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## Delivering the Mental Health First Aid (MHFA) Course within the National Rugby League (NRL): Evaluation Report

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# Delivering the Mental Health First Aid (MHFA) Course within the National Rugby League (NRL): Evaluation Report

## Abstract

Mental illness is a reality for many Australians. The National Survey of Mental Health and Wellbeing, conducted in 2007 with people aged 16-85, revealed that one in five Australians, or 3.2 million people, had a 12-month mental disorder (a mental illness occurring 12 months before the survey took place) (ABS, 2007). The survey further revealed that 16 million Australians (45%) within this age bracket suffered with a mental illness at some point in their lives. While these findings are slowly becoming public knowledge, there is still a limited understanding amongst laypeople regarding the overt and more covert symptoms of mental illness, as well as appropriate methods of treatment and support for those that struggle with such challenges in their daily lives. Despite popular opinion, elite athletes are not exempt from these statistics. The pressures and expectations of clubs, coaches, fans and players themselves can reinforce feelings of isolation and loneliness (Storch and Ohslon, 2009), which discourage those experiencing mental illness to seek help. Compounding this sense of isolation are the physical, mental and emotional demands of elite athleticism partnered with the debilitating stigma that is rampant within the sports industry (Griffin, 2013). In response to the needs of such an underserved population, this report assesses the effectiveness of the Mental Health First Aid course, for stakeholders across the National Rugby League (NRL), and their responses to the course. This course is run over one or two days, depending on the availability of each cohort, and provides an overview of a range of mental illnesses, their symptoms, and how lay people can be better trained in assessing symptoms and referring those in need to mental health care professionals.

## Keywords

first, evaluation, health, mental, delivering, (nrl); league, rugby, national, within, course, (mhfa), aid, report

## Disciplines

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**DELIVERING THE MENTAL HEALTH  
FIRST AID (MHFA) COURSE WITHIN  
THE NATIONAL RUGBY LEAGUE (NRL):**  
Evaluation Report

November 2015

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# Introduction

Mental illness is a reality for many Australians. The National Survey of Mental Health and Wellbeing, conducted in 2007 with people aged 16-85, revealed that one in five Australians, or 3.2 million people, had a 12-month mental disorder (a mental illness occurring 12 months before the survey took place) (ABS, 2007). The survey further revealed that 16 million Australians (45%) within this age bracket suffered with a mental illness at some point in their lives. While these findings are slowly becoming public knowledge, there is still a limited understanding amongst laypeople regarding the overt and more covert symptoms of mental illness, as well as appropriate methods of treatment and support for those that struggle with such challenges in their daily lives. Despite popular opinion, elite athletes are not exempt from these statistics. The pressures and expectations of clubs, coaches,

fans and players themselves can reinforce feelings of isolation and loneliness (Storch and Ohslon, 2009), which discourage those experiencing mental illness to seek help. Compounding this sense of isolation are the physical, mental and emotional demands of elite athleticism partnered with the debilitating stigma that is rampant within the sports industry (Griffin, 2013). In response to the needs of such an underserved population, this report assesses the effectiveness of the Mental Health First Aid course, for stakeholders across the National Rugby League (NRL), and their responses to the course. This course is run over one or two days, depending on the availability of each cohort, and provides an overview of a range of mental illnesses, their symptoms, and how lay people can be better trained in assessing symptoms and referring those in need to mental health care professionals<sup>1</sup>.

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<sup>1</sup> More information about the course can be accessed from <https://mhfa.com.au/>.

# Literature Review

## TRENDS IN MENTAL HEALTH IN AUSTRALIA

Trends within Australia's general population reveal that one in five will be diagnosed with a mental illness at some point in their lives (ABS, 2007). The National Survey further showed that anxiety disorders<sup>1</sup>, affective disorders<sup>2</sup> and substance abuse disorders<sup>3</sup> are the most prevalent 12-month illnesses (those recorded as happening within the 12 months prior to the Survey) (ibid). These conditions are implicated by a range of population characteristics, such as one's employment status, living arrangements, life experiences (homelessness, incarceration), and contact with family and friends. One's smoker status, alcohol consumption, misuse of drugs, general levels of psychological distress, suicidal behaviour, and disability status also have bearing upon mental health.

