Interassociation Consensus Document:

MENTAL HEALTH BEST PRACTICES

Understanding and Supporting Student-Athlete Mental Wellness

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INTRODUCTION

The NCAA convened a multidisciplinary task force at its headquarters in Indianapolis on Nov. 18-20, 2013, to address the myriad of mental health issues facing today's NCAA student-athletes (see Appendixes A and B for the agenda and list of participants, respectively). Many of the task force participants contributed to the book "Mind, Body and Sport: Understanding and Supporting Student-Athlete Mental Wellness," which is based on consensus from the task force, and was distributed to all NCAA member institutions, including the directors of all campus counseling centers. After the production of "Mind, Body and Sport," a core writing group drafted a document titled "Interassociation Consensus Document: Best Practices for Understanding and Supporting Student-Athlete Mental Wellness," which is based on the book plus input from key medical and mental health organizations. Following the first draft of the best practices document, the task force members and representatives from medical and mental health organizations provided edits, and ultimately, endorsements. Appendix C lists the medical, mental health and higher education organizations that have endorsed this document.

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RESOURCES

The SSI offers health and safety programs, along with resources to address relevant issues on campus. Among these resources is **"Mind, Body and Sport,"** which provides information on supporting athlete mental wellness, and **"Addressing Sexual Assault and Interpersonal Violence,"** which offers guidance on athletics' role in support of healthy and safe campuses.

For overall sports medicine guidelines, SSI has developed the **"Sports Medicine Handbook,"** a tool to help institutions develop policies for the protection of student-athlete health and safety.

We are here to ensure the health and safety of all college athletes. For a full list of resources, visit **www.ncaa.org/ssi**.

PURPOSE

"Interassociation Consensus Document: Best Practices for Understanding and Supporting Student-Athlete Mental Wellness" ("Best Practices") is a practical extension of the NCAA publication "Mind, Body and Sport: Understanding and Supporting Student-Athlete Mental Wellness" (www.ncaa.org/health-and-safety/sport-science-institute/introduction-mind-body-and-sport). These "Best Practices" are designed to provide athletics and sports medicine departments – regardless of size and resources – with recommendations for supporting and promoting student-athlete mental health. "Best Practices" are accompanied by a checklist (Appendix D) of the key components for each athletics department.

BACKGROUND

Mental health is an important and often overlooked dimension of overall student-athlete health and optimal functioning. Mental health exists on a continuum, with resilience and thriving on one end of the spectrum and mental health disorders that disrupt a student-athlete's functioning and performance at the other. Approximately one in five adults experiences mental illness in a given year, and this rate tends to be highest among young adults, many of whom are college students.[1] Prevalence estimates of mental illness among college athletes are relatively similar to their non-athlete peers.[2,3] Even in the absence of a clinically diagnosable mental health disorder, student-athletes may have impaired overall well-being as a result of sub-clinical symptoms of mental health disorders such as anxiety, depression and insomnia or the misuse of substances such as alcohol or prescription drugs.

Emerging adulthood is an important and sometimes difficult developmental period. College athletes are faced with similar developmental challenges as their non-athlete peers and additionally must respond to the challenges and opportunities of collegiate sport. The sport environment has both risk and protective factors for mental health disorders. Additionally, genetic predispositions and environmental influences outside of the sport environment may impact mental health.

Mental and physical health are inextricably linked. For example, there is evidence suggesting an elevated risk of injury among athletes who experience anxiety or depression,[4] who abuse alcohol[5] or who have an eating disorder.[6] Furthermore, the athlete's psychological response to injury has the potential to exacerbate existing vulnerabilities to depression or anxiety,[7] substance abuse[8] or disordered eating behaviors.[7-10] Insomnia and sleep disorders can be an indicator or risk factor for mental health challenges, and can compromise academic and athletic performance through direct or indirect pathways.[11-13]

Mental health is a key component of student-athlete wellness, and the athletics department can play a pivotal role in providing an environment that supports wellness while also providing resources so that student-athletes can obtain referrals to mental health services. The sport environment is an important venue for establishing mental health promotion practices, destigmatizing mental health challenges, normalizing care seeking, facilitating early identification of mental health disorders and ensuring that all student-athletes in need receive care from a licensed practitioner who is qualified to provide mental health services. It is also an important venue to learn about the role that mental well-being plays in total health and the ability to thrive, both on and off the field of play. Indeed, sport can provide an exceptional opportunity to promote and develop mental wellness for life.

Student-athlete mental well-being is best served through a collaborative process of engaging the full complement of available campus and community resources, which may include athletics, campus health, counseling services, disability services and community agencies. Identifying the resources that are available and integrating strong professional working relationships across these areas are critical to ensure that professionals are informed and respond quickly and effectively. Such integration links professionals in a collaborative model of care that can enhance the ability of individual service providers and maximize support of student-athlete wellness.

BEST PRACTICES:

The interassociation “Best Practices” address the following key components for understanding and supporting student-athlete mental wellness on the college campus:

1. Clinical Licensure of Practitioners Providing Mental Health Care
2. Procedures for Identification and Referral of Student-Athletes to Qualified Practitioners
3. Pre-Participation Mental Health Screening
4. Health-Promoting Environments that Support Mental Well-Being and Resilience

1 Clinical Licensure of Practitioners Providing Mental Health Care

Evaluation and treatment of student-athletes with possible mental health concerns should be coordinated through the primary athletics health care providers (athletic trainers and team physicians). The athletic trainer is often the first point of contact in managing mental health concerns in student-athletes.[14] The team physician(s) often coordinates multiple aspects of the student-athlete's overall medical and psychological/psychiatric care, and may oversee mental health/psychiatric medication management. Additionally, many board certified primary care (family practice, internal medicine, pediatric) physicians who serve as team physicians have core competencies to treat mental health disorders.

Coordinating and managing mental health care should be distinguished from more formal evaluation and treatment of student-athletes with mental health disorders or mental illness. Formal evaluation and treatment should be conducted by a licensed practitioner who is qualified to provide mental health services. Such licensed practitioners may include*:

- Clinical or counseling psychologists.
- Psychiatrists.
- Licensed clinical social workers.
- Psychiatric mental health nurses.
- Licensed mental health counselors.
- Licensed family therapists/licensed marriage and family therapists.
- Primary care physicians with core competencies to treat mental health disorders.

