	14
Provide clear evidence of their impact	0.00% 0	0.00% 0	28.57% 4	64.29% 9	7.14% 1	14
Has strong governance and communication	0.00% 0	0.00% 0	42.86% 6	50.00% 7	7.14% 1	14
Sustainable pricing and service model	0.00% 0	0.00% 0	21.43% 3	35.71% 5	42.86% 6	14
Offer ongoing support	0.00% 0	0.00% 0	30.77% 4	61.54% 8	7.69% 1	13
Transforms club policies and practices	0.00% 0	0.00% 0	30.77% 4	61.54% 8	7.69% 1	13
Other	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 3	3

The survey concluded with three open questions probing what the most important challenges for community sport clubs in mental health and wellbeing were, what support people need to deliver mental health and wellbeing programs and anything else you would like to tell us about sporting clubs and the delivery of mental health and wellbeing programs. Open ended responses are summarised in Tables 18, 19 and 20 below and presented in full in Appendix 1.

Many responses signalled the limited time, energy and or resources volunteers and the wider membership could put towards mental health and wellbeing provision. One respondent suggested that clubs are “run and operated by volunteers for the purpose of providing tennis, not mental health and wellbeing support. It’s an unfair impost for volunteer operated clubs to provide these types of services.” And there was this statement: “Clubs are run by volunteers with families and jobs so the biggest challenge is the capacity of volunteers to take on more time-sucking responsibilities”. Some respondents felt it was difficult to get members to confide in them or ‘open up’ to people in the

club so they could be offered support. One respondent suggested it was difficult “obtaining the understanding from a member that the club is interested in their mental health and wellbeing without appearing intrusive”. This suggests a lack of awareness around strategies that might encourage communication (reduce stigma) through implementing protective and prevention measures. Many respondents were able to articulate the importance of ‘stigma’ around mental health issues suggesting they were tuned-in to a significant risk. Cost, time and resources were challenges mentioned consistently. The idea of apathy, a lack of priority or even acceptance among members to focus on mental health was mentioned on a number of occasions with two respondents suggesting:

> **Respondent A**: I think most members see mental health and wellbeing as a biproduct of club membership. If connections are strong and trust developed, then support of members struggling with mental health issues comes naturally. I suspect most of our members would not attend information sessions on mental health provided by 'outsiders'.
>
> **Respondent B**: Most players see sport as enjoyable recreation, so it's difficult to expect players, parents etc. to spend more time at clubs discussing a serious issue.

A number of respondents identified the tensions that can exist within sporting clubs around mental health. Some cited a poor culture, a focus on performance and technical ability over welfare, a focus on the ‘top performers’ and a lack of support for young people who are cut from representative teams.

With regards to needs, many outlined they required access to quality programs and presenters. There was again an acknowledgement of the costs associated both financially and in time of implementing quality programs. One participant noted:

> The management committee spends no time considering mental health, as volunteers we spend significant time on the practical aspects of the operations and maintenance of the club so any such programmes would need to be easy to deliver and not require significant input from the committee. (respondent)

Appropriate funding to drive education and training was mentioned a number of times. One respondent suggested that clearly understanding the benefits or impacts of these programs would be an important consideration before investing significant time and effort into implementing them. This signals the importance of providers collecting evidence of their impact in order to demonstrate benefits for time and money invested.

Many spoke about being provided with resources and materials both in print and online to raise awareness, with one respondent suggesting “it needs to be SEEN (posters / social feeds) before people are willing to TALK”. Something ‘simple and easy to implement’ was also a common thread. A smaller number felt the size of their club, the social nature of their participation or that money would be better spent on lower fees and better facilities, made support unnecessary.

When asked if there was anything else they wanted to contribute, members responded in a range of ways. One member lamented the erosion of social spaces and opportunities to connect in sport when they said:

> Creating inclusive environments at a club and association level i.e. more than just fast food sport. Design facilities with club rooms, social areas that invite people and children to connect. The social component of facilities is non-existent in some sports and tacked on in others. Develop an inclusive community facility that supports networking and is not just about money for administrators or associations to fund mid tear competition for adults (state leagues). I get really annoyed at the lack of investment in the social level of sport. It provides the largest health and economic benefits to the community and the funding continually is driven away from the grassroots. Sport has the capacity to connect and sport clubs and associations need to change what they see as their core business to include the social and inclusion components.

There was a sense amongst three respondents that smaller regional clubs were isolated. They 'need to be able to interact with similar clubs and the parent associations need to be able to facilitate regional/zone…events to assist in this'. A summary of comments is provided in Table 18. All participant responses for these three open questions are provided in Appendix 1.

TABLE 18: IMPORTANT CHALLENGES CONFRONTING COMMUNITY SPORTING CLUBS AND MHW PROVISION

Challenge	No of respondents
Volunteer burn-out / time-poor volunteers (capacity and capability)	27
Funding and resources	20
Stigma	15
Apathy around mental health - not seen as a priority by membership in a sporting context	12
Training/education/knowledge/confidence of volunteers (how to recognise, where to start, where to send people for help if required)	13
Having people communicate/creating conversations so help can be offered	11
Member participation, interest and involvement (happy to be recipients of info but not change agents).	7
Relevant resources that can be delivered in a variety of ways - Relatable data and relatable case-studies (interactive and fun ways to deliver)	7
Facilitator/Agency availability and deliverer access and maintenance	6
Poor culture and nepotism	4
Elite/technical performance focus vs athlete welfare (coaches as asset and threat, no support for young people cut from teams)	4
Inclusion	2
Sustainable support frameworks – embedding it in 'who we are' not as an add-on.	2
Targeting the right audience to attend sessions and programs	2
Diverse communities (diverse ages)	2
Passing on knowledge to family members	1
Young people not joining sporting clubs – they miss out on connectedness	1
Access to rural and remote communities	1
Getting club leadership to actively promote amongst their communities	1
Why assume this is a challenge?	1
COVID-19	1

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TABLE 19: WHAT SUPPORT IS NEEDED TO DELIVER MHW PROGRAMS?

Supports	No of respondents
Access to quality providers and speakers	27
Materials, handouts, online resources	18
Funding	12
Training/education (offset financially) - focused on coaches (2)	11
Time to organise	5
Support from leadership/committee	4
Easy to implement	4
Cultural/inclusion awareness	2
Nothing	3
Policy guidance	1

TABLE 20: ANYTHING ELSE YOU WOULD LIKE TO TELL US?

Anything else
Focus on wellness not just illness – focus on resilience
Nothing
Needs to come from the top down via state bodies to clubs
Get more people to join clubs
Measurable outcomes from implementing such programs (what is the benefit?)
Clubs are part of the answer, build on developing the social aspects of clubs
Appropriate scheduling (people are busy)
One program that can be utilised across all sports for continuity of messaging and cut through.
The task is ongoing and the message to be continuously reinforced
There does seem to be a lot of service providers. Maybe having an idea of the best suited to sport would assist in knowing who to contact for assistance in first place.
It is hard enough to find sponsors, volunteers and players to keep the club going. This will need to be managed externally to really have the impact required.

PHASE 4) KEY FINDINGS FROM THE INTERVIEWS

Table 21 provides a summary of the findings of programs against the criteria for 'best practice' in the provision of mental wellbeing programs in sporting clubs. Following this table is a dot-point summary of the key findings from interviews with providers.

TABLE 21: SUMMARY OF ALIGNMENT WITH THE FRAMEWORK AREAS

(Based on Analysis of interview data with program providers)

FRAMEWORK CRITERIA	OVERARCHING OBSERVATIONS
PROGRAMS ARE PART OF A STRATEGIC FRAMEWORK	
Program has explicit ties with an established overarching mental wellbeing framework.	Programs mostly connect to frameworks supported by external, large, well established mental health organisations, such as Beyond Blue and Orygen. Some discussed drawing on an academic literature base. Several of the programs are reliant on the mental health professionals they work with to bring this expertise, such as psychologists. Across many programs this was not an aspect that was articulated clearly other than to refer back to the overarching organisations. Most focus on the promotion and increasing understanding of mental health within the work they undertake so tend to target one level of broader strategic frameworks. Generally, the programs discussed a lack of coordination in the mental health and community sport space and a disconnect between themselves, sporting organisations, community associations and leagues.
Program uses language and approaches consistent with established MWP frameworks.	All programs emphasised the importance of using relatable language in sports clubs, such as limiting the use of jargon. There was minimal discussion of issues with interchangeability or terms like mental health, wellbeing or consideration of the language that might be being used in other settings (e.g. schools, workplaces).
Programs underpinned by well-established models/theories of mental wellbeing provision.	Most programs have been developed in consultation with a range of mental health experts, who draw on their knowledge of models and established practice. There are varying levels of ongoing involvement by experts, some were used only in the initial design, and others offer continued support and guidance. Programs have input/influence from any/a number of the following: psychologists, mental health practitioner (i.e. mental health nurses, counsellors), youth workers, social workers, teachers, educators. Each bring unique expertise, but most programs have only consulted with one of these professionals, a psychologist being the most discussed. Discussion on models/theories was limited, with few organisations being able to articulate the precise models/theories they explicitly drew on. Some providers raised the issue of avoiding responding to particular mental health 'fads' and trying to ensure that what they did draw on and practices they advocated for were supported by the mental health experts they were associated with.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	The focus is predominantly on the individual, although most programs have multiple foci. Programs involved supporting positive mental health and increasing knowledge of support and help seeking behaviour in the individual, whilst also assisting 'others' to provide this guidance (parents, coaches, committee members). Some programs, but not all, address issues of culture, inclusion and their relationship with mental health. Examples included tailoring of

	content for Aboriginal participants, addressing gender relations, masculinity, women's empowerment and the impact of negative club cultures such as drug and alcohol use and exclusionary practices (e.g. coaches encouraging players to harden/toughen up). Limited programs address the policy layer but some encourage clubs to develop a mental health strategy and encourage them to look at how they embed positive mental health practices as part of their everyday club operations. Having committee members in this stage was integral. None explicitly focused on social media use and relationships with mental health, although most programs utilised social media to promote support, raise awareness or create an online community (especially during Covid-19). Programs have particularly different scopes. Several offer a broad breadth of services across education, referral pathways, training at multiple levels of the clubs whereas others are much more niche and focused in their offering, i.e. only working with volunteers and coaches, only working with young people, only working with coaches.
Program utilises well-resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Most programs drew on a range of expertise in their construction and delivery. Across several there is a personal drive from one key individual in the organisation that shapes and influences what and how resources and support are developed (e.g. ex-elite athletes who have experienced mental illness) but this is always supported by guidance from experts. Most had a number of facilitators that received training from the organisations and most recruited facilitators that had expertise in the areas of education, youth work, community development and mental health. Some programs were co-delivered with a facilitator and mental health expert (e.g. psychologist). Programs which were more established were reviewed regularly based on participant feedback and also changes within the sector, their mental health partners were important for supporting updates in content and focus based on latest research and evidence. Some providers were in the pilot stages of program delivery (e.g. first months/year) and therefore were still developing their content and had very small teams of facilitators (e.g. one or two people with personal experience or trained in mental health).
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Most providers discussed tailoring programs to community needs, three providers explicitly stated that they developed initiatives in consultation with local and Aboriginal populations and professionals working in Aboriginal health services to ensure that culturally appropriate programs are designed and provided to meet the needs of local Aboriginal populations.
Initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Five providers specified they worked in regional and/or rural and/or remote Western Australia, and most of these organisations worked in consultation with local health services and community organisations. For example, one provider asked the local mental health services to attend a BBQ that the local sports community holds to raise awareness of mental health. Only one provider discussed working with rural/remote Aboriginal communities specifically and bringing holistic health and wellbeing to the small communities. This provider discussed that in some areas, such as the Pilbara, they did not want to over-burden at capacity mental health providers, so although they consulted with them, they were cautious of not exhausting the limited health provision available.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	This was done in different ways by organisations, however all viewed personable, approachable and relatable voices as critical. For some programs the quality and consistency of the messaging was paramount. Some organisations recognised the value of having an elite level sporting figurehead, who had personal experiences of mental illness to act almost as a storyteller and initial engager. This seemed particularly valuable when working with male teams as a relatable figure. Others were critical of this approach and suggested that it was problematic in the mental health context. Others drew on facilitators who were trained by the organisation but lived in the local community so were

	perceived to be relatable and approachable. Programs emphasised it was important not to overly medicalize sessions, as such, whilst psychologists and mental health practitioners often supported the sessions, they rarely delivered the full program because it was felt they wouldn't always be relatable in this context. One provider utilized a dual approach of having an ex-athlete and a psychologist co-delivering programs, which they found to be highly effective to get a personable and relatable approach, with evidence and tangibility to support it (e.g. the psychologist). Programs working with young people stressed the importance of having facilitators who were skilled at engaging and supporting young people, emphasising that this did require a different skill set. A number also highlighted the importance of having men and women able to facilitate, suggesting that female teams often preferred women facilitators.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Most programs do this but in different ways. A number discussed how initially it was often challenging to engage with clubs and particularly parents who didn't consider that mental health was an issue amongst members at the club. However, the general rising awareness of youth mental health issues and several clubs directly impacted by youth suicide, has resulted in clubs proactively seeking out organisations. Covid-19 has also increased the discussion of mental health within community and clubs and most organisations discussed being busy during the Covid-19 period, except those who had just started and had not gained any traction. Most programs work with club committees to ensure there is commitment from the club overall to supporting positive mental health, a number insist that committee members and leading figures in the clubs such as captains, head coaches, club president's etc. have to be part of the training and key advocates for the program. There is usually the identification of key individuals in the club who will be a point of contact for mental health related issues moving forward.
Program has clearly stated goals or outcomes.	All programs have specific goals but can be vague and vary across the programs. Primary goals focus around raising awareness of mental illness, strategies for positive mental health, challenging stigma, equipping coaches and volunteers with the confidence and skills to support positive mental health, identify mental health challenges, refer players to support, improving the mental health of club members and equipping participants with techniques to support and champion their mental wellbeing. Other objectives included supporting clubs to build inclusive cultures and address negative cultures. The overarching goals can be aligned to three key areas, raising awareness, improving knowledge and understanding and changing attitudes.
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs, i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program.	There were a multitude of delivery formats and methods, such as website, text-based resources and fact sheets, face to face delivery, online module delivery, webinars, short bits of information and awareness raising provided through social media, podcasts and several also have Apps to support individuals. The educational components of program emphasised an interactive delivery style, and not just a facilitator presenting, but engaged participants in discussion, was tailored to their specific context and often scenario based. Education sessions were usually delivered in larger groups for 45 minutes to an hour after club training. There were limitations of what could be done in this time, which the programs recognised, however referred to the online support as something that participants could return to. Two programs offered referral support services where they offer direct mental health support to participants in need, one of whom were not yet able to 'kickstart' their programs. Participants self-identify and the organisation's psychologists and counsellors then work with them on an individual basis to refer them to other support services in the community. One program worked with mental health professionals (psychologists/psychiatrist) to identify young people who could

	use sport as a setting to improve their physical and mental wellbeing, with ongoing treatment and support from the mental health professional. Only some programs return to clubs, although the issue of turnover of players, coaches and volunteers was noted. Not all programs explicitly tailor for cultural diversity, Aboriginal participants or other aspects of diversity. Programs are tailored for youth/adult cohorts with youth often split into young teens and older teens. Programs are also tailored for coaches specifically or other adults (players/parents/non-coaching volunteers), or cohort specific such as programs designed for men.
Program is targeting different cohorts both within and beyond sport clubs.	Programs have different target audiences' different cohorts, with some programs focusing on a singular cohort (e.g. coaches) and others focusing on different cohorts (e.g. youth, parents and volunteers). All providers recognised the importance of adaption to meet their respective cohorts needs. As mentioned, there isn't always evidence of tailoring to ensure the program reflects aspects of diversity. There is also limited connection beyond the club, some programs either work with or have tried to work with state leagues as a platform to connect with clubs but few have worked with sporting associations directly, they are generally club focused. It was noted by some that they would like to work with sporting associations and organisations to support and facilitate more training in mental health and wellbeing in sport.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicate, for Aboriginal people.	Some of the programs had the capacity to adapt and deliver effectively in rural and remote contexts, however less providers discussed adapting their program for Aboriginal people. As mentioned, most providers discussed tailoring programs to suit the cohort or population which it is intended for, however, how this would be done in rural/remote populations and with Aboriginal populations was not stated by most of the providers. One provider did discuss wanting to better understand the rural/remote population with more context possibly provided by Healthway.
Intervention components	
Program has clearly stated outcomes and content is consistent with them	The content and focus of programs were aligned with the core focus of organisations around awareness raising and improving knowledge, although some of the programs had vague outcomes. Where programs were seeking to shift attitudes, there was little evidence of strategies, beyond education, that might achieve this.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	The organisations who provide education ensure that they use appropriate ways to raise awareness of and promote mental wellbeing. Key leaders (e.g. committee members, coaches and captains) were viewed as important to continue to advocate for and promote mental health initiatives. Awareness was also raised through social media sites.
Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues)	All organisations had a comprehensive understanding of the community sport settings and the challenges of this context for supporting positive mental health. These ranged from identification of exclusionary cultures within community sport, the damaging forms of masculinity associated with some forms of community sport, and other damaging health behaviours associated with certain sports. They also suggested that whilst there were aspects that would negatively impact on the mental health of participants, the sports club was often a context of connection within the local community so recognised its power as a platform to raise awareness and increase knowledge. At a practical level, most programs highlighted some of the challenges of working with a volunteer base, the turnover of coaches, volunteers and players, making sustainability and embedding of practices difficult.

Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Inclusive language and careful use of mental health terminology was important to all organisations to avoid terms that further stigmatise/marginalise individuals experiencing mental illness.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language)	Most organisations tailor their program to suit local requirement and local need, they work with clubs in the preparation of programs to draw on specific aspects and will ensure that education for example is personal to that particular club. This is important particularly when working with clubs who have experienced suicide amongst their membership. Several conduct surveys with club members prior to delivering whilst others meet with committee members to gain an understanding of the specific requirements of the club and any existing issues that they may be aware of.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	Most of the programs who have adapted their content to support Aboriginal participants have done so in consultation with local Aboriginal organisations and health providers to ensure they are culturally appropriate. This was not discussed by all programs, and considering the limited programs delivering specifically to rural/remote areas and Aboriginal persons, there may be missed opportunities by some of the providers to understand these contexts and integrate into their program delivery.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Most organisations have received guidance from larger mental health organisations (e.g. Beyond Blue, the WA Mental Health Commission) and refer sporting clubs and members to these organisations for more detailed support and help. There were limited examples of the organisations we spoke with working collaboratively potentially missing opportunities that partnership work can bring.
Evaluation and Efficacy	
Measures are clearly aligned with stated program outcomes and program content	There was a mixed level of evaluation across programs, some had undertaken no evaluation at all, and others were in the process of undertaking fairly robust evaluation involving external organisations and pre-post intervention data collection. Some collected post education evaluation questionnaires but this was highly mixed. Two programs had undertaken extensive research examining their approaches, including undertaking a randomized controlled trial. Some programs used mainly qualitative responses, such as verbal feedback from sporting club members or using their intuition to know whether a program or session is running well.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes	Only a small number of projects discussed using validated tools and pre - post intervention methodologies, but we were unable to access examples of what these were other than in projects that have produced published journal articles. One provider had evaluation reports accessible online to review the measures, method and impact.
What works is known, how it works is known, and repeatability is universal.	The organisations felt they know what works but much of this was intuitive, based on experience and what they see and feel is happening and informal feedback from clubs and individuals they work with. There is little robust evidence available documenting what works in this space and the multiple objectives of organisations will make this challenging.

Evidence collected is publicly available and open to external scrutiny (i.e. On website).	Three projects have publicly available evaluation data and summaries.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program	Most programs have engaged a range of funding partners across government, corporate organisations, and philanthropic funders. Some did not discuss any issues with securing ongoing funding and felt the area continued to be viewed as important and as such accessing funding had become easier. Some organisations stated that ongoing funding was challenging and meeting the requirements of funding bodies can be a lengthy and hard process to work through. These organisations discussed that assistance in funding for pilot stages and evaluation would be helpful to gain initial insights into impact to report on.
The program is financially self-sufficient and not dependent upon grants.	Most are dependent on ongoing funding from external sources, this is important in keeping the cost either low or free to community sports clubs.
The host organization is “mature” (stable, resourceful).	Most organisations were stable, although they had been established from between 2 months-6 years. Some of the organisations in their infancies were struggling to keep going, especially with the impact of Covid-19.
The value and mission of the program fit well with the broader community.	All programs provided evidence of fitting within the value and mission of the broader community.
The program meets legal and compliance responsibilities.	Most providers did not explicitly state if they were meeting legal and compliance measures, although there were examples from two providers that discussed going through rigorous processes with legal organisations to ensure that they met legal and compliance responsibilities.
The program represents 'good value for money' for the club	There were a variety of funding models evident across organisations, some had received funding to enable them to offer programs free to clubs, others had some sponsorship and could offer subsidised rates or free to clubs that met certain criteria (i.e. regional clubs, those in high areas of deprivation). Clubs that are required to pay for the services offered are encouraged to gain sponsorship from local business and/or fundraise.

Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Most programs have considered ongoing sustainability of impact, although this was not always documented especially for the organisations who were in the initial phases of implementing their programs. Key strategies for achieving ongoing impacts included involving club leaders, coaches and parents to support mental health promotion on an ongoing basis, encouraging clubs to develop a mental health strategy, development of Apps that individuals can continue to engage and use, web-based resources, webinars and online training to allow for refreshing of concepts and options for repeat training within some of the programs.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	As above, most encourage leaders, committee members and key influencers in the club to undertake the role of ongoing champion. Some have explicit education sessions targeting individuals to perform this role, one program focuses on supporting young people to become key champions in their club. Another program has a club champion dedicated training session.
The program has a clear strategy for supporting positive culture change within community clubs	Most programs had an overarching desire to support positive culture change, however how this would be done was less well articulated. Organisations often discussed the effect of a club champion promoting positive culture change and how this would make an impact, although how it creates change or what impact this would have was not articulated. The importance of education in changing culture and addressing some aspects of negative culture were generally provided, however there were generally no resources/support available for ensuring tangible action.

Having interviewed a 12 providers that deliver programs into the WA community sport sector, researchers summarised the key take-home messages in the following:

- There were a number of new (e.g. 6 -18-month-old) organisations in WA offering mental health support to the community sport sector. Some of these organisations are focused solely on awareness raising and resource provision, and do not provide educative workshops/sessions, although the majority of the providers did. The providers were in agreement that there has been a rise in the number of organisations offering mental health support services to the community sport sector. They pointed to the need for regulation and guidelines in this space suggesting that the quality of providers varied significantly but clubs were often unaware of how to determine which providers they should be working with and the quality/suitability of the product they were offering. At the moment the sector is relatively unregulated. Although this wasn't evident in the programs we spoke with, all the interviewees highlighted the potential for programs to be established without the necessary expertise and guidance and they felt that it was fairly easy for organisations to sell their product to clubs without any questions regarding quality or value. The majority of providers advocated for a type of accreditation system that would make it easy for clubs and sporting associations to determine if programs were of value and appropriate. Given the sensitivities around delivering mental health interventions and the potential negative impact of poorly delivered interventions, this was determined by the providers as a key priority.
- All providers acknowledged the challenges of working within the voluntary sport sector and recognised that they could often only start a dialogue, raise awareness and provide some basic information to clubs in the time that they had to work with volunteers, coaches and members. Many indicated that they would like to deliver more comprehensive education programs and that this was essential to drive significant changes in culture. The ability to do this currently was limited.
- Many providers acknowledge that work needs to be undertaken to address the exclusionary nature of sport, as a key aspect of promoting positive mental health within community sports club settings. However, most providers feel unable to undertake education and work that begins to address broader aspects of exclusion in club settings. Instead the focus is on basic mental health first aid and awareness raising of mental health issues across a number of their programs. Some indicated that they touched on issues of culture, particularly damaging cultures associated with some forms of masculinities, but felt that their programs were constrained and unable to focus in any depth on this. Issues of health equity were not necessarily able to be addressed by the programs. Similarly, there was a recognition that club sport could be a setting that fosters negative behaviours also connected to poor mental health and wellbeing such as alcohol and drug use. A number of providers interwove education around alcohol and drug use in addition to general information on mental health.
- A significant challenge for the organisations who worked in remote and regional WA was the vast geographical spread of WA, especially in relation to resource allocation. With limited resources, providers who worked in regional and remote WA found it difficult to provide ongoing support and were mindful not to create more mental health issues within the population groups they worked with, especially when they were going to leave the community after a short period of time (e.g. 1-3 days). Organisations who worked in regional and remote WA, detailed the importance of and need for working in these communities. However, they also identified multiple limiting factors associated with this, including the challenges related to reporting when such reports are KPI focused, and the complexities of new providers working in small communities.
- Beyond three of the programs, evaluation of initiatives is limited, making it difficult to make informed judgements regarding the impact of programs on the community sport sector.
- The majority of providers work with AFL clubs and nearly all tend to engage with team sports. There were limited providers working with individual sports despite acknowledging that there can often be significant mental health issues associated with some individual sports. Most providers stated that they would assist any sporting club who asked for assistance but there was a dominant focus on team sports.
- Most acknowledged the gendered dimensions of mental health, which is important to consider in the design and

delivery of programs. The providers who used a co-delivery style with a male and female presenter stated the importance of having both genders deliver the content. One program specifically focussed on men and stated the importance of having a male deliver the program to resonate with males. This program stated that having a woman deliver to a male cohort would not be as effective.

- Only a few providers articulated considerations regarding cultural adjustments and three discussed the adaptation of resources and education for Aboriginal participants. One provider specifically tailored and designed their offerings in consultation with the local Aboriginal community. Several providers mentioned that they tailored their content based on the club or community they worked with; however, they did not detail the specifics of how this is done or in consultation with whom.
- Programs have different capacities and reach. Some chose to focus on a narrow area of work in this space but still provide valuable services. Furthermore, there is limited collaboration between different organisations or sharing of resources/expertise. There is a feeling of competitiveness within the marketplace with different organisations seeking a stake in market share. However, many providers expressed that they wanted greater collaboration between providers and particularly to work more with higher level structures in sport such as leagues and associations to develop a more coherent and strategic approach to raising awareness of mental health. A collaborative approach was seen as a valuable way to distribute consistent messaging and awareness of mental health and wellbeing in the community sport sector.
- Building on the above point, structurally, there seems a considerable disconnect within this space between the mental health providers, sporting associations, leagues and the clubs. Providers tend to work directly with clubs and rely on word of mouth referrals from other clubs, direct approaches and marketing directly to clubs themselves. Some providers work with schools to gain further promotion of the organisation. Some have sought to work through leagues and associations at a local level where possible but have found that leagues often want payment to promote their services to their club members. Few work through the State Sporting and Recreation Associations, which potentially limits the opportunity for coordination, regulation and more effective promotion to clubs.
- Whilst acknowledging the limitations of what they could do with community sport participants, most providers were in agreement that offering one or two education sessions to community clubs and then exiting was ineffective and providers needed to offer ongoing support, refresher sessions and continuing training for positive mental health practices to become embedded within the club.
- Related to this, most providers understand the importance of providing ongoing support, however they had limited capacity to do more than one session per year. A significant focus was on awareness raising and creating conversations in the community space, with the aim of empowering club members and leaders to converse on topics of mental health. Linking to local mental health referral services was a key component of most programs as this enabled community members to be aware of the local mental health support services. One program detailed the importance of de-constructing the associated stigma related to contacting health services and are currently designing a video with a major mental health provider, to show the process of what occurs when contacting a mental health provider.
- Several providers discussed the importance of taking co-creation approach, however they found this to be challenging when trying to reach a wider group. Some providers detailed the quality of the messaging and using simplistic yet evidence-based language. The quality and significance of the messages they are providing and how the content was delivered was considered of utmost importance, especially due to the sensitive nature of mental health and wellbeing content. One provider used a co-delivery approach with the lived experience of an ex-athlete, supported by an evidence-base of a psychologist. They detailed the relatability of the athlete's lived experience, paired well with evidence by the psychologist as an effective approach to reach a wider audience.
- Most providers discussed the importance of coaches being trained in first aid mental health at a minimum level standard so that they can assist in mental health awareness and support their clubs' members. One provider targeted coaches through a mental health topic in the AFL level one coaching accreditation process. Other sports

do not appear to have an accreditation process and providers thought this a key area of concern and requires addressing.

Healthway is considered a reputable and resourceful organisation by providers and a key link to sporting and health networks. Program providers considered there were a range of roles for Healthway in this context moving forward.

- An advocacy role with the sports sector and encouraging State Sporting and Recreation Associations and leagues to encourage clubs to engage with mental health was considered to be an important role that Healthway could play.
- Ongoing support for those organisations that Healthway currently works with and establishing networks with organisations in this field who do not currently have partnerships with Healthway.
- Advice and guidance to the sport sector supporting decisions about which providers to engage with and endorsement of quality programs.
- Assisting organisations in understanding cultural considerations of mental health and wellbeing in Aboriginal populations.
- Providing support for regional and remote delivery, helping providers to work alongside existing health service providers in a coordinated way.
- Providing, lobbying for and offering direction on possible funding sources.
- Supporting and assisting providers in their early phases of the organisation (e.g. first year), for a pilot phase to gather the data required to display impact.
- Encouraging greater levels of collaboration between providers.
- Development of resources and tools to support the work providers undertake, for example videos, factsheets, mental health policy templates etc.
- Establishment of a steering group made up of experts in MHW, program deliverers and participants to develop guidance and coherence across the space. This will provide an avenue for collaboration amongst providers and understanding of any gaps within the WA context.
- Advocating for coaches to be mental health first aid accredited to sporting associations and leagues as a minimum requirement.

PHASE 5) ANALYSIS OF INITIATIVES AGAINST CRITERIA

As part of the review process, drawing on the interviews, resources shared with the research team and publicly available resources, we looked to ascertain how providers matched up against criteria developed in phase 1. Programs have been randomised to maintain anonymity. Table 18 provides supplementary notes to explain scores where indicated.

TABLE 22: INTERVIEWED PROVIDERS AGAINST BEST PRACTICE FRAMEWORK

Programs	P2	P8	P6	P3	P15	*P7	P11	P10	P4	P1	P9	P13
1.1 Program has explicit ties with an established overarching mental wellbeing framework. 0=Not evident at all; 1=Weak links; 2=Modest links; 3=Strong links	0	2	2	0	1	3	2	1*	3	1	3	3
1.2 Program uses language and approaches consistent with established MWP frameworks. 0=Unique language and definition of terms; 1=language is partially recognisable but inconsistent; 2=language is almost all consistent with overarching framework; 3=Language is fully consistent with overarching framework.	0	3	1	0	3	3	2	1	2	1	3	3
1.3 Programs underpinned by well-established models/theories of mental wellbeing provision. 0=No evidence of connection to models or theory; 1=Limited connection to models of theory; 2=Moderate connection to models or theory; 3=Strong connection to models and theory	0	3	2	1	3	3	3	0	2	1	3	2
1.4 Program targets the individual (awareness, MH literacy), social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language) 0=not clear; 1=single layer focus; 2=dual layer focus; 3=multi-layer focus	1	2*	2	2	3	2	2	2	2	0	3	3

1.5 Program utilises well-resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base. 0=No evidence of access to credible resources; 1=Limited access to credible resources; 2=Moderate access to credible resources; 3=Ongoing access to highly credible resources.	1	1	2	2	2	2	3	2	3	3	3	3
1.6 Initiatives used with Aboriginal people there is consultation with Aboriginal health professionals, Traditional Owners and relevant Aboriginal organisations. 0=Not evident at all; 1=Weak links; 2=Modest links; 3=Strong links	2	0	1	0	0	0	1	0	3	0	0	0
1.7 Initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations. 0=Not evident at all; 1=Weak links; 2=Modest links; 3=Strong links	2	0	2	0	0	1	2	0	2	0	0	0
1.8 Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative). 0=Voices are impersonal and authoritative; 1=Voices are partly personable, approachable and relatable; 2=Voices mostly personable, approachable and relatable; 3=Voices are personable, approachable and relatable.	3	3	3	2	3	3	3	3	3	3	2*	3
1.9 Program helps clubs establish community support for the need to focus on mental wellbeing. 0=no evidence; 1=some evidence; 2=moderate evidence; 3=strong evidence	1	3	3	2	2	2	3	2	3	3	3	3
Intervention format												
2.1 The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program). 0=Single format (i.e. guest speaker); 1=Dual-format (i.e. guest speaker and diary);	2*	0	1	2*	3	2	3	2	3	3	2*	3

2=Multi-format; 3=High-impact, multi-format.												
2.2 Program is targeting different cohorts both within and beyond sport clubs. 0=Single focus; 1=Two cohorts (i.e. players/coaches); 2=Multiple cohorts within; 3=Multiple cohorts within and beyond club/sport	0*	2*	2	1	2	3	3	2	3	3*	3	2
2.3 Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicate, for Aboriginal people. 0=Not evident at all; 1=Weak links; 2=Modest links; 3=Strong links	1*	1	2	0	1	2	2	1	3	1	1	2
Intervention components												
2.4 Program has clearly stated outcomes and content is consistent with them 0=No alignment evident; 1=Limited alignment; 2=Moderate alignment; 3=Excellent alignment	2	3	2	1	2	3	2	2	3	2	3	3
2.5 Provides appropriate ways to raise awareness of and promote mental wellbeing. 0=No; 1=Limited; 2=Modest; 3=Strong	1	3	2	1	2	3	3	2	2	3	3	3
2.6 Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues) 0=None; 1=Limited; 2=Modest; 3=Strong	0*	3	2	2	1	2	3	2	2	2	3	3