Comorbidity, or the occurrence of more than one disease or disorder, alongside the use of support services for these mental health challenges, are also issues of concern. Of particular significance to this report is the reality that "More than a quarter (26%) of people aged 16-24 years and a similar proportion (25%) of people aged 25-34 years had a 12-month mental disorder compared with 5.9% of those aged 75-85 years" (ABS, 2007, no page numbers). As this is the prime age for NRL players to be at the peak of their careers, it is incumbent upon clubs and other support services to know how to aid players that struggle in their mental health. This age group is also most susceptible to substance abuse: "Among all age groups...younger age groups had higher prevalence of 12-month Substance Use disorders...Of the 2.5 million people aged 16-24 years, 13% (323,500) had a 12-month Substance Use disorder" (ABS, 2007, no page numbers).

It has also been noted that there are "multiple and integrating social, psychological, and biological factors" (ABS, 2007, no page numbers) that impact upon the development of these conditions. These include "individual or societal factors, including economic

disadvantage, poor housing, lack of social support and the level of access to, and use of, health services" (ibid, no page numbers). Once again, there appears a link between social services and the health of the general population. 26% of those with a 12-month mental disorder stated that they felt "their need for counselling [was not] met or only had their need partially met. A slightly higher proportion, 29% did not have their need for information met or only had their need partially met". Crampton (2014) further reiterates this concept in the case of elite-athletes performing at the 2000 Olympics, where support services were effective around the lead-up to the event, but did not sustain afterwards. He argues that "organisations must show genuine concern for each individual's wellbeing by *providing support throughout a performer's career*" (p. 52, emphasis original), and not wait until the point of personal crises and consequent debilitation before these services are utilised (p.46). Considering the prevalence of mental health issues in the community at large, it seems that significant promotion and development of services is required so that consumers receive the help they need.

## MENTAL HEALTH AND ELITE ATHLETES

Whilst there is a perception that elite athletes do not suffer from these conditions, surveys completed with this population suggest otherwise. Gulliver, Griffiths, Mackinnon, Batterham, and Stanimirovic (2015) conducted an internet self-report survey of 244 Australian athletes from the Australian Institute of Sport (AIS) and Australian sporting organisations funded by the Australian Sports Commission, with an average age of 24.91 years (p.256, p.258). The survey asked questions around a range of demographic variables and mental health symptoms (ibid). The general results highlighted that 46.4% of athletes experienced symptoms of at least one mental illness, which were consistent when compared with similar studies from other countries (i.e. France, p.

258). Of the mental illness symptoms cited, depression was noted as the most prevalent (27.2%), followed by eating disorders (22.8%), General Psychological Distress, (16.5%), social anxiety (14.7%), Generalised Anxiety Disorder, or GAD (7.1%) and Panic Disorder (4.5%).

The presence of mental illnesses is further reinforced by the fact that elite athletes experience "a heightened sense of social and public evaluation" (Gulliver, Griffiths, Mackinnon, Batterham, and Stanimirovic 2015, p.259), which could be a trigger to some of the aforementioned social mental disorders (GAD, as well as social anxiety disorder). It is suggested that young athletes be shown how to "perform their sporting-related roles effectively" (ibid), which could potentially bolster their resilience against these illnesses.