**For the treatment of eating disorders, it often is optimal to include a registered dietitian with eating disorders expertise in the multidisciplinary team that includes a licensed mental health professional. It is important to note that treatment of eating disorders is typically recognized as requiring specialized expert care. In situations in which no local mental health professional (either on or off campus) is available with eating disorders expertise, partnership with a dietitian with eating disorders expertise becomes even more crucial.*

The licensed practitioner must adhere to all guidelines for ethical practice of his/her respective practitioner's association and state licensing boards.

While the most critical dimension of this recommendation is that formal care be provided by a licensed practitioner who is qualified to provide mental health services, it is additionally recommended that these professionals have professional training and ideally develop cultural competency relevant to providing care to both a college-age population and to athletes. In essence, cultural competency addresses both societal diversity and the culture of sports.

With regard to societal diversity, cultural competency should extend to treating student-athletes from diverse racial, ethnic, gender identified, and other unique cultural experiences influencing help-seeking. (Consideration should be given to engaging campus inclusion offices to consult with the interdisciplinary health care team.)

With regard to the culture of sports, although some licensed mental health professionals have formalized professional training that is specific to athletics (e.g., licensed clinical psychologist with a sub-specialization in sport psychology or primary care team physician with board certification), individuals without formal training related to athletics are encouraged to complete continuing education credits in this area and to become a member of a relevant professional organization that provides professional development resources and information, such as the American Psychological Association's Society for Sport, Exercise & Performance Psychology or the Association for Applied Sport Psychology (AASP), whose performance consultant certification designates competency in applying psychological strategies to facilitate performance readiness and excellence (see www.appliedsportpsych.org/certified-consultants/find-a-consultant). Additionally, the Collegiate Clinical/Counseling Sport Psychology Association (CCSPA) offers educational material in this domain (www.collegiatesportpsych.org).

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Depending on institutional resources, the licensed practitioner who is qualified to provide mental health services may be employed by the athletics department, sports medicine department or by an administrative unit outside of athletics such as student health services or campus counseling. The practitioner also may be a local provider located off campus. Regardless, **this practitioner should be easily accessible to student-athletes, which includes being accessible through establishment of a self-referral process.** Ensuring that all student-athletes receive mental health care from a licensed practitioner who is qualified to provide mental health services may require hiring relevant personnel, or helping support the dedicated service of an on-campus practitioner affiliated with an administrative unit outside of athletics. Providing office space within or proximate to athletics department facilities is an important way to increase the practitioner's visibility and accessibility. Regardless of the administrative affiliation and physical location of the licensed practitioner providing mental health care to student-athletes, this individual should have autonomous authority, consistent with his or her professional licensure, to determine mental health management for student-athletes. Care provided to student-athletes should be subject to relevant laws governing patient confidentiality, including possible exemption from mandated reporting*, and should comply with ethical standards of the profession.

Important Considerations:

- Each campus should establish an *interdisciplinary team* that supports student-athlete mental wellness; at many institutions, the coordinator of the team will be the team physician or director of medical services. The interdisciplinary team can include the primary athletics health care providers (athletic trainers and team physicians), licensed psychologists, social workers, life skills support staff, registered dietitians, peer support specialists working under the supervision of a licensed mental health provider, faculty athletic representatives, Student-Athlete Advisory Committee (SAAC) representatives and others that contribute to the overall team effort. Each member of the team has a distinct role in supporting student-athlete mental health, and the scope of that role should be defined within competency and licensure.
- Some athletics departments employ or contract with individuals trained and focused on performance enhancement. These individuals can bring an important performance expertise to individuals and teams. However, unless they are licensed practitioners who are qualified to provide mental health services, they should not be providing mental health care to student-athletes. It is important to note that issues that may initially and appropriately be viewed as related to performance may upon further engagement reveal underlying mental health concerns. For example, an athlete who appears to be "choking" or failing to perform to his/her capabilities on key plays may be doing so because of an untreated anxiety disorder. **Sport performance consultants who are not licensed practitioners qualified to provide mental health services should be made aware of institutional protocols for referral of student-athletes with potential mental health concerns.** Very often, there is a continuum of care that ranges from sport performance optimization to debilitating mental health concern, and many student-athletes are more comfortable presenting a "performance" concern as opposed to a "mental health" concern. Thus it is recommended that the interdisciplinary team has the ability to respond to and treat the full spectrum of care.
- Consulting with campus disability services may be advantageous in better understanding how disability-related accommodations or more inclusive practices may mitigate the impact of mental health disorders or concerns. When student-athletes indicate that they are anxious or depressed, or exhibit concerning behaviors, disability services may be able to determine a reasonable accommodation or advise on more inclusive strategies.
- These "Best Practices" do not provide specific details about the clinical care to be provided to student-athletes. It is expected that primary athletics health care providers and mental health professionals will provide evidence-based care that is consistent with the standards for ongoing licensure in their profession.

** Practitioners providing mental health care are required to report imminent risk to self and others; child and elder abuse; and court-ordered release of information. Practitioners providing mental health care should confirm compliance obligations with institutional counsel regarding mandated reporting requirements under Title IX and the Clery Act.*

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2 PROCEDURES FOR IDENTIFICATION AND REFERRAL OF STUDENT-ATHLETES TO QUALIFIED PRACTITIONERS

Athletics departments, working in conjunction with sports medicine personnel, the licensed practitioners who are qualified to provide mental health services, and other stakeholders across the broader campus community who are involved in supporting student-athlete well-being, should have written institutional procedures for: (1) management of emergency mental health situations; and (2) routine mental health referral. For both emergency and non-emergency mental health situations, these procedures should specify both the steps that will be taken to support a given student-athlete who is facing a mental health challenge, and the role-specific training about mental health signs and symptoms and institutional referral processes that will be provided to stakeholders within athletics to help appropriately support this identification and referral process.

Key considerations and suggestions for protocol development and implementation are outlined below.

Mental Health Emergency Action and Management Plan (MHEAMP)

(Note: For life-threatening mental health emergencies, dial 911 or call the National Suicide Hotline at 800-273-8255.)

Emergency mental health-related situations that should be addressed in the MHEAMP include:

- Managing suicidal and/or homicidal ideation.
- Managing victims of sexual assault, with clarification regarding exemption from mandated reporting in this context.
- Managing highly agitated or threatening behavior, acute psychosis (often involving hallucinations and/or delusions) or paranoia.
- Managing acute delirium/confusional state.
- Managing acute intoxication or drug overdose.

Written procedures for managing emergency mental health situations should, at a minimum, include the elements listed below. Please refer to Appendix E for additional information and resources on how to provide adequate response to emergency mental health crises.