2.7 Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references. 1=no communication; 2=modest communication; 3= strong communication	3	3	3	2	3	3	3	2	3	2	3	3
2.8 The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language) 0=Generic program; 1=Limited tailoring (i.e. some communication about program needs); 2=Moderate tailoring (i.e. based upon some data); 3=Excellent tailoring (i.e. based upon communication, quality measures, large sample)	2	2	2	2	2	3	3	3	3	2	3	1
2.9 The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context. 0=Not evident at all; 1=Weak links; 2=Modest links; 3=Strong links	3	0	1	0	0	1	2	0	2	0	0	0
2.10 Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action. 0=No links beyond program; 1=One-way links no real collaboration; 2=Modest collaboration beyond program; 3=Strong collaboration beyond program	2	3	2	2*	2	3	3	2	3	3	3	3
Evaluation												
3.1 Measures are clearly aligned with stated program outcomes and program content 0=No alignment evident; 1=Limited alignment; 2=Moderate alignment; 3=Excellent alignment	1*	0*	2*	0*	2*	3	2*	1	2*	0*	0	3
3.2 The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes 0=No measures or invalid measures taken; 1=Limited measures (i.e. inferior measures, small numbers, post-test only); 2=Moderate measures (i.e. quality measures, small sample, pre-post); 3=Excellent measures (i.e. quality measures, large sample, pre-post)	0	0*	2*	0*	1	3	2*	1	3	0	0	3

3.3 What works is known, how it works is known, and repeatability is universal. 0=if what works is unknown and how it works is not known; 1=if what works is known, how it works is not known, and repeatability is also limited; 2=if what works is known, repeatability is universal, but how it works is not known; 3=if what works is known, how it works is known, but repeatability is limited; 4=if what works is known, how it works is known, and repeatability is universal.	1	0*	2*	0*	0	4	1*	1	4	0	0	4
3.4 Measures have established impact across different settings, sustained over time. 0=No impact established; 1=Impact in a single context; 2=Impact in limited/narrow contexts/time points; 3=Impact across settings and time	1	0*	2*	0*	0	3	1*	1	3	0	0	3
3.5 Evidence collected is publicly available and open to external scrutiny (i.e. on website). 0=Evidence if any cannot be readily located; 1=Evidence is very difficult to locate or shared when asked; 2=Evidence is moderately difficult to locate or shared when asked; 3=Evidence is readily available and open to scrutiny (i.e. published, peer reviewed).	2	0*	0*	0*	0	3	0*	0	0*	0	0	0
Sustainability of program												
4.1 The community and a range of stakeholders have a vested interest in the program. 0=Single stakeholder; 1=Limited amount of invested stakeholder/community members; 2=A moderate amount of invested stakeholder/community members; 3=A range of invested stakeholder/community members.	2	2	2	1	3	3	3	2	3	3	3	3
4.2 The program is financially self-sufficient and not dependent upon grants. 0=Dependent on others; 1=Short-term self-sufficient (next 12 months); 2=Medium-term self-sufficient (next 3 years); 3=Long-term self-sufficient (foreseeable future)	2	2*	2	0	1	2	2*	1*	3	2*	3*	3
4.3 The host organization is “mature” (stable, resourceful). 0=Fresh to market, immature product; 1=New to market, maturing product, limited resources; 2= Established (2-5years), stable, well resourced; 3=Well established (>5years), stable and very well resourced.	3	0*	1	0	2	3	2	0	3	1	3	3
4.4 The value and mission of the program fit well with the broader community. 0=No clear alignment or obvious fit; 2=clear alignment and obvious fit	2	2	2	0	2	2	2	2	2	2	2	2

4.5 The program meets legal and compliance responsibilities. 0=No; 1=Yes	1	1	1	0*1	1	1*	1*	1	1	1	1	1
4.6 The program represents 'good value for money' for the club 0=Relative cost appears high; 1=Relative cost appears equal; 2=Relative cost appears low	2	2	1*	0*	1*	2	2	2	1*	2	2	2
Sustainability of Impact												
4.7 The program has a clear (documented) strategy for achieving ongoing impacts for individual club members. 0=No strategy for ongoing impact (i.e. beyond the initial program focus); 1=Limited strategy for ongoing impact; 2=Modest strategy for ongoing impact; 3=Strong and clearly articulated strategy for ongoing impact (i.e. capacity building).	2	2*	1	0	3	2	3*	2	2	3	0*	3
4.8 The program has a clear strategy for supporting the development of knowledge/ expertise/ championing of mental health within clubs. 0=No clear strategy; 1=Limited strategy; 2=Modest strategy; 3=Well developed strategy	0	2	1	1	2	3	3	3	3	3	3	3
4.9 The program has a clear strategy for supporting positive culture change within community clubs 0=No clear strategy; 1=Limited strategy; 2=Modest strategy; 3=Well developed strategy	0	3*	1	1	2	3	3	2	3	2	3*	3
Total Score	**45**	**53**	**57**	**25***	**55**	**81**	**75**	**47**	**83**	**52**	**64**	**79**

TABLE 23: NOTES*

P2	2.1* Primarily face-to-face in communities, however COVID meant that moving online was necessary. Still trying to figure out how to deliver to some communities during this time. 2.2* In schools and out-of-schools main delivery types – so beyond sporting clubs, but does not deliver from sports clubs in the first instance. 2.3* Unsure on its relevance to urban, focus is in remote/rural 2.6* does not deliver in sporting clubs, so this question does not reflect their target audience, however there is awareness of cultural implications, and tailoring to suit this, gender, ages etc. 3.1/3.3/3.4* Very hard to measure in remote communities. Have written a paper on the social and emotional benefits of yoga for Aboriginal Australian children, showing improved social and emotional wellbeing for those who par-took in the Wellness Walkabout Program. Trying to measure impact with company Research Solutions and also with 180DC (student consultants).
P8	1.4* Nothing re policy levels – all about cultural change, from multiple levels and everyone supporting each other 2.2* Will focus on multiple layers, currently main focus is the coach. Only in initially stages (1 month in) and will target officials, referee's and other influential people in clubs 3.1-3.5* Have not conducted an evaluation as only in initial stages and COVID-19 postponed the initial program implementation/evaluation, however have all the appropriate measures in place to do one. Will be doing pre-, during and post-surveys based on the aims and objectives of the program/content etc. Also, will have a survey for clubs to use to measure impact/what they can change re club culture. 4.2* Partnerships with an external funding partner for 3 years, potentially longer 4.3* organization has been running for 11 years, however this product is only 1 month old 4.7* strategy is the ease of use for community club members and time poor volunteers (anyone can do it!) 4.9* all about changing culture and starting conversations within clubs to support each other
P6	3.1-3.5* Evaluation from external evaluator – discussed the annual process and measurements/impact they are collecting 4.6* Unsure
P3	2.1* It is individual based, however target different supporting people e.g. coaches, club, psychologist to support that person 2.10* Links in with local support and also other ways to support e.g. telehealth in area's that there is currently not enough support 3.1-3.5* Still in initial phase and has not done any evaluation yet as not at this phase. Have a strategy to getting reports from various stakeholders (e.g. client, psych, parents, coach etc), however not at this level yet 4.5* Unsure 4.6* Cost is high for the program/organisation and reliant on having funding, cost for individual is free or subsidised Total score 25* all individualised/tailored program and the program is in infancy. Hard to get a high score currently, especially since COVID-19 hit and reduced funding and implementation

P11	3.1-3.5* Have been conducting qualitative evaluation, however currently designing with XXXXX a formal quant, pre-post-survey to assist in understanding from a deeper perspective and impacting practices 4.2* Unsure how income is generated, mainly through corporate and partnership work. Have not applied for grants 4.5* Unsure, would imagine so if going into schools/organisations 4.7* Focus is on capacity building in the community
P10	1.1* Reference to information/evidence of Beyond Blue/Lifeline – main providers in mental health space 4.2* Pilot project funded by XXXX, potential for ongoing short-term funding 4.5* Unsure
P4	3.1* hard to know specifically the measures that are being collected 3.6* currently getting an external evaluation, not publicly ready yet, but may be in future, so scored 0 for time being 4.6* cost for those in Vic is $1500, all other states et free sessions based on government/state/sporting organisation partnerships. Good value for money if the club makes it worthwhile, however some clubs (if limited interest) may pay the $1500 and only get 2 sessions – so I guess it depends on the club themselves.
P1	2.2* Targets leadership/coaches, however also every coach who does accreditation process through AFL completes a module through TYF 3.1* - evaluation -has an external evaluator – and in early days (est.2019), so only have pilot data and still making changes. Discussed evaluator is looking at measures (direct & indirect impact) and branding, messaging, language use etc. In process of evaluation, however no further details on it. 4.2* receiving funding from an external Foundation ($10 mill to last until end of 2024) 4.9* currently developing action plans for this. Did not discuss specific inclusion strategies however a positive cultural change for mental wellbeing
P9	1.6 *Did not see content of the program, so hard to establish specifically. 2.1* New program, so still establishing. Discussed doing face-to-face and online components already and webinars Evaluation (3) no evaluation has taken place, however plans to, and will do an in-depth evaluation (capability to do so). Have only received generalised feedback so far. 4.2* Hard to specifically tell if the sport component is, however XXXX as a company is. Has federal funding to implement in WA (sport-specific) 4.7* Still in program infancy 4.9* Unsure if this is a written strategy, however discussed the multiple facets of culture change, and discussed how to do this
P15	4.6* unsure re costs

DISCRIMINATING CRITERIA

Standard deviations were calculated for each criterion across all programs to ascertain those criteria that provided the greatest variation in scores. The criteria that could account for greater differences between programs should have the larger standard deviations in scores. When looking to decide between one program or the next, criteria that account most for the differences between programs are going to be the most useful. If for example, none of the programs provide publicly available evaluation data, then this criterion will be of little use to someone trying to distinguish between programs. It is worth noting that 28 of the 33 criteria were scored using a 4-point scale, 1 used a five-point scale, 2 used a three-point scale and 2 used a two-point scale. For the 4-point scale items, standard deviations above 1 or the highest standard deviation for that particular category heading were considered to explain the greatest amount of variation. The others were scanned to see if the criteria were able to distinguish between programs. Table 24 provides an overview of those criteria that lend themselves most to distinguishing between programs. These criteria should form candidates for modification and simplification for use in the sport sector more widely.

TABLE 24: CRITERIA MOST LIKELY TO DIFFERENTIATE BETWEEN PROGRAMS

Strategic framework	Standard Deviation
Initiative has explicit ties with an established overarching mental wellbeing framework.	1.14
Initiative uses language and approaches consistent with established MHW promotion frameworks.	1.19
Initiative is underpinned by well-established models/theories of MHW promotion.	1.16
Intervention format	
The intervention offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	0.94
Intervention components	
Intervention reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues)	0.90
Evaluation and Efficacy	
Measures are clearly aligned with stated program outcomes and program content.	1.15
The program has utilized valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	1.29
What works is known, how it works is known, and repeatability is universal.	1.68
Measures have established impact across different settings, sustained over time.	1.27
Sustainability of program	
The host organization is “mature” (stable, resourceful).	1.29
Sustainability of impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	1.08
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	1.06
The program a clear strategy for supporting positive culture change within community clubs.	1.03

DISCUSSION

A rapid review of literature was undertaken to incorporate a greater focus on rural/remote and Aboriginal communities within the best practice criteria for mental wellbeing initiatives in sporting club contexts. Following that, a market analysis identified initiatives for Mental Wellbeing provision in sport within the state of Western Australia. In addition, a survey was sent to SSAs and community club members to ascertain their need for, use of and evaluation of initiatives and programs to support mental health and wellbeing. Finally, a series of interviews were undertaken with stakeholders representing key MHW programs for community sport. The criteria were used to undertake a review of programs delivering MHW to community sporting clubs. The following provides a discussion around some of the core findings.

Community sport plays an active role in sustaining mental wellbeing. Club participants we surveyed expressed the positive social climate that exists through participation in community sport. Members said that:

- They "connect people, offer engagement roles based on their interests and offer great opportunities with amazing people" (survey respondent).
- They "make sure that all members are treated with respect and in a fair and open manner. We actively encourage participation regardless of skill levels. Last season we focused on good sportsmanship to eliminate bullying in junior competition" (survey respondent).
- "Our club welcomes young and older members of our local community to play social and competitive tennis, which helps people release any stress they may have through exercise, and the exercise promotes good health" (survey respondent).
- "We provide opportunities for playing sport in both competitive and social environments. We provide opportunities for social interaction and friendships among club members and visitors. We provide opportunities for participation in sport for the full spectrum of participants including seniors, juniors, women, young mothers, disabled, etc" (survey respondent).

These findings support the notion that sport, through the provision of a trusting social community network, lends itself to supporting a focus on mental wellbeing (Breslin, Haughey, Donnelly, Kearney, & Prentice, 2017). The social relationships and social integration that occurs in and through sport, can offer important protection against increased risk of distress (anxiety, depression), suicidal ideation, health behaviour and seeking health care (Beutel et al., 2017). Sport can help develop and sustain a sense of belonging through a regular form of social connectedness and this can lead to positive outcomes for mental health (Burns, Evans, Jancey, Portsmouth, & Maycock, 2020). Respondents noted intuitively what Burns et al., (2020) was able to demonstrate, that is, volunteers within clubs report higher levels of social connectedness, wellbeing and self-esteem than non-volunteers. There is potential for the community sport sector to do more than offer the ongoing promotion of positive factors that come from participation in sport. Indeed, with appropriate support through quality programs, community sport could operate more deliberately in the mental health promotion and prevention spaces, as is happening in some workplaces and schooling contexts.

The potential of the community sport sector to contribute more than it currently does to mental health and wellbeing is perhaps recognised in the significant growth of programs aiming to work in this space, albeit in a largely unregulated environment. We identified 45 different programs with some links to mental health and sport. This confirms Breslin's (2019) observation of a growing number of health awareness programs emerging within the sporting landscape. The Western Australian Government also recognises sporting contexts (alongside workplaces and schools) as 'Domain 2 environments' that can create and maintain support beyond participation, in the form of mental prevention initiatives that can be implemented to promote optimal mental health (Mental Health Commission, 2018, p. 25). The state government are looking to invest significantly more in mental health promotion and prevention services by 2025 through supporting organisations and agencies that implement evidence-based and evidence-informed promotion and prevention initiatives (Mental Health Commission, 2019).

Yet despite the significant proliferation of programs that are operating in sport, our data reveals that surprisingly few State Sporting Associations and club respondents (61% of club respondents were serving in club leadership roles), were aware of the range of providers operating and even less aware of the nature of the services they provided. It appears at least for now, that there is no systematic way sporting organisations are being connected with quality providers to support mental health promotion or prevention. When asked what support clubs needed, “referrals to quality resources”, “contacts of organisations that will provide guidance” and “being put in touch with people who can organise these programs and funds to support the programs” were popular requests from club members.

The increased focus on mental wellbeing promotion in community sport is underscored by the growing number of providers, the policy positions of the WA government and is reinforced by representatives of the sporting community itself. Only a small number of SSA respondents (20%) identified mental health as anything less than a moderate to high priority. This fell to 10% for community sport club members, suggesting the sporting community has a will to engage in mental health and wellbeing promotion and potentially prevention activities. It is worth noting however, that the priority to focus on the mental wellbeing of participants was a lower priority than other club related duties such as recruitment and maintenance of the membership, developing female participation, supporting diversity and inclusion and managing the scheduling of games.

Jorm et al. (2007) highlighted the important role members of the public play in supporting mental health and suggested greater community training was needed to address deficiencies in mental health literacy within the Australian public and beyond, (Jorm, 2012; Jorm et al., 2007). Despite many viewing mental health support as a priority, club member capacity to support mental health and wellbeing in sporting clubs was mixed, with approximately two thirds of respondents indicating they would need external support. This was reflected in open questions where many participants suggested they lacked the knowledge and skills to work in this space.

A rapid review (O’Connor et al, 2020) suggested that quality programs delivering mental wellbeing promotion to sporting clubs, need to integrate with overarching mental health and wellbeing strategic frameworks that have been tailored to sport. Our research suggests the sport sector in WA continues to operate outside of any consistent and consolidated framework for MHW provision, with little coordination across the sector. Outside of the broader policy frameworks, there was no real evidence that the strategic framework implemented by state government is linking with on the ground practice in sporting clubs as part of a joined-up process. This potentially contributes to problems identified by the Federal government some time ago, where they recognised mental health provision comprised a ‘collection of often uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice’ (Department of Health, Dec 2015, p. 5). The development of a mental health promotion strategy for sport, as part of state government planning, could be useful for government and providers to link in with.

Organisations delivering mental health and wellbeing programs to sporting clubs can be readily established without appropriate oversight and input from experts and enter a marketplace where clubs would not be in a position to critically appraise either quality or value. Providers we spoke to, advocated for a type of accreditation system that would support clubs and sporting associations to determine if programs were legitimate and appropriate. Noted already is the suggestion from clubs and SSAs that they needed help to locate and access quality providers. They also suggested funding and ‘time to organise’ was a substantial issue.

Two of the most significant barriers raised by sporting associations, clubs and the providers of MHW programs, were:

1) The burden on time-poor volunteers (capacity and capability) and
2) the provision for funding to resource any implementation.