These conditions are not simply a part of athletes' lives during their sporting careers, but can pervade later life, making it imperative for sporting institutions to adhere to more diligent standards to ensure the health and prosperity of their players' wellbeing and personal longevity. Kerr, DeFreese and Marshall (2014) analyse data from 797 retired American sportspeople via online surveys, which revealed trends that are consistent with the general U.S. population. For retired American Football players, these included "higher prevalences and earlier onset of Alzheimer's disease and osteoarthritis" (p.1), "significant memory problems, bodily pain, clinical diagnoses of mild cognitive impairment and depression" (p.7), lower recorded scores of "physical function, depression, fatigue, sleep and pain interference" (pp.2, 6-7), uncontrolled eating and alcohol dependence (p.5), and the presence of injury as an important factor "in an athlete's psychological response to career transition" (p.7). For those athletes heading towards retirement, no social services exist to aid them in transitioning into this stage of life (pp.7-8).

2 These are: panic disorder, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder.

3 These are: depressive episode (severe, moderate or mild), dysthymia, and bipolar affective disorder.

4 These are: alcohol harmful use, alcohol dependence, and drug use disorders.



## INJURY AND DEPRESSION

Despite evidence that high levels of physical activity correlate with positive mental health (Gulliver, Griffiths, Mackinnon Batterham, and Stanimirovic, 2015, p.255), many athletes suffer from depression amongst other ailments as a result of injury (Dietrich and Shuer, 1997), especially in relation to performance and failure-based depression (Hammond, Gialloredo, Kubas and Davis, 2013). In an industry where performance is closely tied to one's sense of worth and identity, the personal significance of failure is enhanced for elite athletes (Hammond, Gialloredo, Kubas and Davis, 2013, pp.276-277), and thus merits serious consideration around the kinds of supports offered. Athletes are more susceptible to other challenges in their mental health, such as a "heightened risk for suicide, citing possible risk factors such as injury, pressure to win, substance abuse, and a comparatively early retirement from their professional career" (Gulliver, Griffiths, Mackinnon Batterham, and Stanimirovic 2015, p.256). While these realities are well understood by athletes and their coaches, families and friends, there is little support for mental health awareness and treatment. Dietrich and Shuer (1997) highlight that the "emotional distress experienced by athletes with chronic injuries" (p.104) is not removed from the "constant state of pain and injury" (ibid), and some athletes' levels of trauma have been recorded as comparable to the trauma felt from experiencing a natural disaster (via a self-report battery called the Impact of Scale Event, p.105). Many athletes with constant injury avoid dealing with it effectively, embodying the ethos of adages such as "no pain, no gain" and "hurt is temporary, pride is forever" (Dietrich and Shuer, 1997, p. 104) reinforcing stereotypes that athletes are "superheroes" whose audiences rarely see the "emotional pain associated with injury and vulnerability" (p.108). In the course of a training session, the symptoms of a mental illness may retreat

temporary, which prompts the athlete to assume the pain was imaginary, only to have it resurface more violently at a later time due to a lack of proper treatment (ibid, p.105). Another reality that distorts the true picture of mental health in elite athlete is the fact that they tend to "minimise the apparent signs of weakness...[and] sometimes [athletes] resemble symptoms of mental disorders (e.g. meticulous attention to diet, relative hyperactivity) thereby confounding recognition of illness" (Factor and Reardon, 2009, p.962). While the rate of diagnosis is similar to that of the general population, "the impact of the symptoms [are] exacerbated by high levels of pain" (p.964) that are a usual part of an athlete's training.

These attitudes and practices encourage athletes to ignore and press through pain rather than seeking appropriate medical help. What starts as physical ailments can often lead to emotional and / or mental health problems. Minor injuries are similarly ignored, until they affect the athlete "to such a degree that it is apparent to coaches and teammates alike" (Dietrich and Shuer, 1997, p. 104). Rather than seeking assistance at the first sign of symptoms, which could prevent further difficulty, athletes tend to suppress these, proving that the very culture that ought to encourage peak performance actually hinders it in the case of dealing effectively with injury. "The numerous psychosocial ramifications of injury, including the disruption of social support networks, a compromised relationship with coaches, and a possible change in playing position and team hierarchy, weigh heavily on the minds of injured athletes" (Dietrich and Shuer, 1997, p. 104). Added to this, there is no real sense of clear rehabilitation for mental / psychiatric issues: "Although modern technology has increased the speed of physiological recovery, no equivalent inroads have been made in the psychological or psychiatric treatment to facilitate mental health recovery" (ibid,