- Identify situations in which the individual responding to the crisis situation should immediately contact emergency medical services.
- Identify situations in which the individual responding to the crisis situation should contact a trained on-call counselor, including the campus crisis center designated to address sexual assault.
- Identify trained on-call counselors who will be able to provide direct and consultative crisis intervention to the student-athlete in need to help stabilize the situation and recommend next steps for action. Working with on-campus health and counseling resources will facilitate identifying such trained personnel.
- Designate the management expectations of each stakeholder within athletics during a crisis situation (e.g., coach, sports medicine personnel).
- Specify steps to be taken by each stakeholder after an emergency situation has resolved to provide appropriate resources and follow-up care to the student-athlete who experienced the mental health emergency.
- Specify a procedure for reviewing preventive and emergency procedures after the resolution of the emergency situation.

MHEAMPs should be made available to all stakeholders who may be involved in caring for the well-being of student-athletes, including coaches and other staff members, and should also be made easily available online. Specific information should be communicated to each stakeholder about his/her role in managing a crisis situation, including when to contact emergency medical services, when and how to contact a trained on-call counselor and how to approach a student-athlete in an emergency mental health situation. There should be timely communication with stakeholders about the importance of reviewing their roles in emergency action plans.

Routine Mental Health Referral

- All stakeholders within athletics who work with student-athletes should be aware of written institutional procedures regarding the referral of student-athletes with non-emergency mental health concerns. As part of the referral process, it is important to identify a point person within athletics (e.g., head athletic trainer, team physician) who is responsible for facilitating such referrals.
- As part of this communication process, individuals within athletics who work directly with student-athletes (e.g., coaching and other staff members) should be provided with role-appropriate training about the signs and symptoms of mental health disorders and about behaviors to monitor that may reflect psychological concerns. Resources are available on the NCAA Sport Science Institute website to help facilitate this communication (www.ncaa.org/mentalhealth).
- Coaches, administrators or other nonclinical staff within athletics who are concerned about the mental health of a student-athlete should communicate their concerns through institutionally designated communication channels for injuries and illnesses. This usually means communicating with the primary athletics health care providers (athletic trainers and team physicians).
- Although it is recommended that the referral and care coordination process be through a point person in athletics, institutions may establish different procedures to facilitate the referral process and to coordinate care. What is most important is that all stakeholders be aware that should there be a potential mental health concern, it is their responsibility to facilitate referral of the student-athlete to the appropriate personnel as specified by their institutional plan.

Protocol Development and Implementation Tips

Written procedures for routine mental health referrals should engage a wide range of campus support staff and include the following considerations:

- Establish the process by which protocol development will take place. This process should involve broad-based participation of key campus constituencies, within and outside of athletics. Possible groups to include are from sports medicine, campus health and counseling services, the faculty athletic representative and other engaged faculty, academic support services for student-athletes, disability services, student affairs, campus security, athletics administration, coaching and student-athletes.
- Allocate sufficient resources to allow for the development, implementation and ongoing evaluation or review of protocols. This may require reprioritizing existing resources.
- Develop a plan for reviewing the protocols to assess their implementation, including how often they will be reviewed and by whom.
- Consider the diversity of your student-athletes (cultural, racial, ethnic, disability, sexual orientation, gender) and create protocols that reflect and support these differences.
- Strive for protocol development to take place in collaboration with or awareness of campus-wide mental health strategic planning processes, and that athletics/sports medicine department protocols are consistent with other campus protocols.

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- In concert with campus counseling professionals, establish an ongoing dialogue with off-campus community resources that could potentially be involved in caring for a student-athlete who is experiencing a mental health challenge (e.g., local police, emergency care providers, community mental health providers) and consider consulting with them during the protocol development process.
- Be transparent with student-athletes and parents about the content of the protocols and the circumstances under which they could be invoked. Communicate protocols with families systematically through handbooks, websites, etc.
- Principles of confidentiality should be clearly established and communicated to all stakeholders. It may be helpful to consult legal services regarding how confidentiality of student-athlete care limits a clinician's communication about potentially at-risk students with sports medicine staff, athletics administration, coaches and college administration. Some student-athletes may find that a limited level of communication with coaches about their mental health care seeking is appropriate. It is important to note that an informed consent process that identifies the construct of care, and includes a release of information, is an appropriate approach for allowing a clinician to confirm athlete participation in counseling. Institutions that refer student-athletes for care off-campus should have clear communication strategies about confidentiality of student-athlete care, and pathways for how and what information is communicated, pending student-athlete consent.
- Consult legal services and/or risk management to ensure that the protocols comply with applicable laws.

3 Pre-Participation Mental Health Screening

It is recommended that mental health screening questionnaires be considered part of the pre-participation exam. In accordance with the recommendation of the U.S. Preventive Services Task Force,[15-16] it is also recommended that a procedure be established specifying when and to whom symptomatic or at-risk student-athletes identified through this screening process will be referred. The decision about what screening questionnaire approach will be used should be made in consultation with the primary athletics health care providers and the licensed practitioners who are qualified to provide mental health services to student-athletes.

The National Athletic Trainers' Association[16] has recommended a series of nine questions about mental well-being for inclusion in pre-participation exams (see Appendix F). These questions can serve as a starting point for mental health screening. An answer of "yes" to any the nine questions leads to follow-up discussion between the student-athlete and a member of the primary athletics health care provider team and/or point person for determination about whether the student-athlete should be referred to a licensed practitioner who is qualified to provide mental health services for further evaluation.

Institutions may alternatively, or additionally, consider using validated instruments to screen for specific mental health disorders and risk behaviors. Short-form screening instruments for disordered eating, depression, anxiety, substance abuse, sleep disorders and attention deficit/hyperactivity disorders are included in Appendix F. The screening tools listed are suggested for use based on their relevance for a college population, abbreviated nature and expert endorsement, but they are not inclusive of all mental health issues that could impact college student-athletes. **NOTE: Screening tools are not validated as stand-alone assessments for mental health disorders, and must be incorporated into the entire pre-participation evaluation. Trained experts at institutions may appropriately select other screening approaches. Athletics may alternatively or additionally choose to join with campus-wide screening programs conducted in conjunction with campus counseling centers, such as College Response (www.mentalhealthscreening.org).**

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4 Health-Promoting Environments That Support Mental Well-Being and Resilience

The athletics environment can help support positive psychological well-being among all student-athletes by normalizing care seeking and fostering experiences and interactions that promote personal growth, self-acceptance, autonomy and positive relations with others.[17] **The way we communicate about mental health can demonstrate our commitment to inclusion and wellness, and our support of all student-athletes, including those with a history of mental health concerns or those experiencing mental health concerns for the first time in college.**

It is recommended that the primary athletics health care providers and the licensed practitioners who are qualified to provide mental health services to student-athletes meet on an annual basis. This meeting serves as an overview of the institution's mental health care protocols. Ideally, this meeting should have the explicit endorsement of the team coaches because coaches help to foster a culture about the importance of seeking mental health care when needed.