This was also raised in interviews with providers who lamented the lack of 'contact time' with clubs to effect change and consequently could do little more than provide an 'introduction to' MHW support. They were clearly tuned into the limited resources clubs had and whilst they could readily 'scale up' to do more protection and intervention work with clubs, clubs were looking for something 'simple and easy to implement'. The sentiments raised by survey respondents pointed to the 'unfair impost for volunteer operated clubs to provide these types of services', and 'the capacity of volunteers to take on more time-sucking responsibilities' was limited (survey respondents). They suggested initiatives in mental wellbeing should be driven from the top down with appropriate levels of funding and resourcing that posed a minimal 'extra' burden on volunteers. Within other 'Domain 2 environments' (workplaces and schools), people can be more readily paid to implement programs embedded within a job-description with directives and guidance via a recognisable management and reporting structure. In order to deliver effective promotion and prevention strategies beyond awareness raising in sport settings, the approach to resourcing (capacity and capability) needs careful consideration.

The preference amongst SSA and community sporting club participants was for one-off speaker events, special one-off promotional rounds, general sharing of information or educational days to raise awareness of mental wellbeing. This preference is understandable given capacity and capability outlined above. A handful of SSAs were embedding MHW into strategic plans or as part of a more systemic focus. Education sessions were usually delivered in larger groups for 45 minutes to an hour after club training with notable limitations as to what can be achieved in this time, deferring to additional online support. The majority of providers were in agreement that offering one or two education sessions to community clubs and then exiting, was less than effective.

The literature suggests the most successful outcomes happen when programs are systemic, ongoing, multi-modal and messages are repeated across different contexts (work, school, sport). Workplaces that implement **protection** through systemic risk reduction and increasing protective factors, **promotion** of mental health and referral for **intervention** provide a desirable model for sporting clubs that may be difficult to implement. Jorm (2012) pushed for a greater need for training within the community to increase the public's knowledge of how to: Prevent mental disorders from progressing; recognise them when they are and; support help-seeking and self-help strategies. Sport offers a potential site for greater education and training, but what we know from educational design is that education works best when it builds upon existing knowledge (people become frustrated with poorly designed material), provides timely descriptive feedback and offers repeated opportunities to practice/use the material (Ericsson, 2006). One off presentations are consequently limited in the extent to which they can develop new knowledge. Depending upon the complexity of the content, learning develops best through repeated opportunities to work with the content spaced over several days, and the use of different activities to vary the interactions learners have with new knowledge (Department of Education and Training, 2017).

People shape the factors that influence mental health within their club and their own mental health is in-turn shaped by the physical and sociocultural environment (Rimer and Glanz, 2005; WHO, 2004). More effective programs would see providers collaborating with clubs over time, offering refresher sessions and feedback, so that positive mental health practices become embedded across the various layers, structures and actors within clubs. This approach should be underpinned and reinforced by sporting associations/peak bodies and sit within a familiar state-wide strategy, operating across media, family, workplace and school environments. There was little indication of a willingness for a distributed educational format from SSAs and Club members. Innovative ways to get club members to re-engage with content (i.e. through online platforms) following an initial session are worth exploring. Whilst there are opportunities for important outcomes as a consequence of awareness raising (i.e. stigma reduction, help-seeking support), additional benefits from more substantive engagement with programs (mental health literacy, more supportive cultural change), may be missed through the provision one-off speaker events.

Worth noting, SSAs and club participants were receptive to receiving suggestions and strategies to impact club culture related to mental health and wellbeing. A few respondents from the sporting sector recognised club culture was an

issue, citing a focus on athlete performance over welfare as an important concern. Another mentioned 'fast food sport' was detracting from opportunities to foster social connectedness. Providers were also aware of the work that needs to be undertaken to address risks to mental health within sporting club environments and saw this as a key aspect of promoting positive mental health within community sports club settings. However, most providers felt they were unable to tackle this issue, instead focusing on basic mental health first aid and awareness raising of mental health issues. Some indicated that they touched on particularly damaging cultures associated with some forms of masculinities, but their ability to deliver more comprehensive education programs that drove significant changes in culture was limited. The literature suggests confronting risk at the source (i.e. alignment to masculine ideals of 'toughness' and stoicism) whilst developing protective factors (i.e. creating more supportive, connected, inclusive environments that cultivated an identity and sense of belonging for a range of vulnerable people) could be an effective strategy.

Program providers that form a legitimate partnership with State Sporting Associations or clusters of clubs, are perhaps more likely to tune into the organisations current capacities (knowledge, skills, understandings) and develop tailored content where collaboration and co-design are a central feature. They may also be more likely to tune into the diversity, equity, cultural inclusivity needs of clubs and members aligning with WA's plan for mental health promotion (Mental Health Commission, 2018). There was little evidence of strong partnerships and collaborations between program providers and SSAs in our data.

As well as hosting sport competitions, sporting clubs are being increasingly called upon to address a range of positive community initiatives that potentially ask them to choose one cause over another. Given cross-over between aims and objectives of MHW promotion and other agendas tied to, LGBTI+ inclusion, gender-based violence, gender equality, mental health, cultural competence, alcohol and drug use and more, it is worth considering how common messages across these causes might be better 'packaged' as part of an overall strategic health promotion framework within the sport sector. This approach might draw from other 'settings-based' approaches to health promotion or similar holistic frames applied in other areas. It might also involve supporting providers across these different causes to collaborate and develop a common set of 'culture change' resources/practices/policies that have an impact beyond a specific cause. By having different causes deliver consistent messages around common risks and protections linked to sporting clubs, different providers can reinforce each other's messages, as clubs progressively engage with and support the wide range of community causes on offer. As part of hosting a Pride Cup round and a Mental Health Promotion round, a sporting club can engage with a common set of 'cultural support' messaging twice in a season.

Most of the providers suggested they had short to medium term funding (up to three years) and many consequently could make the programs relatively cheap for participants. Funding however is often tied to outcomes and particularly if public money is to contribute to SSAs, sporting clubs or indeed providers to facilitate MHW provision in sports, then these programs need to be evidence-based and evidenc- informed to align with the State Governments mental health promotion plan. The WA government signalled a 72% shortfall in promotion and prevention spending (Mental Health Commission, 2019), but without an evidence base to support impact within the sport sector, accessing any additional funding may prove difficult. Where evidence does exist through robust evaluation, there is a case for gaining access to this funding is it is doing the 'work of health promotion', particularly to service under-represented populations/sports and ease the burden on volunteers. Our findings suggest only 3 of the 12 programs drew upon robust measures of impact on clearly targeted outcomes. To support sporting communities to better understand the benefits or impacts of MHW programs for their communities, and to encourage them to invest precious time and energy, robust evaluation that points to tangible outcomes would be an important consideration. Accounting for the greater benefits that come from creating more socially inclusive and supportive community networks, can help to build a business case for the investment of volunteer resources and public money.

Despite the significant number of providers in this space, many were only just starting up or only just starting to look at expanding into WA. Some of these were looking to peak bodies for support in their early phase to gather data required to demonstrate impact. Surprisingly few of the programs were well known by SSAs and community sport respondents.

Given many of the providers worked in metropolitan areas and because the bulk of respondents were based around city centres, more of the programs were recognised by people from these areas. Five providers interviewed specified they worked in regional and/or rural and/or remote Western Australia, working in consultation with local health services and community organisations. Three had developed initiatives in consultation with relevant Aboriginal communities and professionals and only one provider discussed explicitly working with rural/remote Aboriginal communities where concerns were raised about a stressed system. Given the size of WA and the prevalence of mental health concerns in regional and remote communities, as well as for Aboriginal people, this aspect of supporting mental health through sport needs to be more strategically developed.

Programs that scored highly against the 'best practice' criteria stood out the most on select criteria. Those that could clearly articulate a strategic alignment to a mental wellbeing framework underpinned by clear models or theory for MHW promotion; those that offered a variety of high-impact delivery methods and modalities to suit a range of participant needs; those that had a detailed understanding of the sport settings in which they were operating; those that utilised valid and reliable measures to ascertain their impact against clearly stated program goals and; those that had a documented strategy for achieving ongoing impacts for individual club members while supporting the development of capacity and capability within clubs to impact culture, were most likely to be successful. That is not to say there is no role for more niche programs that offered one or two things extremely well. There is room for collaboration across program providers to better utilise their relevant strengths matched to the needs of sporting clubs and contexts. There is significant room to share with SSAs and clubs, the various strengths of these programs and what they have to offer.

This research concurs with Breslin et al. (2019) who identified a need for guidelines for the implementation and evaluation of mental health programs in non-elite sporting contexts because they impact a significant number of people worldwide. In developing consensus statements to support mental wellbeing in sport, they identified the growing number of health awareness programs emerging within the sporting landscape. These programs varied considerably in content, design, theory and evaluation with a degree of uncertainty about the outcomes or their effectiveness. There was a lack of agreement on minimal training requirements for supporting content development and provision and they recognised a greater need for evidence-based recommendations within the sector. There is a lot of hard work and energy being invested into this sector. Some oversight and direction would be welcome to ensure this energy is being utilised to its fullest potential. Sport is considered an important community asset that even without additional intervention, can sustain community health. As stressed by one respondent in the surveys: 'Continuing to support community clubs in general goes a long way to supporting mental health in the community'. There is potential to build on existing strengths.

RECOMMENDATIONS

The following recommendations are made from the project:

Translate and Disseminate Quality Criteria

A rapid review into regional/remote and Aboriginal community MHW provision saw additions to a set of quality criteria for the provision of MHW in community sport. These criteria need to be developed into common language statements and piloted amongst community sporting clubs and SSAs. A complementary education component is also recommended to give key decision makers some guidance and insight around selecting a provider. Feedback regarding usability can be incorporated before wider dissemination.

Promote the Market Analysis

A comprehensive list of providers in Victoria is presented in tables within this report. These tables provide summary data on major providers and what they offer. This information can be collapsed and presented in a way that can help clubs make more informed decisions about what providers are out there and what they offer.

Support SSAs, Clubs and Providers to Do More

Awareness raising, some mental health first aid strategies and a focus on reducing stigma attached to help seeking are incredibly important outcomes. Currently, these are the major deliverables in this space occurring through one-off events with follow up web-based resources. This meets the needs of time poor clubs who, whilst indicating MHW provision is a priority, lack the confidence and capacity to deliver it without support and consequently continue to request one-off events. Many sports are looking for time effective, 'easy to implement' programs. Providers of programs felt that whilst awareness raising was important, they were unable to undertake potentially more impactful intervention work that begins to address both risk and protective factors that underpin mental health problems (prevention). Many of these link to masculine norms and access, inclusion and health equity issues more broadly. The cultural conditions of sporting clubs present a range of important and modifiable risk and resource factors. Being able to increase protective factors whilst diminishing risk in and through sport is an attractive proposition. There is a willingness by SSAs and clubs to, for example, address policies and practices to support mental health and wellbeing, but there are limited resources. If the value proposition is clear and there is confidence change can and will likely occur by doing more (through evidence-based practice), then this could activate the sector. Supporting and resourcing this work centrally, at least initially, could be a role for SSAs and peak bodies. Ascertaining what works for whom and how, through evaluating approaches and using appropriate measures will be important.

Address the Health Equity Vacuum in Sport

Stepping back from the singular mental health cause, reveals a range of similar causes attempting to do similar work within the sporting sector (i.e. create inclusive, supportive and socially connected communities that help to establish identity, purpose and promote health). It is recommended that in line with State Government strategic planning, organisations like SportWest and Healthway consider how they might move within and beyond the boundaries that sit between the host of sport related causes, including mental health, to reform cultural and social practices that continue to marginalise people within sporting contexts and adversely impact health, including mental health, more widely. One approach, consistent with MHW provision in workplaces that may resonate with sporting clubs, is to consider widening risk management frameworks. Risk management processes are already familiar within sport settings and these can be extended beyond physical risk from injury. By extending risk assessment frameworks to encompass cultural safety, social and emotional safety and mental health and wellbeing, clubs can begin to consider and implement strategies

that mitigate risk across different layers of their organisation. There is a role to play in supporting clubs to identify risks and establish appropriate ways to address them with concrete examples, thus helping them to provide a safe 'workplace' or 'play-place' for their members. These can be prompted through compliance, rental agreements with local government and funding provision frameworks and may also tie in with existing child-safety legislation and policies.

Develop a Mental Health Promotion Strategy for Sport

Given the ad-hoc nature of MHW provision in the community sport sector and the calls amongst providers for greater guidance and regulation, there is a significant opportunity for peak bodies to take a leadership role and develop this potentially fruitful and health enhancing space. Unlike large workplaces where policy reform can be more readily regulated, catering for the unique context of sport, with its volunteer base and wide cross section of community requires particular insight and presents unique challenges. The State Governments strategic planning suggests sport warrants attention as a supportive environment for mental health and wellbeing. Consequently, if public/private funds and scarce volunteer resources are to be invested in the sector, how these get deployed needs to be carefully considered and monitored. The report recommends that Healthway and SportWest work collaboratively with other relevant agencies to establish a steering group comprising representation from MHW experts, including experts with links to overarching strategic government frameworks, providers of MHW programs and sporting club participants. This group can work towards achieving some or all of the following:

- Play an advocacy role and help to establish an authorizing environment. Incentivise the sporting community and funding bodies to take action on not just mental health, but health equity, and to do it with a focus on quality and consistency.
- Establish an authorising role that can lead to the recognition and accreditation of quality programs.
- Support and facilitate collaboration amongst providers to help grow and improve service provision, variety and program reach, particularly into remote and Aboriginal communities.
- Establish clear outcomes for the sector that link with overarching frameworks/strategies and other relevant sectors (schooling, workplaces). This amongst other things can help develop a consistent messaging around mental health that is reinforced across different contexts.
- Establish appropriate evaluation tools and practices linked to clear outcomes. Whilst encouraging varied intervention approaches (not a one-size fits all), consistent outcomes and measures enable comparison within and across sectors and establishes what is working in this space. Support quality programs to evaluate their impact and contribute to the evidence base using a consistent set of evaluation tools.
- Despite the importance of 'education' within the delivery of mental health and wellbeing support, many programs are developed from clinical frames and models. There is room to consider the educational design of programs and support them to effectively deliver knowledge, skills and understandings through different modalities using sound educational approaches (pedagogy/andragogy).
- Consider how best to incentivise the sector and support clubs to invest resources time and energy on MHW and more broadly health equity, given the obvious constraints on resources (volunteer time, costs). For example:
    - Embed mental health and social and emotional safety into existing risk management frameworks whilst providing ideas for action (policy, environment, social and individual knowledge).
    - Embed where possible MHW promotion and health equity into coach education training and accreditation.
    - Provide compelling evidence as to the impact appropriate supportive programs can have on a community.
    - Where clubs are effectively doing the work of health promotion, consider how best to appropriately resource and support them.
    - Consider how local government could leverage scheduling, facility provision and hire rates as incentive to adopt particular foci.
    - Leverage SSAs to embed MHW within their strategic planning and framework.

- Progress MHW promotion in sport beyond low awareness raising to incorporate promotion and prevention whilst linking more tightly with appropriate referral systems for intervention. Where providers don't have space or time to broach complex cultural change, consider centralising this process.
- Improve reach and impact by redressing the apparent narrow focus of MHW provision in metropolitan areas delivered to predominantly team sports. In doing so, encompass more broadly the sport sector and those who participate in it. Given the growth of informal sport participation, there is also potential to consider linkages into other relevant areas such as self-organised community sport, fun runs, parkrun, lifesaving clubs and large events.
- Provide centralised messaging to clubs such as policy samples, posters and social media messaging that create a supportive environment, display health enhancing language, and reinforce sporting spaces as safe and inclusive.