p.105). When athletes do resume training after such an occurrence, they usually do so "just below the pain threshold" (p.108), which is a "short-term solution" that can "create long-term problems" (p.109), and "[these] athletes [are] risking further injury, [and] the psychological manifestations of training under these conditions exacerbate the initial distress" (Dietrich and Shuer, 1997, p.109). This can result in protecting the injured part of the body and consequently overtraining surrounding areas to compensate (ibid). As injury and the mental health of athletes are indelibly linked, serving one part of the athlete's condition without the other only promotes a continued sense of "cognitive dissonance" (ibid p.107).

## SEEKING HELP

Elite athletes have stated several factors which inhibit them from seeking help from a mental health professional: a lack of mental health literacy, negative past experiences of help-seeking, and the overwhelming sense of stigma associated with accessing these resources (Gulliver, Griffiths and Christensen, 2012; Yang, Peek-Asa, Corlette, Cheng, Foster and Albright, 2007). Other barriers to seeking help are athletes not recognising they have a problem, which may result from a failure to discern emotions from symptoms of mental illness, not knowing when to seek help, and concern for expectations of others, namely coaches, family and friends (Griffiths and Chistensen, 2012, pp.9-10). Conversely, having a working relationship with a health service professional, alongside a positive attitude towards seeking help from family, friends and coaches helps to facilitate help-seeking (ibid pp.167-168).

# Mental Health First Aid and The National Rugby League (NRL)

This report reflects upon the impacts of teaching the Mental Health First Aid (MHFA) course to NRL players and NRL staff between November 2013 and July 2015, where a total of eight courses were conducted over a duration of 1 or 2 days, depending on the availability of the participating cohort. A total of 120 responses were collected, reflecting attitudes and the experiences of players and staff as a result of completing the course. A general overview of the course is given below, followed by data analysis from feedback forms that were completed by participants after course completion<sup>5</sup>.

## The MHFA Course

The MHFA course was developed by Betty Kitchener AM and Professor Tony Jorm in 2001 through Mental Health First Aid Australia, a national not-for-profit organisation focused on mental health training and research<sup>6</sup>. The MHFA course teaches strategies to members of the general public and specific population groups, including Vietnamese, Indigenous Australian, Nursing students and those with an intellectual disability<sup>7</sup>. Courses are conducted by an accredited MHFA Instructor, who is independent from the organisation and delivers the programs to the general public, or specific workplace where they are employed. Several empirical studies have been undertaken on the effectiveness of the MHFA with various stakeholder groups with most key finding suggested a positive impact and affect on participants ability to assist people experience mental health issues<sup>8</sup>.

## What do MHFA Course Participants Learn?

MHFA courses teach mental health first aid strategies to members of the public. Mental health first aid is the help provided to a person who is developing a mental health problem, or in a mental health-related crisis, until appropriate professional treatment is received or the crisis resolves. Course content is derived from a number of consensus studies incorporating the expertise of hundreds of researchers, clinicians, mental health consumer advocates and carer advocates across the world.

MHFA courses can provide members of the community with:

- Skills in how to recognise the signs and symptoms of mental health problems;
- Knowledge of the possible causes or risk factors for these mental health problems;
- Awareness of the evidenced based medical, psychological and alternative treatments available;
- Skills in how to give appropriate initial help and support someone experiencing a mental health problem;
- Skills in how to take appropriate action if a crisis situation arises involving suicidal behaviour, panic attack, stress reaction to trauma, overdose or threatening psychotic behaviour.