Because of the frequency of their interactions with student-athletes, coaches, faculty athletics representatives, SAAC representatives and fellow student-athletes play a central role in helping to identify student-athletes who may benefit from accessing resources related to mental health, normalizing care seeking and fostering a health-promoting environment that supports mental well-being and resilience. It is thus recommended that the following educational information be communicated to student-athletes and coaches on an annual basis. This educational information is meant to help create a culture of awareness and sensitivity to mental health disorders.

Information for SAAC Representatives and Student-Athletes

- Self-care, stress management and personal health promoting practices.
- Signs and symptoms of mental health disorders.
- Programming about peer intervention response to peers in distress or to effectively and safely intervene in cases of sexual assault, interpersonal violence and hazing; trainings include Step UP! (http://stepupprogram.org/) or the Mentors in Violence Prevention Program (https://www.mvpstrat.com/mvp-programs/).
- The importance of sleep in well-being and performance, including the sleep environment, sleep duration and sleep timing.

Information for Coaches and Faculty Athletics Representatives

- Programming to support first responders, such as the QPR Gatekeeper Training for Suicide Prevention (www.qprinstitute.com/). Additional resources are available on the NCAA Sport Science Institute mental health website (www.ncaa.org/mentalhealth).
- Signs and symptoms of mental health disorders.
- The importance of creating, and how to create, a positive team culture that promotes personal growth, self-acceptance, autonomy and positive relations with others, and the importance of formal and informal interactions with student-athletes in supporting these positive processes.
- Information about sexual assault, interpersonal violence and hazing.

  Coaches, administrators and other athletics personnel should reference the NCAA guide "Addressing Sexual Assault and Interpersonal Violence: Athletics' Role in Supporting Safe and Healthy Campuses" to ensure compliance with federal regulations related to addressing hostile environments and educating all stakeholders about rights and responsibilities (see www.ncaa.org/violenceprevention).

- The role coaches can play in encouraging and supporting team members who are facing mental health challenges to seek appropriate care from a licensed qualified practitioner. **Coaches should learn about the importance of being attentive and empathic in their interactions with student-athletes who are facing mental health challenges, while understanding that their role is not to manage the situation themselves. They should instead follow the specific referral process as outlined by their institution's mental health referral plan.**
- Information about the importance of sleep in both well-being and performance, including the sleep environment, sleep duration and sleep timing.

Resources available to help facilitate appropriate education of coaches about the role they can play in creating a health-promoting sport environment can be found at http://athletewellness.uncg.edu/coaches-assist/.

Other Important Athletics Department Considerations

It is recommended that athletics administration, sports medicine personnel and licensed practitioners who are qualified to provide mental health services jointly review the following topics. While these additional considerations do not comprise formal guidelines, they are nonetheless important considerations that should be thoughtfully addressed. The questions below are intended to guide this process.

Medication Management Plan

- What procedures are in place to ensure that student-athletes taking psychiatric/psychotropic and/or opiate medication are being monitored?
- Does the sports medicine staff pre-participation exam require student-athletes to list all medications and supplements they are taking?
- Does the athletics department require student-athletes to provide documentation from personal physicians that demonstrates appropriate diagnostic evaluation and treatment protocols for medication use? (Such a requirement is important to help determine safety factors for pre-participation clearance, and to assure adherence with NCAA drug-testing policies. See www.ncaa.org/drugtesting for NCAA reporting forms for stimulant medications for ADHD and for anabolic agents and peptide hormones for hormonal disorders.)

Transitional Care

- Is there a clearly delineated transition of care plan for student-athletes who are leaving the college sport environment that is in the interest of continuing medical care and student-athlete welfare?
- Who is responsible for initiating transition of care?
- Who is responsible for providing student-athletes with information about community mental health resources?
- Who is responsible for providing student-athletes with adequate medication, as necessary, until continuing care is established?
- Is there a plan for helping student-athletes who have been away from campus while seeking care for mental health issues transition back to campus and to sport participation?
- Who is responsible for facilitating the academic waiver process, should a waiver be needed for a student-athlete who is returning to campus after seeking mental health treatment? (If the student-athlete is seeking a waiver as a disability-related accommodation, consult campus disability services.)

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Financial Support

- What are the institutional policies related to athletics financial awards and team engagement for student-athletes who are unable to continue sport participation, either temporarily or permanently, due to mental health considerations?
- What is the institutional approach/delineation of strategies for financial support of student-athletes in need of extended outpatient treatment or inpatient care?

Communication Strategies

- What institutional departments are informed in the event of a critical incident involving a student-athlete?
- Who are the key institutional stakeholders to advise and assist with community response to a critical incident involving a student-athlete?
- Have student-athletes been asked about involving their family or support network in their care?

Disability Services and Reasonable Accommodation

- Is there a working relationship with disability services staff?
  - Is there a point of contact for student-athletes?
- Has the campus disability services office been utilized to determine reasonable accommodations?
- Has the campus disability services office been consulted on how to increase inclusive practices that may increase engagement of student-athletes?


HydroGrip 5

REFERENCES

1. Brown GT, Hainline B, Kroshus E, Wilfert M. Mind, Body and Sport: Understanding and Supporting Student-Athlete Mental Wellness. NCAA Publications, 2014.

2. Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings. Rockville, MD: Substance Abuse and Mental Health Services Administration; NSDUH Series H-47, HHS Publication No. (SMA) 13-4805, 2012.

3. Weigand S, Cohen J, Merenstein D. Susceptibility for depression in current and retired student athletes. Sports Health 2013;5:263-266.

4. Yang J, Cheng G, Zhag Y et al. Influence of symptoms of depression and anxiety on injury hazard among collegiate American football players. Res Sports Med 2014;22:147-160.

5. Shirreffs SM, Maughan RJ. The effect of alcohol on athletic performance. Curr Sports Med Rep 2006;5:192-196.

6. Greenleaf C, Petrie, TA, Carter J et al. Female collegiate athletes: prevalence of eating disorders and disordered eating behaviors. J Am Coll Health 2009;57:489-495.

7. Rauh MJ, Nichols JF, Barrack MT. Relationships among injury and disordered eating, menstrual dysfunction, and low bone mineral density in high school athletes: a prospective study. J Athl Train 2010;45:243-252.