REFERENCES

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407. doi:10.3109/09540261.2014.928270

Aromataris, E., & Munn, Z. (2020). JBI Reviewer's Manual. JBI. Joanna Briggs Institute. doi: https://doi. org/10.46658/JBIRM-19-01. Australian Institute of Health and Welfare. (2020). *Australia's Children*. Retrieved from Canberra

Asztalos, M., Wijndaele, K., De Bourdeaudhuij, I., Philippaerts, R., Matton, L., Duvigneaud, N., . . . Cardon, G. (2009). Specific associations between types of physical activity and components of mental health. *Journal of Science and Medicine in Sport, 12*(4), 468-474. doi:https://doi.org/10.1016/j.jsams.2008.06.009

Australian Medical Association (May, 2020). *Joint statement – COVID-19 Impact likely to lead to increased rates of suicide and mental illness.* Accessed from: https://ama.com.au/media/joint-statement-covid-19-impact-likely-lead-increased-rates-suicide-and-mental-illness

Baker, C. (2020). *Mental health statistics for England: prevalence, services and funding, Briefing Paper*. Retrieved from https://www.parliament.uk/commons-library:

Bauman, N. J. (2016). The stigma of mental health in athletes: are mental toughness and mental health seen as contradictory in elite sport? *British Journal of Sports Medicine, 50*(3), 135. doi:10.1136/bjsports-2015-095570

Baxter, A. J., Scott, K. M., Ferrari, A. J., Norman, R. E., Vos, T., & Whiteford, H. A. (2014). Challenging the myth of an 'epidemic' of common mental disorders: Trends in the global prevalence of anxiety and depression between 1990 and 2010. *Depression and Anxiety, 31*(6), 506-516. doi:10.1002/da.22230

Beutel, M. E., Klein, E. M., Brähler, E., Reiner, I., Jünger, C., Michal, M., . . . Tibubos, A. N. (2017). Loneliness in the general population: prevalence, determinants and relations to mental health. *BMC Psychiatry, 17*(1), 97. doi:10.1186/s12888-017-1262-x

Beyond Blue. (accessed May 2020). *Heads Up: Developing a workplace mental health strategy*. Retrieved from https://www.headsup.org.au/docs/default-source/resources/393615_1117_bl1833_acc-2.pdf?sfvrsn=f5cf264d_4:

Beyond Blue. (accessed, June 2020). *Good practice framework for mental health and 1wellbeing in first responder organisations*. Retrieved from https://www.headsup.org.au/docs/default-source/resources/323923_0416_bl1675_acc_lr146142db5e846dcbbbd0ff0000c17e5d.pdf?sfvrsn=2:

Bishop L, Ransom A, Laverty, M, & Gale, L (2017). *Mental health in remote and rural communities*. Canberra: Royal Flying Doctor Service of Australia. 3 Rural Doctors

Breslin, G., Haughey, T. J., Donnelly, P., Kearney, C., & Prentice, G. (2017). Promoting mental health awareness in sport clubs. *Journal of Public Mental Health, 16*. doi:10.1108/JPMH-08-2016-0040

Breslin, G., Smith, A., Donohue, B., Donnelly, P., Shannon, S., Haughey, T. J., . . . Leavey, G. (2019). International consensus statement on the psychosocial and policy-related approaches to mental health awareness programmes in sport. *BMJ Open Sport; Exercise Medicine, 5*(1), doi:10.1136/bmjsem-2019-000585

Burns, S., Evans, M., Jancey, J., Portsmouth, L., & Maycock, B. (2020). Influences of club connectedness among young adults in Western Australian community-based sports clubs. *BMC Public Health, 20*(1), 733. doi:10.1186/s12889-020-08836-w

Byron, P., Rasmussen, S., Wright Toussaint, D., Lobo, R., Robinson, K. H., & Paradise, B. (2017). *'You learn from each other': LGBTIQ Young People's Mental Health Help-seeking and the RAD Australia Online Directory*. A report published by Western Sydney University.

Centre for Rural and Remote Mental Health (2017). *Rural Suicide and its Prevention: a CRRMH Prevention Paper – Summary*. https://www.crrmh.com.au/content/uploads/Summary_CRRMH-PositionPaper_26112017_FINAL.pdf A

Connell, R. W. (2005). Growing up masculine: Rethinking the significance of adolescence in the making of masculinities. *Irish journal of sociology, 14*(2), 11-28.

Department of Education and Training. (2017). *High impact teaching strategies: Excellence in teaching and learning*. Retrieved from Melbourne, Victoria: https://www.education.vic.gov.au/Documents/school/teachers/support/high-impact-teaching-strategies.pdf

Department of Health. (Dec 2015). *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services*. Retrieved from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response:

Donovan, R. J., & Anwar-McHenry, J. (2016). Act-Belong-Commit: lifestyle medicine for keeping mentally healthy. *American Journal of Lifestyle Medicine*, 10(3), 193-199.

Ellis, B. H., Winer, J. P., Murray, K., Barrett, C., Parekh, R., & Trinh, N.-H. T. (2019). *Understanding the Mental Health of Refugees: Trauma, Stress, and the Cultural Context*. 253-273. doi:10.1007/978-3-030-20174-6_13

Ericsson, K. A. (2006). The influence of experience and deliberate practice on the development of superior expert performance. *The Cambridge handbook of expertise and expert performance*, 38, 685-705.

Fisher, J. R., Tran, T. D., Hammargerg, K., Sastry, J., Nguyen, H., Rowe, H., ... & Kirkman, M. (2020). Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey. *The Medical Journal of Australia*, 1 Preprint.

Giles-Corti, B., Wood, L., Donovan, R., Rosenberg, M., Saunders, J., & Mills, C. (2004). Opportunities and challenges for promoting health in a changing world. *Health Promotion Journal of Australia*, 15(1), 17-23.

Robert Wood Johnson Foundation, (2013). *Mental Health by the Numbers*. Retrieved from: https://www.rwjf.org/en/blog/2013/01/mental_health_bythe.html:

Rural Doctors Association of Australia. (2016). *Mental health care in rural Australia: A RDAA background paper*. Canberra: RDAA.

Rural Doctors Association of Australia. (2018). *Submission to the Senate Community Affairs References Committee Inquiry into the Accessibility and quality of mental health services in rural and remote Australia*. https://www.rdaa.com.au/documents/item/471

Hajkowicz, S., Cook, H., Wilhelmseder, L., & Boughen, N. (2013). *The Future of Australian Sport: Megatrends shaping the sports sector over coming decades.* A Consultancy Report for the Australian Sports Commission. In: CSIRO, Australia Canberra.

Harvey, S. B., Deady, M., Wang, M.-J., Mykletun, A., Butterworth, P., Christensen, H., & Mitchell, P. B. (2017). Is the prevalence of mental illness increasing in Australia? Evidence from national health surveys and administrative data, 2001–2014. *Medical Journal of Australia, 206*(11), 490-493. doi:10.5694/mja16.00295

Hazell T, Dalton H, Caton T, Perkins D (2017) *Rural Suicide and its Prevention: A CRRMH position paper*. Centre for Rural and Remote Mental Health, University of Newcastle, Australia.

Howard, L. M., Trevillion, K., & Agnew-Davies, R. (2010). Domestic violence and mental health. *International Review of Psychiatry*, 22(5), 525-534. doi:10.3109/09540261.2010.512283

Hurley, D., Swann, C., Allen, M. S., Okely, A. D., & Vella, S. A. (2017). The role of community sports clubs in adolescent mental health: the perspectives of adolescent males' parents. *Qualitative Research in Sport, Exercise and Health, 9*(3), 372-388. doi:10.1080/2159676X.2016.1275751

Jorm, A. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist, 67*(3), 231-243. doi:10.1037/a0025957

Jorm, A., Kitchener, B., Kanowski, L., & Kelly, C. (2007). Mental health first aid training for members of the public. *International Journal of Clinical and Health Psychology, 7*(1), 141-151.

Kessler, R., McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., . . . Williams, D. R. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *British Journal of Psychiatry, 197*(5), 378-385. doi:10.1192/bjp.bp.110.080499

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

King, T. L., Shields, M., Sojo, V., Daraganova, G., Currier, D., O'Neil, A., . . . Milner, A. (2020). Expressions of masculinity and associations with suicidal ideation among young males. *BMC Psychiatry, 20*, 1-10.

Kuskoff, E., & Parsell, C. (2020). Preventing Domestic Violence by Changing Australian Gender Relations: Issues and Considerations. *Australian Social Work*, 73(2), 227-235. doi:10.1080/0312407X.2019.1641529

Leavey, G., Rothi, D., & Paul, R. (2011). Trust, autonomy and relationships: The help-seeking preferences of young people in secondary level schools in London (UK). *Journal of Adolescence, 34*(4), 685-693. doi:https://doi.org/10.1016/j.adolescence.2010.09.004

Liddle, S. K., Deane, F. P., & Vella, S. A. (2017). Addressing mental health through sport: a review of sporting organizations' websites. *Early Intervention in Psychiatry*, 11(2), 93-103. doi:10.1111/eip.12337

Mazzer, K. R., & Rickwood, D. J. (2015). Mental health in sport: coaches' views of their role and efficacy in supporting young people's mental health. *International Journal of Health Promotion and Education*, 53(2), 102-114. doi:10.1080/14635240.2014.965841

McCusker, Michael & Galupo, M.. (2011). The Impact of Men Seeking Help for Depression on Perceptions of Masculine and Feminine Characteristics. Psychology of Men & Masculinity, 12, 275-284. https://doi.org/10.1037/a0021071

Mental Health Commission (2011). *Mental Health 2020: Making it personal and everybody's business. Reforming Western Australia's mental health system*. Mental Health Commission, Government of Western Australia.

Mental Health Commission. (2018). *Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025*. Mental Health Commission, Government of Western Australia. Retrieved from https://www.mhc.wa.gov.au/media/2829/mhc-prevention-plan.pdf

Mental Health Commission (2019). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) Update 2018*. Mental Health Commission, Government of Western Australia.

National Rural Health Alliance. (2016). *Mental health in rural and remote Australia*. Canberra: National Rural Health Alliance Inc.

Northern Territory Health (2016). *Northern Territory Health: Aboriginal Cultural Security Framework*. Northern Territory Government.

O'Connor, J., Jeanes, R., Grove, C., Lambert, K., Bevan, N. and Truskewycz. H., (2020). *Mental Wellbeing Provision in Victorian Sport.* Monash University. Report. https://doi.org/10.26180/13158416

Pierce, D., & Brewer, C. (2012). Factors Promoting Use of Mental Health Services in a Rural Area of Australia. *Journal of Community Medical Health Education,* 2:190. doi: 10.4172/2161- 0711.1000190

Rothì, D. M., & Leavey, G. (2006). Mental Health Help-Seeking and Young People: A Review. *Pastoral Care in Education, 24*(3), 4-13. doi:10.1111/j.1468-0122.2006.00373.x

Rice, S. M., Purcell, R., & McGorry, P. D. (2018). Adolescent and Young Adult Male Mental Health: Transforming System Failures Into Proactive Models of Engagement. *Journal of Adolescent Health*, 62(3, Supplement), S9-S17. doi:https://doi.org/10.1016/j.jadohealth.2017.07.024

Rimer, B. K., & Glanz, K. (2005). Theory at a glance: Application to health promotion and health behavior. Department of Health and Humans Services, National Institutes of Health, 12-14.

Sawyer, M. G., Arney, F. M., Baghurst, P. A., Clark, J. J., Graetz, B. W., Kosky, R. J., . . . Zubrick, S. R. (2001). The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and well-being. *Australian and New Zealand Journal of Psychiatry, 35*(6), 806-814. doi:10.1046/j.1440-1614.2001.00964.x

The Men's Project & Flood, M, (2018). The Man Box: A Study on Being a Young Man in Australia. Jesuit Social Services: Melbourne.

Vines, R. (2011) Equity in health and wellbeing: Why does regional, rural and remote Australia matter? *InPsych: The Bulletin of the Australian Psychological Society Ltd,* 33(5), 8.

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., . . . Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The Lancet, 382*(9904), 1575-1586. doi:https://doi.org/10.1016/S0140-6736(13)61611-6

WHO (1986) The Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, 21 November 1986.http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

WHO (2004). *Prevention of Mental Disorders: Effective Interventions and Policy Options, Summary Report*. Retrieved from Geneva:

WHO (2012). *Adolescent mental health*: Geneva: WHO Press.

WHO (2014). *Health Topics, Mental Health*. Retrieved from https://www.who.int/health-topics/mental-health -tab=tab_2

APPENDIX

APPENDIX 1: OPEN RESPONSES TO QUESTIONS IN SURVEY

QUESTION: What are the most important challenges that confront community sports clubs trying to engage in mental health and wellbeing programs?

- Getting people to engage
- I think there is still some stigma around mental health, however the more we talk about & promote the program the better it is getting
- I can't think of any, but I am sure if there were programs offered the clubs would take them up.
- Getting people to take it seriously, having people admit to needing help (especially men), stigmas
- To many priorities not enough time, people, money
- resourcing and qualified facilitators
- Access to funds to facilitate and embed mental health programs within the ongoing operations and culture of sport in WA.
- Getting the members to understand the changed rules, getting them back to the sport
- Time management
- volunteer time
- At the moment, COVID-19
- willingness to engage with men and young males about the importance of mental health
- Supporting & encouragement for all participants not just the top performers. Emphasis on community participation rather than individual success.
- Focus on community when lots of participants/ parents are manipulating clubs to benefit themselves.
- The popularity of the sport affects the reach of the club influence. Most players see sport as enjoyable recreation, so it's difficult to expect players, parents etc to spend more time at clubs discussing a serious issue.
- Not knowing where to start, and having the time and resources to do something.
- Stress
- society stigma, poor leadership, dealing with mental health issues flippantly, off putting misunderstood terminology in mental health
- To many people to have personal interactions with, more representatives would help this and give more diverse averages of people
- The associated stigma surrounding mental health and the management
- suicide rates in younger people/money
- Time and additional workload on volunteers, stigma associated with mental health and wellbeing, knowledge about the best resources to use
- I think the total lack of mental health information and training through the sport governing body at least at state level. I have been in a situation with my son who battled some demons of mental health and the response from the sporting body was to cut the kid from a state team which was the second year running he had been selected. There was no help, support, guidance. Hands were washed clean and he was sent on his merry way
- Opposition teams not playing in good spirit. Lack of funds and awareness.
- costs, as a not for profit organisation costs of all resources are limited
- Support to open up the conversation and the time to enact
- Implementation - committee members already have significant responsibilities.
- Getting people to talk about it, and focusing on it
- Costs
- Time
- Time
- Getting people to admit they have an issue or challenge - there is a lot of old school pressure applied to younger players, seen as a "rite of passage" to play at the club.
- how to include people with mental illness at our club
- stigma associated with mental health and wellbeing
- It is not regarded as important as technical ability.
- Clubs run be volunteers barely have enough time to manage the core business of the club. People find it hard to find the time to be involved or upskill themselves.
- As average people who happen to be members of a sporting club..... We meet once a week so therefore we

ourselves may not be aware of any members having Mental Health issues. We are not in any way qualified to assess any members issues, should they have any.
- Open Communication between members and the feeling of comfort in the way members are treated between each other
- Lack of understanding in some communities and the attitude of 'Pull yourself together" or "Toughen up Princess" whereas the "Are you bogged mate" program in the rural areas is a great way of relating to farming we need to develop similar themes for sport
- Cost
- generating interest
- Different needs for different age groups
- Time, resources and capacity
- volunteer time and preparation and facilitation of resources
- The cost
- Engaging members to participate
- Financial and relevant contexts
- Locating resources and facilitators
- Acceptance by members
- Lack of funding/ resources to this specific area (HR).
- Maintaining the people involved who are able to deliver mental health programs
- I think most members see mental health and wellbeing as a bi-product of club membership. If connections are strong and trust developed then support of members struggling with mental health issues comes naturally. I suspect most of our members would not attend information sessions on mental health provided by 'outsiders'.
- Getting the club leaders to be more active in promoting & educating their respective club communities to the importance of mental health & wellbeing. They can & must try to make a difference - not be passive in their approach to this subject. Re on line education - you can lead a horse to water but you can't make them drink.
- resources, skills, and facilities
- Inexperience, not knowing ,"what to say", overcoming stigmas, application and no one size fits all - each case is unique
- Clubs are run by volunteers with families and jobs so the biggest challenge is the capacity of volunteers to take on more time-sucking responsibilities.
- Capacity and capability of the volunteer cohort within clubs
- when spreading the message becomes "compulsory" or target driven it really diminishes the impact. We want interactive and fun ways to incorporate the promotion of a positive mental health initiative. Volunteers are time poor in sporting organisations so striking a good balance can be difficult. We are very aware of the need to promote a strong message and build our mental health awareness culture in junior Netball.
- Getting people involved, getting responses from local mental health services to participate
- volunteers, trust, referral agencies availability
- Different groups, kids, women and men
- Embracing it as part of their day to day operations 'who we are' rather than a stand-a-lone project. Education for individuals (staff members and volunteers) who are not health professionals. Promoting (and communicating) the positive and proactive impact that sport and recreation can have on these areas.
- volunteers
- having the right literature and delivering the content to the relevant audience
- Selling the importance of mental health
- Deliverers available, getting the right people in the room from the club
- Lack of time and knowledge for the very small number of volunteers willing to actually contribute
- Getting people who need help to put their hand up. This applies to both men and women
- Not knowing where or how to find resources or help
- The stigma associated with mental illness as well as access to rural and remote communities where mental health issues can be more prevalent.
- Funding for these programs and our ability to utilise them for everyone's benefit
- Knowing how to identify and respond to issues that arise
- lack of knowledge and lack or resources
- Not sure
- Not seen as being an issue or priority
- Targeting the right audience top attend the sessions and programs
- Time, money, member engagement
- Perception that it is not their direct and primary purpose - that by focusing on this then they are 'taking away'

from what they are doing in promoting their club. Adding yet another task to the already exhausted volunteer committee.
- time, cost, apathy
- Volunteer buy in/time, relatable case studies, relatable data on local community experiencing mental health, clubs/volunteer confidence to deliver service locally.
- Apathy from players in relation to mental health
- Trying to educate in a positive fun way rather than sit down talks.
- Funding is a major impact
- Obtaining the understanding from a member that the club is interested in their mental health and wellbeing without appearing intrusive
- Member uptake/motivation
- run and operated by volunteers for the purpose of providing tennis, not mental health and wellbeing support. Its an unfair impost for volunteer operated clubs to provide these types of services.
- Cost, time, stigma and lack of knowledge
- Creating an environment where the discussions can take place, creating sustainable support frameworks and outcomes, resourcing to deliver the programs
- The balance of Coaches wishing to achieve and elite performance and athlete welfare. Coaches are our biggest asset and threat.
- Knowing where to start. Being aware of potential mental health issues within their club
- Why do you assume so many people and organisation have this challenge? To me you are inviting people to not deal with their issues without paid help.
- Getting members on board to help with other members. They will take the literature & talks very well but as to implementing the procedures not many wish to be involved.
- Getting people to open up who are at risk
- Recognising when there is a problem
- As a volunteer making the time to listen, be trained then assist in wellbeing programs
- don't know
- Attracting the interest and involvement of the membership
- Acceptance and participation in programs
- Breaking down barriers for engagement within their local communities. However also have relevant resources that are able to be delivered in a variety of ways to suit members. For example, face-to-face, online etc.
- Participation
- I think #1 is the stigma and #2 which I think is the biggest one, is how to. Where to start for some of them is the most difficult part because they may have the best intentions, but feel lost in how to action those intentions
- Willingness to make it a priority. They don't see it as their role, or realise the positive impact that they could have.
- Lack of resources to champion and execute - we're just volunteers, already busy running the club
- support from members
- time poor volunteers
- Poor culture and nepotism
- Being approachable and knowing where to send people for help if they require it.
- Member participation
- Biggest challenge is knowing who actually needs help and whether they are willing to reach out for it
- There are so many other challenges like money, upgrading facilities and the fact we are all volunteers that sometimes all your spare energy and time is used up. Perhaps the focus needs to be that mental health and wellbeing can positively impact if you volunteer at clubs and get engaged in providing help,
- From our tennis club perspective with mainly social players and low level competition people can get help elsewhere.
- Admission of a mental health issue
- Two things. Stigma and the fact that young people are not accessing our club and many others. They are not getting the sense of community that comes with belonging to a club.
- Funding and resources
- Creating conversations that members can be part of. Passing on knowledge to members and their families
- Getting people to communicating about it so you can help
- People being proactive

QUESTION: What support do you need to deliver mental health and wellbeing programs?