Over the years, the Standard MHFA course has been the platform to create other specialised courses, including Youth MHFA, Aboriginal and Torres Strait Islander MHFA and Vietnamese MHFA<sup>9</sup>. MHFA Australia continues to work towards creating sustainable opportunities to enhance professional sectors to respond proactively to mental health concerns by also creating adaptation of the material suited for a particular sector, including Nursing and Medical Students, and Financial Counsellors. With the success of the course nationally, MHFA has also expanded to be delivered and adapted in over 20 countries around the world, including China, USA and South Africa.

In 2013, the NRL Welfare and Education National Manager, decided to introduce the Standard MHFA course as a means to bolster mental health literacies across the game, and to further promote organisational capacity in dealing effectively with mental health issues. A designated Mental Health First Aid Instructor was assigned with the task to subsequently implement the MHFA course across the game; with an initial focus to have Welfare & Education and Career Coaching staff trained, followed by Player Ambassadors and other key staff and players across the NRL.

## DATA ANALYSIS / DISCUSSION

Each survey consisted of ten questions taken directly from the MHFA Course Evaluation form to gauge participants' responses to the course. In total, 120 responses were collated

from a number of clubs: Sydney Roosters, Wests Tigers, St George Dragons, Mackay Cutters, Parramatta Eels, Melbourne Storm, New Zealand Vodafone Warriors, Manly Sea Eagles, Bay Roskill Rugby League, and Auckland Rugby League. The first five questions were measured on a scale of 1 (lowest score) to 10 (highest score). The following questions were asked:

1. How new was this material to you?
2. How easy was it to understand?
3. How well was it presented?
4. How relevant was the content for you?
5. How suitable was the venue?

The second set of five questions asked for personal reflections from participants. The number of responses varied. The following questions were asked:

1. What is your overall response to this course? (120 responses)
2. What do you consider to be the strengths of the course? (120 responses)
3. What do you consider to be the weaknesses of the course? (108 responses)
4. Are there any other issues which you think should be included in this course? (101 responses)
5. How did you hear about this course? (114 responses)

Participants' responses are presented below. Questions 1 - 5 are presented in graphs. Reflection questions 6 - 9, which required an open response from participants, is presented in the findings below as key ideas that were shared across the feedback forms. That is, themes gained from the responses given by participants are weaved into the first 5 questions, supporting the respective weighted average provided under each graph. Question 10 is presented as a graph. Question 5, "How suitable was the venue", was not present on the 2013 course feedback form, so this question had a total of 83 responses (compared to 120 for all other questions). Where number scores did not have any entries (for example no participants entered 1 for newness of material in Question 1), they are not included in the respective graphs.

5 Data was collated from the following feedback forms <https://www.surveymonkey.com/r/NRLMHFAFeedback>

6 Information from this and the next section taken from <https://mhfa.com.au/about/our-activities/what-we-do-mental-health-first-aid>

7 See <https://mhfa.com.au/courses/public> for the list of tailored versions of the course.

8 For a detailed reference list of such studies, including impact, visit <https://mhfa.com.au/our-impact/our-global-impact>

9 See <https://mhfa.com.au/resources/mental-health-first-aid-downloads> for the different formats of the MHFA course.



Please see figure 1 (below).

Given that 67.5% (81) respondents scored 8-10 for the newness of material (Figure 1), the MHFA course is filling a much needed void in mental health literacy within the NRL community. This is reflected in participants' responses:

*"Excellent course with a new perspective on mental health. Need more courses available in this space."*

*"I found the content very interesting and dispelled many myths about mental health / illness. Gives me some great tools to use going forward."*

*"I found that mental health is a growing issue in our community. Overall I'm empowered with the knowledge I now have on mental health."*

Other participants stated that completing the course was an "eye-opener" and "improved awareness and understanding". As a result of gaining more insight into these issues, participants left feeling "empowered with the

knowledge I now have" and "new tools to apply and share with my club and family and friends", as well as having more confidence "to respond appropriately", especially in "situations I have not yet encountered". One participant found that the course "gave a new clarity on the connection between social pressure and mental illness", showing that the course is not only providing more information, but is empowering those involved to understand less obvious issues that impact upon mental health issues.