8. Leddy MH, Lambert MJ, Ogles BM. Psychological consequences of athletic injury among high-level competitors. Res Q Exerc Sport 1994;65:347-354.

9. Best Practices for Understanding and Supporting Student-Athlete Mental Wellness

10. Yuso DA, Buckman JF, White HR et al. Risk for excessive alcohol use and drinking-related problems in college student athletes. Addict Behav 2008;33:1546-1556.

11. Sundgot-Borgen J. Risk and trigger factors for the development of eating disorders in female elite athletes. Med Sci Sports Exerc 1994;26:414-419.

12. Savis JC (2010). Sleep and athletic performance: overview and implications for sport psychology. Sport Psychologist 1994;8:111-125.

13. Mah CD, Mah KE, Kezirian EJ et al. The effects of sleep extension on the athletic performance of collegiate basketball players. Sleep 2011;34:943-950.

14. Lund HG, Reider BD, Whiting AB et al. Sleep patterns and predictors of disturbed sleep in a large population of college students. J Adolesc Health 2010;46:124-132.

15. Neal TL, Diamond AB, Goldman S et al. Inter-association recommendations for developing a plan to recognize and refer student-athletes with psychological concerns at the collegiate level: an executive summary of a consensus statement. J Athl Train 2013;48:716-720.

16. O'Connor E, Rossom RC, Henninger M et al. Screening for depression in adults: an updated systematic evidence review for the U.S. Preventive Services Task Force. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, July 2015.

17. Conley KM, Bolin DJ, Carek PJ et al. National Athletic Trainers' Association position statement: pre-participation physical examinations and disqualifying conditions. J Athl Train 2014;49:102-120.

18. Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

19. Carroll JFX, McGinley JJ. A screening form for identifying mental health problems in alcohol/other drug dependent persons. Alcohol Treat Quarterly 2001;19:33-47.

20. Hill LS, Reid F, Morgan JF et al. SCOFF, the development of an eating disorder screening questionnaire. Int J Eat Disord. 2010;43:344-351.

21. Baer L, Jacobs DG, Meszler-Reizes et al. Development of a brief screening instrument: the HANDS. Psychother Psychosom 2000;69:35-41.

22. Beck AT, Steer RA. Beck Anxiety Inventory Manual. San Antonio: Harcourt Brace and Company, 1993.

23. Bush K, Kivlahan DR, McDonell MB et al. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Arch Int Med 1998;158:1789-1795.

24. Adamson SJ, Kay-Lambkin FJ, Baker AL et al. An improved brief measure of cannabis misuse: the Cannabis Use Disorders Identification Test-Revised (CUDIT-R). Drug Alc Dep 2010;110:37-143.

25. Yang Y, Chung F. A screening tool of obstructive sleep apnea: STOP-Bang questionnaire. Sleep Med Clin 2013;8:65-72.

26. Bastien, C.H., Vallieres, A, Morin CM. Validation of the Insomnia Severity Index as an outcome measure for insomnia research. Sleep Med 2001;2:297-307.

27. Adult ADHD Self-Report Scale-V1.1 (ASRS-V1.1) Symptoms Checklist. World Health Organization 2003.

APPENDIXES

APPENDIX A

A G E N D A
National Collegiate Athletic Association
Mental Health Task Force

NCAA national office — November 18-20, 2013

DAY 1

1. Welcome and introductions. (Brian Hainline)

a. Task force members. [Supplement No. 1 – to be distributed at meeting]
b. Purpose of task force.
c. Timeline of initiatives.

2. The scope of the problem.

a. Student-athlete perspective. (Bradley Maldonado)
b. ATC perspective. (Rachel Sharpe)
c. Team physician perspective. (Jeffrey Anderson)
d. Coach perspective. (Cathy Wright-Eger)
e. Retired athlete perspective. (Aaron Taylor – via video conference)
f. Psychologist perspective. (Chris Carr, Jamie Davidson)
g. Psychiatrist perspective. (Todd Stull)

3. Clinical conditions and concerns.

a. Depression/anxiety. (Research Team, discussion)
b. Disordered sleeping. (Michael Grandner, discussion)
c. Disordered eating – eating disorder. (Ron Thompson, Research Team, discussion)

DAY 2

4. Addictive behaviors.

a. Gambling. (Research Team/Jeff Derevensky, Tom Paskus, discussion)
b. Substance abuse. (Brian Hainline, Markie Rexroat, discussion)
c. Alcohol abuse. (Mary Wilfert – 15 minutes, discussion)

5. Violence.

a. Suicide. (David Lester, Victor Schwartz)
b. Sexual assault and interpersonal violence – SaVE Act and Title IX requirements.
(Mary Wilfert – 15 minutes, Deborah Wilson – 15 minutes)
c. Sexual abuse.
(1) Student-athlete with history of sexual abuse. (Cindy Aron)
(2) Sexual abuse on campus.
(a) Student-student. (Research Team)
(b) Coach/authority figure. (Research Team)
(3) Group discussion.

6. Harassment and discrimination.

a. Hazing. (Mary Wilfert, Research Team)
b. Special considerations.
(1) LGBT. (Karen Morrison – 15 minutes)
(2) Ethnicity. (Terrie Williams – 15 minutes)
c. Group discussion. (15 minutes)

7. Stressors specific to student-athletes.

Stress and happiness among student-athletes (Research Team)
a. Athlete identification. (Research Team)
b. Time allocation. (Research Team)
c. Impact of coaches. (Research Team)
d. Support networks and social connections. (Research Team)
e. Injury. (Margot Patukian)

8. Interassociation Recommendations in Developing a Plan for Recognition and Referral of Student-Athletes with Psychological Concerns at the Collegiate Level. (Tim Neal)

9. Identifying/developing best practices. (Chris Klenck)

APPENDIX A CONTINUED

DAY 3

10. Medical/hardship waivers. (Marci Ridpath)

11. Resources. (Mary Wilfert)

a. Stay in Bounds. [Supplement No. 2 – to be distributed at meeting]
b. Mental Health Handbook. [Supplement No. 3 – to be distributed at meeting]
c. Sports Medicine Handbook. [Supplement No. 4 – to be distributed at meeting]

12. Break-out group sessions.

a. Intervention and treatment protocols. (Chris Carr, Scott Goldman, Nicki Moore, Frank Webbe)
b. Educational programs. (Bren Stevens, A.A. Moore, Penny Semaia)
c. Barriers to accessing campus services. (Ken Chew, Jamie Davidson, Ron Thompson, Tim Saltys)
(1) Collaboration models and strategies. (Chris Klenck, Gary Williams, Drew LeDonne, Rain Henderson)