- We have the State of Mind program - the NRL provide all of the resources for
- Being put in touch with people who can organise these programs and funds to support the programs.
- Quality speakers
- Wellness coaches from outside of the sport offered to each club Within Clubs/Assoc too few people are already doing too much.
- financial support and knowledge of who to go to
- Funding and expert resources/providers
- Not sure - perhaps referrals to good online resources that could be shared
- Resources
- Not too sure
- Coaches & sporting organisations representatives required to have Mental health awareness qualification.
- framework examples
- Access to support.
- Flags, banners, eye catching material that can be placed in the field or club house so that everyone can see. Pan-flits, posters for members to take home, purchasable merchandise such as hats, shirts so that mental health symbols are more common. Make all clubs have a dedicated mental health officer/Chaplin, just someone who's present and available every training session/game day.
- That would depend on the size and scope of the programs
- Reassurance
- understanding how leadership/role models (eg older players) behaviour and words impacts others, most effective communication styles to impact mental health, a reality check on suicide/mental health numbers, easy to use and understand programs
- Committee, community and participation
- understanding
- Access to relevant, sports specific content.
- Trained professionals in bedded in the sport that can be accessed. Most sporting organisations are run by Parents
- Liaison officer
- Training and resources. Club volunteers sacrifice paid work to attend, so any incentive to offset expenses to the individual or grant to the club would be valuable
- Contacts of organisations that will provide guidance
- Funding for resources. External trainers or personnel to facilitate delivery.
- not sure
- Money
- Speakers
- Understanding from members
- it needs to be SEEN (posters / social feeds) before people are willing to TALK
- club support, inclusion training
- prominent sports people role modelling good mental health awareness
- Access to materials and funding to organize mental health seminars in my club.
- Something simple and easy to implement at club level.
- None
- None needed at this time
- The provision of some printed materials for small clubs so officials can help support their members
- Grant funding
- a mobile practitioner to create some interest
- resources
- A coordinator to oversee the program and liaise with the club as to available dates, times etc.
- Suitable presenters who can engage with a cross section of clubs and programs.
- No idea
- Technical expertise re mental health and associated costs
- Committee support
- Nil
- Ideally, State or Government implementation so that it MUST be carried out
- resources, funding

- Perhaps input to Council members and coaches to help them recognise signs of stress etc.
- As NRL WA we get fantastic support from our Community Department...as well as haveing some valuable funding support from the WA Government to allow us to facilitate State of Mind programs across the state to all Rugby League clubs - an excellent initiative.
- resources, training and facilities
- Policy guidance, education, materials (online and paper) for distribution
- Outside providers and funding
- Toolkits; best practice and easy to source resources aimed at the varying ages/demography of club members
- A strong interactive method of delivering the message. As an association we were going to engage a guest speaker for the 2020 season before the impacts of COVID hit us to help promote the benefits of junior sport done right.
- People to assist in running events, engaging with services
- creating a hub within your community, effective time management to run programs within a season
- Facilitators
- Education support information, training and resources - practical and operational as well as strategic. Information and promotions, written and verbal for both individual clubs, State Sporting Associations and the entire industry. Relevant case studies. Information and access to the groups listed previously in this survey - many of them do excellent and valued work, however they are not well known, nor is there a common directory providing the relevant information, websites and contact personnel.
- programs and information targeted to the correct demographic or have a guest speaker delivery these on a night where we can have teams available.
- Social media, strategies to connect
- Unsure
- Easy to implement, easy to know where to refer individuals who need extra help
- Funding. We have the expertise and there are providers, we just need to be able to fund it
- Our State of Mind program has been supported financially by the State Government and is well resourced from the NRL
- Contacts, funding, resources
- Appropriate content to deliver for sessions, professional contacts for program participants (post-session) & promotion of such programs.
- Knowledge of them, ability to access them and being able to have our members access them
- Staff Education and Training & support for clubs
- SSA delivered program in partnership with provider that fully engages the club
- not sure
- Materials
- Any support is better than what most community clubs currently are able to receive
- Education, guidance
- Content and resources
- Resources and knowledge of how to incorporate this into what they are already doing - instead of seeing it as a separate standalone type program.
- don’t know
- Data and relatable case studies in community sport, approachable professional contacts when faced with questions/challenges, social media presence & champions of change.
- NRL do a great job and provide plenty of help
- Personal experiences from people, the uplifting and downside to MH. Handouts are also good to have on site as well as mailed out.
- We need funding to be able to acquire resources
- Unsure how to respond as delivery is not generally recognised as a club responsibility as sporting clubs are not qualified to deliver professional such programs
- web based tools which members can received automated communication as members of an affiliated club.
- Peer-reviewed and or academically produced content/collateral
- Effective Delivery Partner, material that can be shared across multiple platforms, programs that can be adapted to different audiences/environments, effective reporting on impact
- Funding and program collateral (e.g. online resources)
- Recommended providers, fee support
- Why do you think that we have a need for these programs? Money would be better spent on lower cost of providing good venues and fees to players.
- Posters and guest speakers

- Qualified speaker with sports experience
- Finding out what resources are out there
- More hours in a day!
- I don't deliver mental health and wellbeing programs
- I really don't know. The management committee spends no time considering mental health, as volunteers we spend significant time on the practical aspects of the operations and maintenance of the club so any such programs would need to be easy to deliver and not require significant input from the committee.
- Acceptance by Committee
- A straight forward process that provides relevant information, with support to deliver in flexible environments and methods.
- Posters. Information
- Relatable and easy to deliver programs - the more support we can get in that space, the easier it is for us to deliver and hopefully get the desired outcome to fruition
- A developed program from professionals, with resources and guidelines on how to role it out and deliver it.
- Resources that don't cost us time and/or money
- Information/pamphlets/support
- someone else to drive it and run it that is getting paid
- Appropriate Governance
- More information/frameworks, as we are a volunteer sporting club, money to run these days and these can be time consuming for the committee of the club to organise
- Access to guest speakers
- Nothing more than being a ear to talk to if required
- Money and manpower
- I don't think it is necessary at club level, there are many other sources for mental health support.
- Outside professional's
- Effective simple resources and time.
- Education on how to speak to members

QUESTION: Is there anything else you would like to tell us about supporting clubs to deliver mental health and wellbeing programs?

- I think the programs should have a face to face a few times a year to capture more people
- The Belonging to the Club might be the best preventative measure to avoid mental health issues Advocating sport/club membership through Health Sector S
- Nothing comes to mind - we are a small club
- No
- No
- I think it's essential for people to not be flippant about mental health issues and understand how they personally can help/hinder in a proactive way
- getting out to the younger indigenous people
- This is a welcome yet well overdue initiative should it progress to WA Baseball. This is a major topic that for too long has been washed under the carpet and it does not lay with sporting clubs alone, but the state and national governing bodies
- Encourage the conversation to be had via the peak sporting organisation
- The biggest issue is time to do and work load for committee members.
- No
- Focus on the positives. Maybe utilise state wide teams support. E.g. kids footy, have access to eagles and dockers support people to help.
- no
- is it better top focus on the gap or the solution. Much of this is focused on the gap or the thing that is wrong.. but perhaps ask us what we are doing well as a club?
- Its really important and much needed
- This is a frank statement form myself personally..... If there were any of our club members or friends and family for that matter, who had mental health issues I would hope that the correct diagnosis of their condition would be forthright. But unfortunately, in our town of Kalgoorlie Boulder WA we do not have access to a psychiatrist, unless you travel over 600klm to Perth. Our regions do not have the medical professionals. We have a number of counsellor services and GP's but precise treatment is not available without a diagnosis.
- Mental health is a very important aspect of our membership and is tightly monitored

- Small isolated clubs need to be able to interact with similar clubs and the parent associations need to be able to facilitate regional/zone competition and training events to assist in this
- no
- It is hard enough to find sponsors, volunteers and players to keep the club going. This will need to be managed externally to really have the impact required.
- Nil
- We are keen to have an impact in the area
- No
- there does seem to be a lot of service providers. Maybe having an idea of the best suited to sport would assist in knowing who to contact for assistance in first place.
- No.
- We all just need to keep aggressively promoting the need for this education & the role of clubs to really make a difference in this space. Clubs are there not just for the on field activity but also to use sport as a means to enrich people's lives & wellbeing - physically & mentally.
- creating inclusive environments at a club and association level ie more than just fast food sport. Design facilities with club rooms, social areas that invite people and children to connect. The social component of facilities is nonexistent in some sports and tacked on in others. Develop an inclusive community facility that supports networking and is not just about money for administrators or associations to fund mid tear competition for adults (state leagues). I get really annoyed at the lack of investment in the social level of sport. It provides the largest health and economic benefits to the community and the funding continually is driven away from the grassroots. Sport has the capacity to connect and sport clubs and associations need to change what they see as their core business to include the social and inclusion components.
- NO
- funding availability to sustain mental health programs within a sporting club environment
- I believe the sport and recreation has (could have) a integral role to play in these messages and programs, the provision of support and resources would greatly assist in the sport and recreation industry to feel confident in taking on this essential role.
- No. However this survey is built around only having involvement with one sport. Ppl can be involved at a high level with more than one
- N.A
- We feel mental health is implicit in playing team sport but would like to help our coaches know how to do more
- The task is ongoing and the message to be continuously reinforced
- Needs to be clear and easy for volunteers that isn’t overly time consuming
- no
- no
- Volunteers are 'tired', therefore, concept should be simple, easy and impactful. Anything less will be seen as more work and be pushed to the back.
- I believe it is such an important issue that sports club should be aware of. From my personal experience I wish i was able to give talk to kids and adults about my journey
- NA
- no
- Unfortunately, Motorsport competitors are individuals driven to succeed and not always very interested in mental health issues when discussed at club level.
- No.
- One program that can be utilised across all sports for continuity of messaging and cut through.
- Even in this COVID-19 environment, SWA staff are dealing with poor behaviour that negatively impacts the mental health and wellbeing of our members.
- This all sounds to me like "follow the money".
- Guest speakers need to be able to deliver their talks on scheduled game days otherwise most members are to busy to come to extra meetings
- No
- I think clubs are already part of the answer to improved mental health in the community, in line with the Act Belong Commit message. The problem with mental health is that it is not always easy to recognise when someone is suffering and it would be good to have information at hand for quick action/referral when something comes up that is serious enough to warrant professional help. Close friendships are probably the best insurance against mental issues and clubs provide a real opportunity for close friendships which is priceless. Continuing to support community clubs in general goes a long way to supporting mental health in the community.

- Being a member of a club, it is every members' responsibility to be inclusive with all members
- Are there any easily identifiable benefits for the club/members from conducting such programmes? How can we identify if any of the club members require such support? Is there a way to show measurable outcomes from these programmes?
- Posters regarding - Be Kind, Be Nice
- Flexible delivery methods are a must to ensure programs have a greater reach.
- Could make more use of slogans and heroes. Needs to be much more openness and willingness to talk about mental health.
- People are generally happy with being included and able to play to release endorphins
- Getting people to try joining a club is the first step
- Ensure the Governance is appropriate first
- Can be difficult engaging members, general / broad information may be more effective.
- No
- It is critical put need to come from the top down so via state bodies to clubs
- I don't think it is necessary at the level of my club.
- In the current climate, there is a growing need for mental health programs and services. These need to focus on resilience. I'm not sure that the people involved in sporting clubs are the ones who really need it. Its the ones who aren't that do.
- More conversation needs to be had about the wellness not the illness. Only speaking in deficit language paints a negative picture and scares people out of having conversations. Combine wellness practices (so you can work on things when you are ok not only react when sh*t hits the fan)
- Perhaps simple documentation, YouTube etc. to post on our website and Facebook page

APPENDIX 2: PROGRAM PROVIDER ASSESSMENT WITH FRAMEWORK, NOTES TO ACCOMPANY CODING FRAMEWORK.

Project Code	P2
Program has explicit ties with an established overarching mental wellbeing framework.	More of a Physical Activity, Sport, Health focus. No explicit or targeted links to mental wellbeing.
Program uses language and approaches consistent with established MWP frameworks.	Not this program's focus.
Programs underpinned by well-established models/theories of mental wellbeing provision.	N/A.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Targets individuals in a community. No explicit targeting beyond keeping the individual engaged and active while delivering some subtle health messages.
Program utilises well resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Not for mental health, but there was some consultation with other practitioners around approaches. Training provided to volunteers to deliver the programs.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Focus of this organisation is on Indigenous health, so have consulted with local Indigenous populations, health professionals and organisations.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Focus is on rural and remote Indigenous populations, so does consult with local community and health services.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Unclear. Volunteers undergo training to ensure culturally sensitive and relevant. Nature of the program is informal and flexible which may be approachable.
Program helps clubs establish community support for the need to focus on mental wellbeing.	No specific links to clubs. Visit rural/remote communities to do various activities with youth 1 to 3 times a year.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	A key strength is the program's flexibility to deliver in changing contexts. Face to face group sessions aimed to maximise engagement. 4 instructors that enable ongoing support for each other and youth. Also, able to create subgroups to meet their and the community needs. e.g. age, gender. COVID- online resources and some equipment hampers.
Program is targeting different cohorts both within and beyond sport clubs.	In school and out of school context. Small rural/remote communities, whoever is present and wants to join in, is able to. No links with sports clubs. Rural areas, limited population.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Unsure how this would adapt in urban area, however very applicable to remote/rural and

	Indigenous populations (which are the focus of this program).

Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Outcomes are linked to education and participation in physical activity and preventative health measures. Key component is maximised engagement and inclusion.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Engaging program but does not explicitly promote mental wellbeing. Yoga program may have links but they are secondary and any wellbeing links are not explicit.
Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues)	Focus on cultural and community complexities. Adapting to each community and their diverse needs. Program reflects the flexibility required to deliver programs in remote, predominantly, indigenous community areas.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Unclear. Cultural sensitivity training is a requirement. All volunteers undergo training.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language)	Communicate with community but unsure if tailored to their needs thoroughly. When volunteers arrive, they adapt the session to the numbers and kids, ages, gender, cultural needs. The programmed sessions are activity based and flexible.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	Very much so.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Provider is known by other service providers in communities but, no explicit links.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content	Some measures taken at times but largely not within their capacity or expertise to execute. Difficult to get consent from minors. Communities are complex and make evaluation difficult.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	N/A
What works is known, how it works is known, and repeatability is universal.	Trial and error approach. Seems to be informed by observations and anecdotal evidence. Some experts consulted but unclear.
Measures have established impact across different settings, sustained over time.	N/A
Evidence collected is publicly available and open to external scrutiny (i.e. on website).	One community paper available online on one of the programs.

Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	Community enjoy the program but complexities when working with small remote communities make it difficult to ensure the continued funding.
The program is financially self-sufficient and not dependent upon grants.	No, grant dependent.
The host organization is “mature” (stable, resourceful).	Mature, yes. Launched around 2011 2.0FTE (3 staff).
The value and mission of the program fit well with the broader community.	Aims to serve the communities they reach, but outcomes are spread thin and unsure on last effect.
The program meets legal and compliance responsibilities.	Assumed yes.
The program represents 'good value for money' for the club	N/A
Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	The program is clear but how to achieve and measure outcomes is uncertain. Many factors complicate this. Anticipated will adapt as needed but no clear strategy.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	N/A
The program has a clear strategy for supporting positive culture change within community clubs	N/A

Project Code	P7
Program has explicit ties with an established overarching mental wellbeing framework.	Positive Mental Wellbeing/ psychology.
Program uses language and approaches consistent with established MWP frameworks.	Yes.
Programs underpinned by well-established models/theories of mental wellbeing provision.	Strong Health Promotion principles- community development.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Yes, largely awareness and promotion. Targets communities, policy, media. Will depend on the club context and their needs too.
Program utilises well-resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	XXXXX University involved in research and guidance. Links to professional services at local and state levels.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Did not discuss any specific consultation with Indigenous populations or health professionals.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Stated that will tailor to community's needs, however did not discuss this explicitly.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Yes, strong emphasis on marketing and making information reach its (varied) target audience.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Yes. Main priority is to support community and their members to use and promote overarching brand.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Yes, they have a diverse range of modalities. Online presence via social media to webinars. During COVID adapted material to provide principles at home and during a pandemic. Also have ongoing communication with clubs to support their way of employing brand and message. This could be in policy, through fundraising events or promotional material around the club. Also, able to link to other services for additional support.
Program is targeting different cohorts both within and beyond sport clubs.	Yes. In the sport context it targets members, in the hope that ABC becomes a part of their 'outside sport' life.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s	Would be able to adapt if required.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Yes.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Yes. Large marketing campaigns to promote message and have a brand.

Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues).	Yes. Program maintains flexibility to work with a variety of contexts. Able to be tailored to unique community.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Yes. Ongoing support and communication to partnered clubs.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Yes. Contextual information gathered to meet needs of community and club.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	If necessary, the organisation would do this, however did not explicitly discuss.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Yes. Links to state and local providers.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content	Yes.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes	State based- Conducted yearly 600/ 400 metro, 200 regional. Pre and post surveys to all members. Interviews with key stakeholders. There are evaluations of partnership program 2-3 years. Team at XXXXX Uni doing evaluations. New evaluation framework as part of new funding. New parts to the survey.
What works is known, how it works is known, and repeatability is universal.	Yes.
Measures have established impact across different settings, sustained over time.	Yes.
Evidence collected is publicly available and open to external scrutiny (i.e. on website).	Yes, state based, yearly evaluation available.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	Yes.
The program is financially self-sufficient and not dependent upon grants.	Based on a 3 yearly funding basis.
The host organization is “mature” (stable, resourceful).	Yes. 12 years.
The value and mission of the program fit well with the broader community.	Yes.
The program meets legal and compliance responsibilities.	Yes.
The program represents 'good value for money' for the club.	Yes. Can run program for free.
Sustainability of Impact	

The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Unsure.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Unsure. But resources and support to assist clubs.
The program has a clear strategy for supporting positive culture change within community clubs.	Yes. Key focus area.

Project Code	P6
Program has explicit ties with an established overarching mental wellbeing framework.	Overarching educational organisation, outsource sport organisation to deliver MHW awareness and information to football community using educational organisation as their primary resource. Links to official MHW framework.
Program uses language and approaches consistent with established MWP frameworks.	Yes, linked to MHW framework. Delivery unclear at this stage.
Programs underpinned by well-established models/theories of mental wellbeing provision.	Yes.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Yes but, educational information and delivery will be tailored to the community/clubs/ regions. Targeting depends on community/clubs/regions.
Program utilises well resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Well-resourced via overarching organisation. Dependent on funding. Supported continued at various levels. Training for key people- coaches, committee members, champions. Delivery still being designed.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Unclear specifically however discussed tailoring to community's needs.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Focus is on regional WA, however does some in rural communities also and consults with localised organisations and mental health organisations.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	In the community, champions. Some high-profile AFL club members to help endorse message.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Yes, intention to be a conduit support community and link them to service providers.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	The delivery intends to be flexible to meet state, regional and community/club requirements. Online resources available.
Program is targeting different cohorts both within and beyond sport clubs.	Males 25-40, in football clubs. Peripheral club community. As communities change i.e. more juniors, women. May have scope to target too. But because it is grant based to target specific group, this is not priority.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Has the ability to adapt and deliver in different geographical contexts and with Indigenous persons. Still designing program.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Two outcomes- Hope to have people internally with skills and education to identify when people are struggling and create and support links and relationship with local service providers.

Provides appropriate ways to raise awareness of and promote mental wellbeing.	Yes, flexible, needs based.
Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues).	Yes, detailed understanding of unique needs and contexts of regions, communities.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Yes, overarching organisation, but delivery is still being developed.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Yes, is dependent on local knowledge to deliver message.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	Delivery still being designed, but has this potential.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Yes, links with overarching organisation. Endeavours to link to local service providers.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	External Evaluator from partner organisation, annually.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	N/A
What works is known, how it works is known, and repeatability is universal.	N/A
Measures have established impact across different settings, sustained over time.	N/A
Evidence collected is publicly available and open to external scrutiny (i.e. on website).	N/A
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	Yes, multiple partners. 3-year program
The program is financially self-sufficient and not dependent upon grants.	Initiative is a 3-year program based on funding.
The host organization is “mature” (stable, resourceful).	In second year and resourceful.
The value and mission of the program fit well with the broader community.	Yes.
The program meets legal and compliance responsibilities.	Yes.
Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	No, some phases still in development. Guided by intended outcomes.

The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Yes, but some phases still in development. Guided by intended outcomes.
The program has a clear strategy for supporting positive culture change within community clubs.	Yes, education of key people. Some phases still in development. Guided by intended outcomes.

Project Code	P15
Program has explicit ties with an established overarching mental wellbeing framework.	Is guided by Therapeutic communities, Living Works/ASIST, Alcohol and Other Drugs guidelines. Not MH evaluated but also use The Rite of Passage Framework.
Program uses language and approaches consistent with established MWP frameworks.	Yes. Reinforced.
Programs underpinned by well-established models/theories of mental wellbeing provision.	Yes. See above. Is guided by Therapeutic communities, Living Works/ ASIST, Alcohol and Other Drugs guidelines.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Program targets individual and their circles. Provide individual with tools to manage their own MH.
Program utilises well-resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Comprehensive training of facilitators, use of experts to educate and deliver. Psychologists, nutritionists, sport psychologists etc. holistic view.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Unclear.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Unclear.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Yes- depending on the group will find speakers for the program. For example, if sport, then will find a sport speaker with lived experience.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Work less in clubs but can. Focus more on the individual and their interactions in their circles. If individual is involved in sport then there is some cross over, but also into school and beyond.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Yes, Large range of modalities. Completely adaptable to meet the needs of the client. E.g. MH camp was mainly recruiting girls, identified needed to reach boys so developed sport MH camp and increased reach to boys. Have social media groups, clinics, various camps, school programs.
Program is targeting different cohorts both within and beyond sport clubs.	Program mainly targets 14-18. But also can target 10-12 year old's. Not specifically sport club based.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Has the ability to adapt, however not designed specifically for it.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Yes.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Yes. Range of delivery methods.

Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues).	No. More focused on school settings and less about sport club settings. Does have a sport camp to deliver MH messaging.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Yes.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Yes, consolation with context
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	N/A.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Not explicit.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	Sport program not well evaluated. Other programs better. Pre-survey, post survey, a more intensive feedback form, includes qualitative information. Sometimes reports to parents- post camp. Mainly tracking pre and post knowledge such as confidence dealing with subject matter, facilitator feedback.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	Unsure on exact methods or content of survey. But used to evolve programs.
What works is known, how it works is known, and repeatability is universal.	Unclear.
Measures have established impact across different settings, sustained over time.	No
Evidence collected is publicly available and open to external scrutiny (i.e. on website).	No.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	Yes.
The program is financially self-sufficient and not dependent upon grants.	No. Events fundraising and grants
The host organization is “mature” (stable, resourceful).	Yes
The value and mission of the program fit well with the broader community.	Yes, youth focus. School age.
The program meets legal and compliance responsibilities.	Yes.
The program represents 'good value for money' for the club.	Unsure of cost.
Sustainability of Impact	

The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Yes, at individual level. Supports individual young person to be MH aware and a contact point for peers and community.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Not in clubs but with individuals.
The program has a clear strategy for supporting positive culture change within community clubs.	Discussed needing positive culture change within community clubs, but not explicitly how this is done.

Project Code	P10
Program has explicit ties with an established overarching mental wellbeing framework.	No, primarily focused on basic delivery of information.
Program uses language and approaches consistent with established MWP frameworks.	Yes, raise awareness and de-stigmatise.
Programs underpinned by well-established models/theories of mental wellbeing provision.	No.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Program is not explicit in focusing on this. More about starting the conversation in the club community.
Program utilises well-resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	No, but does have intention to provide/ refer Mental Health training to club champions.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Did not discuss, unclear.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	N/A.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Yes. Focus on niche target audience. Men deliver message to help men.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Yes. Initial starting point but not formalised forms of ongoing support. But community focused.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Social media presence, during covid a webinar. Some online content but mainly face to face in clubs.
Program is targeting different cohorts both within and beyond sport clubs.	No, niche cohort but to try and have follow on affect into families and broader community but not explicit.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Has capacity to do so, however did not discuss.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Yes. Raise awareness educate, destigmatise amongst men to assist with help seeking behaviours and conversations.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Yes.
Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues).	Yes.
Program consistently and continuously communicates its strategy through supportive	Yes.

language that avoids prejudicial or pejorative references.	
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Local knowledge of clubs Is used, but not baseline measures.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	N/A.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Intends to link to other services.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	Used K10 as a snap shot. But not evaluation of program outside comments.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	Yes, but unsure of how this is used to evaluate program.
What works is known, how it works is known, and repeatability is universal.	N/A
Measures have established impact across different settings, sustained over time.	No.
Evidence collected is publicly available and open to external scrutiny (i.e. on website).	No.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	MH commission funded.
The program is financially self-sufficient and not dependent upon grants.	Unsure.
The host organization is “mature” (stable, resourceful).	No, sept 2019.
The value and mission of the program fit well with the broader community.	Yes.
The program meets legal and compliance responsibilities.	Unsure.
The program represents 'good value for money' for the club.	Yes.
Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	No.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Not clear but planning to develop champions in clubs.
The program has a clear strategy for supporting positive culture change within community clubs	In planning stages.

Project Code	P3
Program has explicit ties with an established overarching mental wellbeing framework.	Not explicit ties to any existing framework.
Program uses language and approaches consistent with established MWP frameworks.	Yes.
Programs underpinned by well-established models/theories of mental wellbeing provision.	Yes, advisors and experts involved to guide design with evidence-based practices.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Targets individual and their interaction in social domains (sport).
Program utilises well resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Yes, intent to holistically connect to psychologists, parents, teachers, coaches. Provide MH First aid training to clubs/teams with client. Provide training and support to client and club. Case by case basis.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Unclear.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Currently metro-based and just starting out.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Yes.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Helps club support client. This is in training etc. so has a broader benefit to club to not only be trained but also have awareness for those that may be struggling.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Entirely case by case management with connection to psychologists, teachers, parents, peers, coaches. 1:1 support with a range of professionals with the ability to make the program flexible in response to the clients needs. Rigorous support for client.
Program is targeting different cohorts both within and beyond sport clubs.	Only targeted at supporting child in therapy and supporting their engagement in sport. sport club gets some training and education to support child.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s	Unclear currently.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Number of programs. 1:1 individual support program- support client. Postvention program- when there is a suicide, being able to act and support the community. Sport equipment program- supply sport equipment to the disadvantaged client.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Personalised. Some Questions on confidentiality and anonymity of the client.

Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues).	Yes. Many sport contexts to understanding but endeavour to thoroughly network and know the environment before engaging with clubs/community
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Yes.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Yes. Entirely focused on the client and their needs and context when they are signed up.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	N/A.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	Intend to take 6 data points across year. Comprehensive reports on clients progress from psychologist, parent, client, teachers, coach, peers.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	NA
What works is known, how it works is known, and repeatability is universal.	NA
Measures have established impact across different settings, sustained over time.	NA
Evidence collected is publicly available and open to external scrutiny (i.e. on website).	NA
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	A number of stakeholders involved based around an individual.
The program is financially self-sufficient and not dependent upon grants.	No. Dependent on grants.
The host organization is “mature” (stable, resourceful).	No. 7months running
The value and mission of the program fit well with the broader community.	Yes, in terms of MH awareness and support. But individual focus.
The program meets legal and compliance responsibilities.	unsure
The program represents 'good value for money' for the club.	Yes, for the club, costly for the organisation taking an individualised approach.
Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Not currently.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Through the training of individual in club to support client but not beyond that.
The program has a clear strategy for supporting positive culture change within community clubs.	Through the training of individual in club to support client but not beyond that.

Project Code	P8
Program has explicit ties with an established overarching mental wellbeing framework.	Joiners Interpersonal-Psychological Theory for suicide prevention guides their overall approach to their content and campaigns. In regards to the campaign and resources, unclear on explicit nature of links.
Program uses language and approaches consistent with established MWP frameworks.	Yes. Also checked by advisory committee of experts to meet MH appropriate language (i.e. do no harm) and in their targeted community (i.e. sport specific).
Programs underpinned by well-established models/theories of mental wellbeing provision.	Organisation uses Joiners Interpersonal-Psychological Theory for Suicide Prevention to guide their campaigns, content and approaches.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Program targets Coach at one level with the intention to expand to other groups in sport. Usable resources to focus on early intervention. Also has 10-point-self-evaluation too kit to challenge these levels that make individuals feel unsafe, unwelcome etc or unable to have conversations.
Program utilises well resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Yes, many resources to support early intervention/ suicide prevention. Focused on identifying when someone is struggling, how to have conversations and then what to do next. Advisory committee assists to ensure content appropriate and intentional to meet community needs. Some training and support available. Tools aimed to be easy to use and not require training to execute at community/club level.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Not currently.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Unclear.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Is targeted at the community and grassroots level. About inclusion, being a part of the team, fun and enjoyment.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Self-evaluation to identify any club culture or issues surrounding MH. Red flag system. The club can take action to make changes that they may be able to.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Resources online Tool kits Self-evaluation But just content to assist coaches and share around clubs to promote MH awareness, suicide prevention.
Program is targeting different cohorts both within and beyond sport clubs.	Yes, multiple campaigns from this organisation, that go beyond the sporting domain.

Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Has the ability to, unsure if would do this.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Not clearly stated. Feeling supported, belonging, connected. Provide tools for coaches (as influential members) to have conversations and create safe environments. Behavioural change/ culture change. Evaluation still being designed.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Yes. Early intervention and providing people with resources to identify and initiate hard conversations.
Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues).	Details not clear but look for input from the community they wish to serve. Advisors from many sport sectors included at community and elite levels.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Yes.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Yes. Advisors. 10-point scale. Pilot programs to be conducted in future.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	N/A
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Yes, essential for organisation to link with external providers and SSOs. SSOs, councils and organisations provide avenues into sporting clubs and may assist in creating further reach of the campaign.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	Currently in development. Only the club resource for now. 10-point scale to detect any issues.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	Currently in development.
What works is known, how it works is known, and repeatability is universal.	No.
Measures have established impact across different settings, sustained over time.	Currently in development.
Evidence collected is publicly available and open to external scrutiny (i.e. on website).	Not currently.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	3-year funding external company.
The program is financially self-sufficient and not dependent upon grants.	Requires funding.

The host organization is “mature” (stable, resourceful).	Yes, and reputable.
The value and mission of the program fit well with the broader community.	Yes, early intervention, suicide prevention.
The program meets legal and compliance responsibilities.	Yes.
The program represents 'good value for money' for the club.	Free for clubs.
Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Still in development, but initial stage is focused on coaches. Piloting of programs may also determine this.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Yes, but more to be determined through pilots.
The program has a clear strategy for supporting positive culture change within community clubs.	Yes, resource based. More refinement on strategy through pilots.

Project Code	P11
Program has explicit ties with an established overarching mental wellbeing framework.	Not one single framework but, evidence based and best practice strategies inform the program.
Program uses language and approaches consistent with established MWP frameworks.	Yes.
Programs underpinned by well-established models/theories of mental wellbeing provision.	Evidence based and best practice strategies inform the program.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Yes, depending on the context they work in, the information is catered to meet the layers. Unsure on policy levels but, do indicate establishing formal partnerships to ensure ongoing nature of program.
Program utilises well-resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Yes. Psychologist integral to inform program design, content and delivery in various settings.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Discussed tailoring to community's needs.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Does some work in regional/remote, discussed need to consult with local people, however details of this were not disclosed.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Yes, high profile athlete but maintains modest image and emphasises physical activity for all and grassroots approaches. Balanced with Psychologist to give weighting to evidence and information.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Yes, key focus of the program is to establish MH practices and support in communities.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	In person workshops, ideally ongoing, but dependent on requests. E-Learning on their website that provides modules to learn more about MH. Small organisation, facilitators contactable relatively easily online. Over COVID-19, online content developed and online delivery increased.
Program is targeting different cohorts both within and beyond sport clubs.	Yes, able to work in many settings. In sports, a key focus is to connect the sport club and their members to the broader community and service providers.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Has the capacity to deliver in different geographical context and for Indigenous persons.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Yes.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Yes. 11 workshops. Partnerships with SSO to get leaders involved. 3 year buy in, 3 tier approach, inform, depth, empowerment.

Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues).	Yes. Comprehensive. Aware of diversity across different settings/ clubs/ communities.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Yes.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Conversation with leaders to determine context and requirements. Awareness of providers within the local community and willingness to link up with them.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	Not explicitly discussed, however appeared to do so.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Yes. Key component is their willingness to link participants to service in their local community and their context.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	Yes.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	Pre and post data from their E-learning. Devising more evaluation opportunities with a University.
What works is known, how it works is known, and repeatability is universal.	Unclear.
Measures have established impact across different settings, sustained over time.	Evaluation a new component, looking to expand beyond online.
Evidence collected is publicly available and open to external scrutiny (i.e. on website).	No.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	Yes.
The program is financially self-sufficient and not dependent upon grants.	Unsure
The host organization is “mature” (stable, resourceful).	3 years, but has buy in from a university
The value and mission of the program fit well with the broader community.	Yes.
The program meets legal and compliance responsibilities.	Yes.
Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Yes, 3 years minimum buy in. 3 tier approach to inform, deepen understanding and empower.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Yes

The program has a clear strategy for supporting positive culture change within community clubs.	Yes, but maintains flexibility to work in these diverse contexts.

Project Code	P13
Program has explicit ties with an established overarching mental wellbeing framework.	Was established based on WHO and Ottawa Charter frameworks. Healthy Minds established with Beyond Blue.
Program uses language and approaches consistent with established MWP frameworks.	Consistent language. Consistency is key with this provider, and uses language consistently across all programs.
Programs underpinned by well-established models/theories of mental wellbeing provision.	Programs based on evidence, models and frameworks.
Program targets the individual, social (i.e. Masculine norms, social climate), media (i.e. Social media) and policy layers (i.e. Policy against the use of harmful language).	Mental health program not directly doing this, however does because of the wider programs that is implemented alongside it, has wider social impacts, and policy and media layers.
Program utilises well resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Continually updating resources and content. Currently going through this process.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Unclear.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Unclear.
Program voices are seen to be personable, approachable and relatable (i.e. Not overly authoritative).	Personable and relatable language used.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Focussed on sporting community cultural change and support, specific program focusses on mental wellbeing, and all programs support/tie into one another.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. Different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Delivery can be face-to-face, online, webinars. Different levels and sessions, so provider consistently comes back and checks in with the club (within seasons and over years).
Program is targeting different cohorts both within and beyond sport clubs.	Focus is on sporting club leadership (committee and influencers) specifically.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Has the capacity to do so.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Overall very clear and concise, with the content supporting and consistent with the outcomes.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Focuses on three main goals, and is very conscious of discussing mental health and wellbeing in a specific way (e.g. will not go lower than 14 years old - too young to provide to and sporting clubs don't have the mechanisms to continue that support).

Program reflects a detailed understanding of sport settings and organisations (i.e. Knowledge of developmental, cultural, social and systemic issues).	Whole basis is cultural change – very aware of the issues with sporting clubs e.g. time, volunteer base, hyper-masculinity and so on.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Uses supportive language consistently within strategy and content delivery.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. Language)	Specific program does not draw on local knowledge (however does change provider details to suit local needs). Looking into how this can be amended, as not a specific mental health provider. Overall other programs are tailored.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	N/A
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Very much so links into other work and messaging provided.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	Evaluation was after initial implementation, currently in 2 year evaluation process of Tassie program.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	Has done an evaluation of the program when originally implemented including qualitative and quantitative data (pre and post). Other programs have gone through an RCT.
What works is known, how it works is known, and repeatability is universal.	Yes, could be replicated.
Measures have established impact across different settings, sustained over time.	Unsure which measures are being used in current evaluation. Have report from previous evaluation. Programs changing based on evidence.
Evidence collected is publicly available and open to external scrutiny (i.e. On website).	Not currently.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	A vested interest from community and stakeholders too. Support from government (Federal and State). Works with clubs, leagues/associations.
The program is financially self-sufficient and not dependent upon grants.	Receives ongoing funding federally and additional support from State's.
The host organization is "mature" (stable, resourceful).	Ongoing for over 20 years.
The value and mission of the program fit well with the broader community.	Whole community change approach that aligns with the community, and club.
The program meets legal and compliance responsibilities.	Yes.
The program represents 'good value for money' for the club.	Free for clubs.
Sustainability of Impact	

The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Currently updated strategy. Continuously revising and updating strategy and has a strategic manager.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Focus is on the leadership/influencers of the club, however can deliver to whole of clubs too. Aim is focussed on the leadership creating change, and if new leadership enters the club, start program afresh.
The program has a clear strategy for supporting positive culture change within community clubs.	Primary focus on creating positive club culture.

Project Code	P9
Program has explicit ties with an established overarching mental wellbeing framework.	Many frameworks (from website), and also using evidence-based approach.
Program uses language and approaches consistent with established MWP frameworks.	Appears to use language consistent with framework
Programs underpinned by well-established models/theories of mental wellbeing provision.	Very evidence-based. Would like to do a project asking the stakeholders (e.g youth sports participants) on their experiences with providers, what their needs are.
Program targets the individual, social (i.e. Masculine norms, social climate), media (i.e. Social media) and policy layers (i.e. Policy against the use of harmful language).	Discussed the different layers (first example of challenging hegemonic masculinity in clubs) and the different intersections within these.
Program utilises well resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Use evidence for everything and conduct research.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Unclear.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Unclear.
Program voices are seen to be personable, approachable and relatable (i.e. Not overly authoritative).	Approachable and accessible voices.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Helping leaders (e.g. coaches, parents) and community members to focus on mental wellbeing (main focus on depression and anxiety, but lots of interest in other areas that they want to address also).
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. Different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Fairly new program, however has different components (e.g. face to face delivery, webinars, online resources). Covid put a hold on many of the project intentions.
Program is targeting different cohorts both within and beyond sport clubs.	Does this and also targets PE teachers who have a wider influence, as thought that those who would be disengaged in sport clubs would not be getting as much assistance. Want to have a wider reach.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Has the capacity to do this.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Clearly aligned with research team.

Provides appropriate ways to raise awareness of and promote mental wellbeing.	Discussed how to start the conversation and appropriate ways to help someone (flow chart resource in toolkit online).
Program reflects a detailed understanding of sport settings and organisations (i.e. Knowledge of developmental, cultural, social and systemic issues).	Discussed specifics to the sporting context, but also to the systemic, cultural and social issues within sport (and wider society).
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Ensures to use supportive language.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	N/A.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. Language).	Discussed need to work with the stakeholder groups (e.g. youth from minority groups) to co-design the content and facilitate sessions.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Works with other elements of organisation and other research projects.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	Has not conducted evaluation (however wants to). Just some generalised post session feedback forms.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	Not at this stage.
What works is known, how it works is known, and repeatability is universal.	Not at this stage.
Measures have established impact across different settings, sustained over time.	Not at this stage.
Evidence collected is publicly available and open to external scrutiny (i.e. On website).	Not at this stage.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	A number of stakeholders eg. research team, community members (everyone welcome approach) and schools/PE teachers.
The program is financially self-sufficient and not dependent upon grants.	Funded from grants currently.
The host organization is “mature” (stable, resourceful).	Organisation is mature, the program currently does not appear to be.
The value and mission of the program fit well with the broader community.	Want to help train as many people as possible to help in this space and be educated on mental health/wellbeing, signs and symptoms and how to assist.
The program meets legal and compliance responsibilities.	Cannot state explicitly.
The program represents ‘good value for money’ for the club.	Unsure.

Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Still in its infancy.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Primary foci of the program with sports clubs.
The program has a clear strategy for supporting positive culture change within community clubs.	Wants to address multiple facets of culture change (e.g. intersections).

Project Code	P1
Program has explicit ties with an established overarching mental wellbeing framework.	No overarching mental wellbeing framework discussed. Psychologists established content.
Program uses language and approaches consistent with established MWP frameworks.	Language is consistent for coaches in football. Uses simplistic language, no link to MWP framework specifically.
Programs underpinned by well-established models/theories of mental wellbeing provision.	Underpinned by sport psychologists and coach delivery.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Cannot not state if program does address the multi-layered levels. Targets coaches specifically (and leaders within club). To be fully accredited, all coaches in club, plus President and board members have to complete training.
Program utilises well resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Use research and are evaluating delivery, content etc. 8-hour training for psychologists to be involved, 2-day training course for facilitators.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Unclear.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Unclear.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Use expertise from psych's, however use coach's language for program delivery to not be authoritative and relatable.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Focuses on assisting coaches (and leaders) to help their own wellbeing, however also help the clubs (and wider communities) mental wellbeing also.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Delivers an initial face to face module, then online modules, also has podcasts, e-learning too. Has shifted to online delivery for COVID. Suits different cohorts needs (e.g. junior coaches, youth coaches and adult coaches).
Program is targeting different cohorts both within and beyond sport clubs.	Targets AFL coaches specifically (and leaders in the club), however uses a local psychologist so that the connection can continue, and to have local knowledge/assistance. Also partners with State leagues.
Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Unsure.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Focus on awareness, action (stigma – coaches with confidence and skills) and accreditation (changing attitudes and behaviours) and is consistent with them.

Provides appropriate ways to raise awareness of and promote mental wellbeing.	Focus on helping yourself (the coach) and helping others, creating conversations, assisting to refer other people.
Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues).	Takes a leadership/top-down approach.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	The program appears to, based on the language used and foci of the program.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Links with local psychologist (who goes through training) and changes program based on the communities needs. Specifically detailed that the local knowledge and support is integral.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	N/A
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Partners with AFL coaches and AFL Players associations and State leagues. Has a compulsory online module (15 mins) for all AFL coaches to complete when going through their accreditation process.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content	Currently is using an external evaluator. Unsure specifically what they are evaluating, although stated a number of the measures (in terms of direct and indirect impact), but also brand, messaging, language use
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	Unclear.
What works is known, how it works is known, and repeatability is universal.	Unclear.
Measures have established impact across different settings, sustained over time.	Unclear.
Evidence collected is publicly available and open to external scrutiny (i.e. On website).	Commenced last year (2019), so only have pilot data, and still making lots of changes.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	Through the partnerships and funding from charities, philanthropists. Community from coaches and local psychologists.
The program is financially self-sufficient and not dependent upon grants.	Dependent on philanthropy which will last until the end of 2024.
The host organization is “mature” (stable, resourceful).	Relatively new (2019 launched), however are resourceful.
The value and mission of the program fit well with the broader community.	Focus on community wellbeing and helping others.
The program meets legal and compliance responsibilities.	Went through rigorous risk management/compliance funding partners.

The program represents 'good value for money' for the club.	Free for clubs.
Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	For the coaches/leaders who do the program and this may filter into the club/community.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Directly for the coaches/leaders, want them to be champions within the club, and have all the leadership group be involved (the club won't get accreditation unless they all are).
The program has a clear strategy for supporting positive culture change within community clubs.	Currently creating action plans for this. Did not discuss specific inclusion strategies however concept is to create a positive cultural change for mental wellbeing.

Project Code	P4
Program has explicit ties with an established overarching mental wellbeing framework.	In establishment of program consulted with the big mental health organisations (e.g. Lifeline, Beyond Blue) to ensure correct resources, content etc. Continues to consult with clinical team and use overarching frameworks such as ADF framework, Orygen framework and Mind framework.
Program uses language and approaches consistent with established MWP frameworks.	Ensures to use consistent and appropriate language across platforms.
Programs underpinned by well-established models/theories of mental wellbeing provision.	Unable to determine. Takes a holistic, inclusive approach.
Program targets the individual, social (i.e. masculine norms, social climate), media (i.e. social media) and policy layers (i.e. policy against the use of harmful language).	Appears to do so. Discussed different levels involved in sporting clubs, however may not address all of these layers.
Program utilises well resourced expertise that can continually provide training, support and alignment of the program to a contemporary evidence base.	Always updating and doing personal development staff to ensure up to date. Underpinned with evidence, and the data that they collect from all of the programs and app.
For initiatives used with Aboriginal people, there is consultation with Aboriginal health professionals, Traditional Owners and relevant organisations focused on the needs of Aboriginal people	Yes, was currently in consultation with Indigenous health professionals and Traditional Owners for developing a mental health and wellbeing program for Indigenous persons.
For initiatives used in rural and/or remote areas there is consultation with rural health services and community organisations.	Yes, currently doing this.
Program voices are seen to be personable, approachable and relatable (i.e. not overly authoritative).	Use locals to connect to the community members and gain interest, be approachable.
Program helps clubs establish community support for the need to focus on mental wellbeing.	Very focussed on community support, hence the local people being involved. The program trainers also are trained up, however need to be passionate about mental health and wellbeing, and come from a sporting background (preferable) to create relatability to the audience. Focus is on mental wellbeing, prevention as the main aim.
Programs	
Intervention format	
The program offers a variety of high-impact delivery methods and modalities to suit a range of participant needs (i.e. different delivery methods (online, podcast, one to one, peer, in groups); intervention/program types and; duration and frequency of intervention/program).	Caters to a range of methods and modalities. Two sessions face-to-face. Some clubs that started in the initial year are still involved. App component to keep engaged, however welfare officers are able to be contacted at any time. Do follow up phone calls if anyone is high risk from the app. Referral process too. Different programs to suit different audiences/needs. Also do podcasts.
Program is targeting different cohorts both within and beyond sport clubs.	Mainly aimed at young people, however the app is for everyone and ultimately want to help anyone and everyone who needs it. Using local legends helps to go beyond the sports clubs. Important for parents/caregivers/coaches to be involved too. Whole-of-club/community approach.

Program has the capacity to adapt and deliver effectively in urban and rural/remote contexts and, where applicable, for Aboriginal people/s.	Very much so.
Intervention components	
Program has clearly stated outcomes and content is consistent with them.	Every club starts with a mental health session (e.g. mental first aid session), and then focus on what the club want to.
Provides appropriate ways to raise awareness of and promote mental wellbeing.	Goes through support and mechanisms to assist with coping as well as promoting mental wellbeing.
Program reflects a detailed understanding of sport settings and organisations (i.e. knowledge of developmental, cultural, social and systemic issues)	Discussed issues of time with volunteers, and a lot of problems that Presidents face e.g. sessions that come in once and then go, and being overburdened. Highlighted the important of programs being consistent and providing ongoing support.
Program consistently and continuously communicates its strategy through supportive language that avoids prejudicial or pejorative references.	Strategy reiterated in communications with clear language.
The program draws on local knowledge and baseline measures to tailor itself to local needs (whilst maintaining integrity to a framework, i.e. language).	Using a local representative to be involved, very much tailored to local community.
The intervention, where applicable, draws on Aboriginal people and rural/remote knowledge and understandings and is integrated into delivery approaches and context.	Currently working on a project with Indigenous communities in collaboration with partners to support engagement, content, app-specific. This was tailored to the specific community this organisation is working with.
Program links to and works collaboratively with other programs and initiatives to extend messaging, leverage existing activity and create collaborative action.	Would like to engage with other mental health and wellbeing programs in sport, however have found that challenging. Would like to engage with VicHealth at a strategic level, and an advisory group for this space. Does work with other programs, has received federal funding, and partnerships with sporting organisations and State government for collaborative action.
Evaluation	
Measures are clearly aligned with stated program outcomes and program content.	Stated that bases everything off data and evaluation. Have not seen measures, however described that they would not do things unless it's based off data.
The program has utilised valid and reliable measures/methods to understand its impact on mental health promotion and mental health outcomes.	Uses DASS-21 for screening on app, and a number of other measures both at baseline of program delivery and end of program delivery and through the app
What works is known, how it works is known, and repeatability is universal.	Yes, it would be able to be.
Measures have established impact across different settings, sustained over time.	Have been collecting data for a while now from the programs and app, and continuing to do so, whilst refining. Currently in process of ensuring the measures/data is reliable through. Working with external evaluation company to evaluate programs/data/content.

Evidence collected is publicly available and open to external scrutiny (i.e. on website).	It will be through the evaluation, however not currently.
Sustainability of program	
The community and a range of stakeholders have a vested interest in the program.	A number of different stakeholders (community, locals, facilitators, staff, government, sporting organisations). Leagues/Associations often refer this organisation to sporting clubs.
The program is financially self-sufficient and not dependent upon grants.	Grants are helpful, but not reliant on them, just helps to ensure cost is free for sporting clubs/schools.
The host organization is “mature” (stable, resourceful).	Has been operating for almost 6 years and is highly resourceful.
The value and mission of the program fit well with the broader community.	Prevention is key, and want to fit within the broader and local community’s needs.
The program meets legal and compliance responsibilities.	Discussed the legal and ethical components involved with the app. Has a legal representative.
The program represents 'good value for money' for the club.	$1500 to be involved in the program (in Victoria). For the time being other States have access to ‘free’ programs, based on funding (including WA). At worst, clubs will receive 2 training sessions, however will provide ongoing support, resources, app.
Sustainability of Impact	
The program has a clear (documented) strategy for achieving ongoing impacts for individual club members.	Through the app they monitor the individual impacts, so there is data on it.
The program has a clear strategy for supporting the development of knowledge/expertise/championing of mental health within clubs.	Targets mental health and wellbeing within clubs with ongoing support, and helping one another within the club community.
The program has a clear strategy for supporting positive culture change within community clubs.	Data to show that the program does assist in creating positive culture change, that is a big focus of the program.