Please see figure 2 and 3 (below).

Given the stigma and general lack of understanding that surround mental health issues, and the fact that the course covers a lot of information in a short time, it is vital that presenters offer information in a clear, concise and digestible manner (Figure 2). The presentation of content impacts on how well it is received, a concept reinforced by participants' experience:

*"I thoroughly enjoyed this course and learnt quite a lot. There was a lot of information delivered exceptionally well."*

*"Presenter made it easy to understand and broke down into everyday language."*

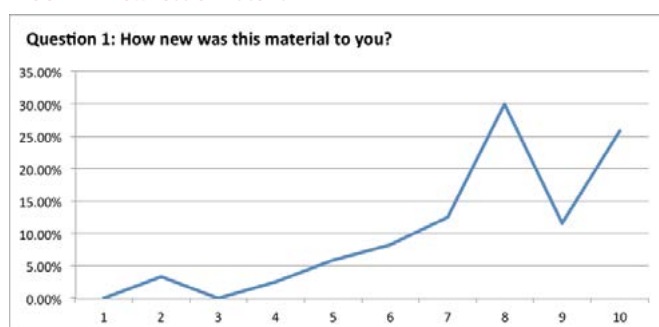
*"MHFA Instructor presented the content in an easy to understand and practical manner, gave it relevance."*

*"The delivery of content [was considered a strength] which can be mundane but because of the Instructor's approach...very well done."*

As a result of the course content being presented in a clear manner (Figure 3), some participants found that the information was "easy to absorb", and "the instructor kept my attention". The manner of delivery was also helpful in "making people feel comfortable ground" which was understood to "assist people discuss [a] difficult cultural topic".

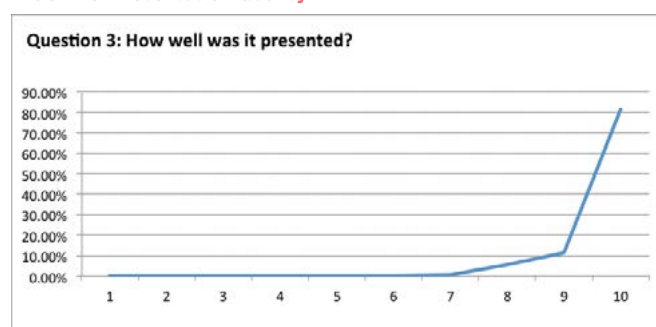
Participants found the diversity of delivery modes (videos, role plays, and lecture-style sharing) helpful and engaging, which encouraged positive responses to the

FIGURE 1: Newness of Material



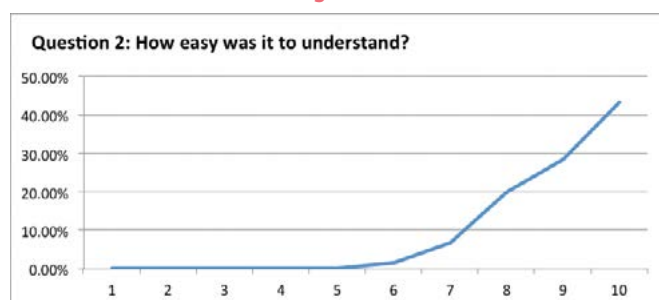
Weighted average: 7.87

FIGURE 3: Presentation Quality



Weighted Average: 9.74

FIGURE 2: Ease of Understanding



Weighted Average: 9.05

information being presented. Many stated that the modes of presentation were “practical”, “engaging” and made use of “relevant examples”. Another important element was the “presenter’s real life experience” and that he “was really knowledgeable” and had a “professional manner”. The quality of presentation therefore impacted upon the ability of participants to engage with and assimilate the information offered, which is attested to by the weighted average of 9.74, the highest of all score averages.