13. Break-out group discussions. (Jim Whitehead)

14. Next steps

APPENDIX B

NCAA Mental Health Task Force

Jeffrey Anderson, MD; Director of Sports Medicine, University of Connecticut

Chris Carr, Ph.D., HSPP; St. Vincent Sports Performance, Indianapolis; Consulting Sport Psychologist, Purdue University Athletics Department

Kenneth L. Chew, Jr., Psy.D.; Director of the Student Counseling Center, Indiana State University

Jamie Davidson, Ph.D.; Associate Vice President for Student Wellness, University of Nevada, Las Vegas

Jeffrey L. Derevensky, Ph.D.; Director of the International Center for Youth Gambling Problems and High-Risk Behaviors, McGill University

Scott Goldman, Ph.D.; Director of Clinical and Sport Psychology, University of Arizona

Michael Grandner, Ph.D.; Center for Sleep and Circadian Neurobiology, University of Pennsylvania Perelman School of Medicine

Rain Henderson, CEO, Clinton Health Matters Initiative at the Clinton Foundation

James Jackson, Ph.D.; Professor of Psychology and Director of the Institute for Social Research, University of Michigan

Chris Klenck, MD; Head Team Physician, University of Tennessee, Knoxville

Andrew LeDonne, Track and Field Student-Athlete, NCAA Division III Student-Athlete Advisory Committee Representative, Lewis & Clark College

David Lester, Ph.D.; Distinguished Professor of Psychology, Richard Stockton College of New Jersey

Bradley Maldonado, Track and Field Student-Athlete, NCAA Division II Student-Athlete Advisory Committee Representative, Lincoln Memorial University

Cindy Miller Aron, LCSW, CGP; Samaritan Health Services, American Group Psychotherapy Association

Albert Moore, Director of Community Engagement, Gulf South Conference

Nicki Moore, Ph.D.; Senior Associate Athletics Director, Director of Student Life, University of Oklahoma

Timothy Neal, MS, ATC; Assistant Director of Athletics for Sports Medicine, Syracuse University

Margot Putukian, MD, FACSM; Director of Athletic Medicine and Head Team Physician, Princeton University

Marcia Ridpath, MAR Educational Consulting, Association on Higher Education and Disability

Timothy Saltys, Track and Field Student-Athlete, NCAA Division I Student-Athlete Advisory Committee Representative, Indiana University-Purdue University, Fort Wayne

Victor Schwartz, MD; Clinical Associate Professor, New York University School of Medicine

Penny Semaia, Senior Associate Athletics Director of Student Life, University of Pittsburgh

Rachel Sharpe, ATC; Assistant Athletic Trainer, University of South Carolina, Columbia

Bren Stevens, Director of Athletics, University of Charleston (West Virginia)

Todd Stull, MD; International Society for Sport Psychiatry

Aaron Taylor, CBS Sports

Ron Thompson, Ph.D., FAED, CEDS; Consulting Psychologist, Indiana University, Bloomington, Department of Athletics

Frank Webbe, Ph.D.; Professor of Psychology, Florida Institute of Technology

Jim Whitehead, Executive Vice President and CEO, American College of Sports Medicine

Gary Williams, Ph.D.; Director of Athletics, Wittenberg University

Terrie Williams, The Terrie Williams Agency

Deborah Wilson, Associate Athletics Director, Academic Services, George Mason University

Cathy Wright-Eger, Academic Adviser, Purdue University

Staff Participants

Lydia Bell, Associate Director, Research

Brian Hainline, Chief Medical Officer, NCAA

Annie Kearns, Contractor, Research

Karen Morrison, Director, Inclusion

Tom Paskus, Principal Academic Research Scientist, Research

Markie Rexcoat, Assistant Director, Research

Latrice Sales, Associate Director, Sport Science Institute

Mary Wilfert, Associate Director, Sport Science Institute

APPENDIX C

Best Practices Endorsing Organizations

The following organizations have provided endorsements for this document:

- American Academy of Sleep Medicine
- American College of Sports Medicine
- American Medical Society for Sports Medicine
- American Orthopaedic Society for Sports Medicine
- American Osteopathic Academy of Sports Medicine
- Association for Applied Sport Psychology
- Association of Black Psychologists
- College Athletic Trainers' Society
- Collegiate Clinical/Counseling Sport Psychology Association
- Faculty Athletics Representatives Association
- Higher Education Mental Health Alliance
    - American Academy of Child & Adolescent Psychiatry
    - American College Counseling Association
    - American College Health Association
    - American College Personnel Association
    - American Psychiatric Association
    - American Psychological Association
    - Association for University and College Counseling Directors
    - The Jed Foundation
    - NASPA – Student Affairs Administrators in Higher Education
- International Society for Sport Psychiatry
- National Alliance on Mental Illness
- National Athletic Trainers' Association
- National Strength and Conditioning Association
- Society for Sport, Exercise & Performance Psychology
- Sleep Research Society

APPENDIX D

Resource Checklist for Mental Health Care

Below is a checklist that can be used as a resource when evaluating institutional mental health plans. Please note that "Best Practices" do not provide prescriptive details regarding clinical care. As such, care is individualized for the needs of each student-athlete and is based on evidence-based care that is within the scope of practice for the primary athletics health care providers (athletic trainers and team physicians) and the licensed practitioner who is qualified to provide mental health services.

1. Clinical Licensure of Practitioners Providing Mental Health Care

- ❑ Mental health care of student-athletes should be done in collaboration with the primary athletics health care providers (athletic trainers and team physicians) and the licensed practitioners who are qualified to provide mental health services.
- ❑ Formal mental health evaluation and treatment for student-athletes is provided ONLY by practitioners who are qualified to provide mental health services (clinical or counseling psychologists, psychiatrists, licensed clinical social workers, psychiatric mental health nurses, licensed mental health counselors, board certified primary care physicians with core competencies to treat mental health disorders.)
- ❑ Individuals providing mental health care to student-athletes have autonomous authority, consistent with their professional licensure and professional ethical standards, to make mental health management decisions for student-athletes.
- ❑ Individuals providing mental health care to student-athletes should have cultural competency in treating student-athletes from diverse racial, ethnic, gender identified, and other unique cultural experiences influencing help-seeking.
- ❑ Individuals providing mental health care to student-athletes ideally should have cultural competency in working with collegiate student-athletes, as evidenced by professional training related to athletics, continuing education courses related to athletics or other professional development activities or experiences related to athletics.