*Please see figure 4 (below).*

Many respondents felt “empowered” by what they had learned, and now possessed “a better understanding of what may be relevant reasons why people do specific things”. The data shows that mental health is an issue that NRL players and staff considered very relevant to their context, as almost 95% scored 8-10 for this question. Understanding the relevance of such information (Figure 4), combined with effective delivery, are key elements in improving mental health literacy amongst such groups, empowering them to make a difference in their communities and clubs, and shifting mindsets and challenging stigmas that disable conversations around mental health.

One of the most powerful quotes comes from a participant who could identify deeply with the material that was presented:

*“Having lived with mental illness for the past 16 years, the MHFA Instructor has shed a lot more light on my problems I face on a daily basis.”*

This quote highlights the need to have meaningful forums such as the MHFA course, but further, for all those involved in NRL clubs, be they players, support staff, coaches, and even family and friends of players, to do their part in facilitating healthy conversations around this often neglected topic; and develop a working knowledge of how to respond appropriately to those in need.

*Please see figure 5 (below).*

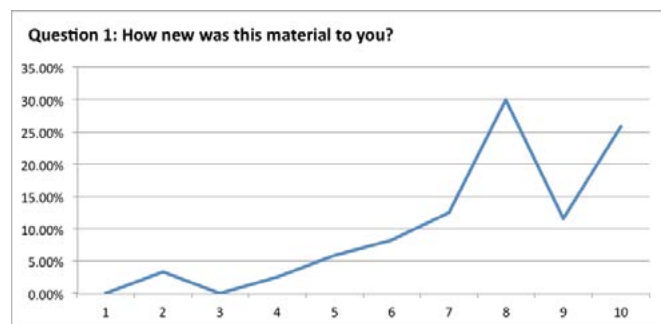
Although the choice of venue may appear a trivial concern, the course presents a vast amount of information in a relatively short amount of time (1 or 2 days, depending on the availability of the participating cohort). Effective learning spaces are more conducive to effective learning, so this ought to be considered by those offering the course (Figure 5). Useful features of such learning spaces include access to projector screens to show demonstration film clips, which make up part of

the course, and spaces that facilitate role-plays and interactive participation from audiences.

*Please see figure 5 (below).*

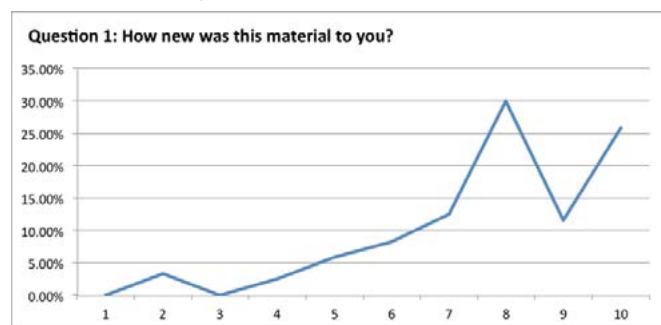
Most participants heard about the course through their local NRL club (Figure 6). It is probable that ‘work’ here indicates the NRL club which employs them at some capacity. The NRL Clubs that were mentioned are the Sydney Roosters, West Tigers, St George Dragons, Parramatta Eels, Melbourne Storm, Manly Sea Eagles, New Zealand Vodafone Warriors, Bay Roskill Rugby League, Queensland Rugby League, Mackay Cutters and Auckland Rugby League. The NRL RLPA (Rugby League Players’ Association<sup>10</sup>) and NRL HQ<sup>11</sup> were also listed. Some participants highlighted individual members from these clubs who invited them to take part in this course. Their roles were listed as welfare and education officers, development officers, HR managers, accreditation managers and bosses and managers. Other comprised of ‘nil’ (unknown meaning) and email correspondence advertising the course. The work of the NRL in promoting this program is kindly acknowledged, and it is seen as beneficial for more stakeholders across the organisation to do the same in seeking to equip their players, staff and communities with the MHFA course.