2. Procedures for Identification and Referral of Student-Athletes to Qualified Practitioners

Mental Health Emergency Action Management Plan (MHEAMP) that specifies:

- ❑ Situations, symptoms or behaviors that are considered mental health emergencies.
- ❑ Written procedures for management of the following mental health emergencies:
  - ❑ Suicidal and/or homicidal ideation.
  - ❑ Sexual assault.
  - ❑ Highly agitated or threatening behavior, acute psychosis or paranoia.
  - ❑ Acute delirium/confusional state.
  - ❑ Acute intoxication or drug overdose.
- ❑ Situations in which the individual responding to the crisis situation should immediately contact emergency medical services (EMS).
- ❑ Individuals responding to the acute crisis should be familiar with the local municipality protocol for involuntary retention, e.g., if the student-athlete is at risk of self-harm or harm to others.
- ❑ Situations in which the individual responding to the crisis situation should contact a trained on-call counselor.

APPENDIX D CONTINUED

- ❑ Identifying trained on-call counselors who will be able to provide direct and consultative crisis intervention.
- ❑ The management expectations of each stakeholder within athletics during a crisis situation.
- ❑ Specific steps to be taken after an emergency situation has resolved to support the student-athlete who has experienced the mental health emergency.
- ❑ A procedure for reviewing preventive and emergency procedures after the resolution of the emergency situation.
- ❑ A formal policy for when student-athlete family members will be contacted in the event of a mental health emergency.

Routine mental health referral plan that specifies:

- ❑ Situations, symptoms or behaviors that may indicate a possible nonemergency mental health concern.
- ❑ The licensed mental health professional to whom student-athletes with possible nonemergency mental health concerns should be referred.
- ❑ Who should be responsible for making the referral to a licensed practitioner who is qualified to provide mental health services.

Communication about mental health management plans:

- ❑ MHEAMPs are provided to all stakeholders within athletics who work with student-athletes, clearly specifying each stakeholder's role in managing a crisis situation.
- ❑ Annual communication is conducted with all stakeholders within athletics who work with student-athletes about the importance of reviewing their role in all emergency action plans – specifically the MHEAMP.
- ❑ All stakeholders within athletics who work with student-athletes are provided with written instructions about the practitioners to whom student-athletes with potential non-emergency mental health concerns should be referred.

3. Pre-Participation Mental Health Screening

- ❑ Screening quesionnaire(s) for mental health disorders are considered as part of the pre-participation exam.
- ❑ A procedure is established for when and to whom symptomatic or at-risk student-athletes identified through this screening process will be referred.
- ❑ All decisions related to what approach will be taken to screening (including what screening instrument to consider and what responses or scores on this instrument warrant further follow-up) will be made by the primary athletics health care providers (athletic trainers and team physicians) in collaboration with the licensed practitioners who are qualified to provide mental health services. Examples may include those listed in Appendix F.

4. Health-Promoting Environments that Support Mental Well-Being and Resilience

- ❑ The primary athletics health care providers and the licensed practitioners who are qualified to provide mental health services to student-athletes meet on an annual basis and develop strategies for educating student-athletes about institutional procedures for mental health referrals and management.
- ❑ All SAAC representatives and student-athletes receive information on an annual basis about:
  - ❑ Signs and symptoms of mental health disorders and how to obtain mental health guidance from the primary athletics health care providers (athletic trainers and team physicians) and licensed practitioners who are qualified to provide mental health services.
  - ❑ Programming about preventing and responding to sexual assault, interpersonal violence and hazing.
  - ❑ Programming about peer intervention in the event of teammate mental health distress.
- ❑ All coaches and faculty athletics representatives receive information on an annual basis about:
  - ❑ Programming to support appropriate first response to emergency situations.
  - ❑ Signs and symptoms of mental health disorders.
  - ❑ The importance of, and how to, create a positive team culture that promotes personal growth, autonomy and positive relations with others.
  - ❑ Information about sexual assault, interpersonal violence and hazing.
  - ❑ How to encourage and support team members who are facing mental health challenges to seek appropriate management and referrals from the primary athletics health care providers (athletic trainers and team physicians) and licensed practitioners who are qualified to provide mental health services.
  - ❑ The specific referral process that coaches should follow if they are concerned about a student-athlete's mental health.
  - ❑ The importance of understanding and helping to minimize the possible tension that can exist in student-athletes about adverse consequences for seeking mental health care.

APPENDIX E

Additional Resources: Emergency Response to Mental Health Crises

The National Athletic Trainers' Association[14] has provided detailed recommendations about developing a plan for recognizing and referring collegiate student-athletes with psychological concerns. Athletics departments and sports medicine departments are encouraged to use these recommendations for developing the content of their emergency and routine mental health referral procedures.

The Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA)[17] has outlined core elements for responding to mental health crises (https://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/sma09-4427). An adapted list of these core elements is below. Please refer to the SAMHSA for additional detail.

Core elements in responding to mental health crises:

1. Provide timely access to supports and services.
2. Provide services in the least restrictive manner.
3. Ensure peer support is available.
4. Spend adequate time with the individual in crisis.
5. Consider the context of the individual's overall plan of services when providing emergency interventions.
6. Ensure that individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented provide crisis services.
7. Ensure that individuals in a self-defined crisis are not turned away.
8. Ensure that interveners have a comprehensive understanding of the crisis.
9. Help the individual to regain a sense of control.
10. Attend to issues of culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served.
11. Respect individual rights.
12. Ensure services are trauma-informed.
13. Note recurring crises and consider whether they signal problems in assessment or care.
14. Take meaningful measures to reduce the likelihood of future emergencies.

APPENDIX F

Screening Instruments

NOTE: This is only a *suggested* list of screening instruments. Screening tools have not been validated as stand-alone assessments for mental health disorders, and must be incorporated into the entire pre-participation evaluation. Trained experts at your institution may appropriately select other screening approaches. Athletics may alternatively or additionally choose to join with campus-wide screening programs conducted in conjunction with campus counseling centers, such as College Response (www.mentalhealthscreening.org).

APPENDIX F CONTINUED

SCREENING TOPIC:
GENERAL INDEX

Measure: NATA suggestion for mental health-related survey.

Reference: Conley KM, Bolin DJ, Carek PJ. National Athletic Trainers' Association position statement: preparticipation physical examinations and disqualifying conditions. J Athl Train 2014;49:102-120. [16]

Adapted from: Carroll JFX, McGinley JJ. A screening form for identifying mental health problems in alcohol/other drug dependent persons. Alcohol Treat Quarterly 2001;19:33-47. [18]

1. I often have trouble sleeping.
2. I wish I had more energy most days of the week.
3. I think about things over and over.
4. I feel anxious and nervous much of the time.
5. I often feel sad or depressed.
6. I struggle with being confident.
7. I don't feel hopeful about the future.
8. I have a hard time managing my emotions (frustration, anger, impatience).
9. I have feelings of hurting myself or others.