**FIGURE 4: Relevance of Material**



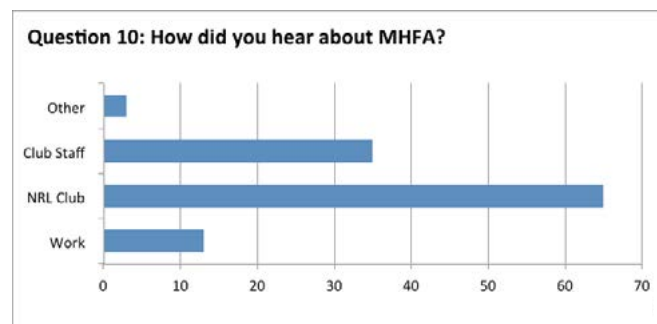
Weighted Average: 9.17

**FIGURE 5: Suitability of Venue**



Weighted Average: 9.02

**FIGURE 6: Recruitment into course**



<sup>10</sup> More information available from <http://www.rlpa.com.au/>

<sup>11</sup> More information available from <http://www.smh.com.au/rugby-league>

# Recommendations

On further reviewing responses from Questions 8 & 9 of the MHFA evaluation form (areas of development and possible inclusions), some participants mentioned that they would like to find out more information about mental health, and requested a follow-up course be developed. Others stated that they would like to see more attention given to the following areas:

- More national and international examples
- More effective breakdown “with engagement tools”
- Use of more specific case studies from a Rugby League context
- More focus on cultural / linguistic / religious difference and sensitivity, and the application of this Western mental first aid within these diverse perspectives
- Further information on the use of prescription drugs and their effect on mental health
- The relationship between gambling and mental health
- Other addictions (including tobacco), and how their psychological, biological and behavioural implications

- More focus on depression, and the role of substance abuse in depression and suicide
- Mental health in 16 - 30 year olds, and formulating this program for Junior Rugby League
- The relationship between mental illness and sporting injuries
- The relationship between body image, food, and eating disorders
- The impact of bullying and peer pressure.

Implementing these recommendations into future delivery of the course would be fruitful for NRL communities, as they deal with the above issues on a regular basis. While the information that was presented has been shown to be helpful in raising awareness and helping to shift mindsets and club culture, addressing the above issues will do even more to provide support and a firm knowledge base for players, staff and those who support them. This, in turn, will promote healthy and professional conversations around mental health and wellbeing within and across these communities.

# Conclusion

The literature explored in this report highlights the prevalence of mental health issues within the general population alongside the need of mental health literacy within the general population. As a result of this lack of accurate information, stigmas emerge that shape perceptions of and interactions with mental health, especially in elite sports like Rugby League. It is therefore important for organisations like the NRL and others to equip their staff members and players with sound knowledge around mental health, and provide support to players who face mental health challenges, as well as to their colleagues, to ensure that there is consistent and professional support at hand at all times for all community members seeking advice or professional assistance. The MHFA course is a vital tool in promoting and providing support networks for NRL clubs. This course has the potential to shift organisational

culture and mindsets around mental health and encourage dialogue around a topic that has for too long been considered taboo and a source of confusion and shame. NRL players are, on the whole, considered to be role models within the community, especially in the eyes of aspiring football players and fans. If these players are able to show the acceptability and normalcy of being able to speak out on issues around mental health, this can have a considerable effect on breaking down stigmas and engaging with the community at large, encouraging more deliberate and informed conversations around this often misunderstood reality. Ongoing public initiatives like the NRL State of Mind<sup>12</sup> campaign continue to support such efforts, and further reiterate the importance of having a shared vision on responding effectively to mental health issues through innovative and engaging resources.

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<sup>12</sup> More information on this campaign can be found via their website: <http://www.nrlstateofmind.com.au>

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