Scoring: Responses of "Yes" or "No."

Interpretation: Any response of "Yes" should lead to follow-up discussion between the student-athlete and a member of the primary athletics health care provider team and/or point person for determination about whether the student-athlete should be referred to a licensed mental health professional for further evaluation.

SCREENING TOPIC:
DISORDERED EATING

Measure: SCOFF questionnaire

Reference: Hill LS, Reid F, Morgan JF et al. SCOFF, the development of an eating disorder screening questionnaire. Int J Eat Disord. 2010;43:344-351. [19]

Do you make yourself sick because you feel uncomfortably full?

10. Do you worry that you have lost control over how much you eat?

11. Have you recently lost more than 15 pounds in a three-month period?

12. Do you believe yourself to be fat when others say you are thin?

13. Would you say food dominates your life?

Scoring: Responses of "Yes" or "No."

Interpretation: Any response of "Yes" should lead to follow-up discussion between the student-athlete and a member of the primary athletics health care provider team and/or point person for determination about whether the student-athlete should be referred to a licensed mental health professional for further evaluation.

APPENDIX F CONTINUED

SCREENING TOPIC:
DEPRESSION

Measure: Harvard Department of Psychiatry/National Depression Screening Day Scale

Reference: Baer L, Jacobs DG, Meszler-Reizes et al. Development of a brief screening instrument: the HANDS. Psychother Psychosom 2000;69:35-41.[20]

Over the past two weeks, how often have you:

1. Been feeling low in energy, slowed down?
2. Blamed yourself for things?
3. Had poor appetite?
4. Had difficulty falling asleep, staying asleep?
5. Been feeling hopeless about the future?
6. Been feeling blue?
7. Been feeling no interest in things?
8. Had feelings of worthlessness?
9. Thought about or wanted to commit suicide?
10. Had difficulty concentrating or making decisions?

Scoring: None or a little of the time=0 points; Some of the time=1 point; Most of the time=2 points; All of the time=3 points. Sum item scores.

Interpretation: Score of 0-8: symptoms are not consistent with a major depressive episode. A complete evaluation is not recommended, except in the case of a positive response to the suicide question (item 9). Score of 9-16: Symptoms are consistent with a major depressive episode. Presence of a major depressive disorder is likely. A complete evaluation is recommended. Severity level is typically mild or moderate, depending upon the degree of impairment. Score of 17-30: Symptoms are strongly consistent with criteria for a major depressive episode. Presence of major depressive disorder is very likely. A complete evaluation is strongly recommended. In this higher range, the severity level may be more severe and require immediate attention. Note: Further evaluation is recommended for any individual who scores one point or more on the suicide question (item 9), regardless of the total score.

SCREENING TOPIC:
ANXIETY

Measure: Beck Anxiety Inventory

Reference: Beck AT, Steer RA. Beck Anxiety Inventory Manual. San Antonio: Harcourt Brace and Company, 1993. [21]

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by indicating the response option using: 0 for not at all; 1 for mildly but it didn't bother me too much; 2 for moderately – it wasn't pleasant at times; 3 for severely – it bothered me a lot.

1. Numbness or tingling
2. Feeling hot
3. Wobbliness in legs
4. Unable to relax
5. Fear of worst happening
6. Dizzy or lightheaded
7. Heart pounding/racing
8. Unsteady
9. Terrified or afraid
10. Nervous
11. Feeling of choking
12. Hands trembling
13. Shaky/unsteady
14. Fear of losing control
15. Difficulty in breathing
16. Fear of dying
17. Scared
18. Indigestion
19. Faint/lightheaded
20. Face flushed
21. Hot/cold sweats

Scoring: Sum item scores.

Interpretation: 0-21 indicates low anxiety, 21-35 indicates moderate anxiety, more than 36 indicates high anxiety. Individuals scoring in the moderate anxiety range or higher should have a follow-up discussion between the student-athlete and a member of the primary athletics health care provider team and/or point person for determination about whether the student-athlete should be referred to a licensed mental health professional for further evaluation.

APPENDIX F CONTINUED

SCREENING TOPIC:
ALCOHOL USE

Measure: Alcohol Use Disorders Identification Test (AUDIT-C)

Reference: Bush K, Kivlahan DR, McDonell MB et al. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Arch Int Med 1998;158:1789-1795. [22]

1. How often do you have a drink containing alcohol? [score 0 for never, 1 for monthly or less, 2 for two-four times a month, 3 for two-three times a week, 4 for four or more times a week]

2. How many drinks containing alcohol do you have on a typical day when you are drinking? [score 0 for one or two drinks, 1 for three or four drinks, 2 for five or six drinks, for seven to nine drinks, and 4 for 10 or more drinks]

3. How often do you have six or more drinks on one occasion? [score 0 for never, 1 for less than monthly, 2 for monthly, 3 for weekly, 4 for daily or almost daily]

Scoring: Each question is scored on a 0-4 scale. Points are summed to give total score.

Interpretation: Maximum score is 12. A score of $\geq$4 identifies 86 percent of men who report drinking above recommended levels that meet the criteria for alcohol use disorders. A score of $\geq$2 identifies 84 percent of women who report hazardous drinking or alcohol use disorders. Individuals meeting or exceeding these thresholds should be referred for further evaluation from a mental health professional.

SCREENING TOPIC:

CANNABIS USE

Measure: Cannabis Use Disorder Identification Test (CUDIT-R)

Reference: Adamson SJ, Kay-Lambkin FJ, Baker AL et al. An improved brief measure of cannabis misuse: the Cannabis Use Disorders Identification Test-Revised (CUDIT-R). Drug Alc Dep 2010; 110:37-143.[23]

1. How often do you use cannabis? [score 0 for never, 1 for once a month or less, 2 for two-four times a month, 3 for two-three times a week, 4 for four or more times a week]

2. How many hours were you "stoned" on a typical day when you were using cannabis? [score 0 for less than one hour, 1 for one or two hours, 2 for three or four hours, 3 for five or six hours, 4 for seven or more hours]

3. How often during the past six months did you find that you were not able to stop using cannabis once you had started? [score 0 for never, 1 for less than monthly, 2 for monthly, 3 for weekly, 4 for daily or almost daily]

4. How often during the past six months did you fail to do what was normally expected from you because of using cannabis? [score 0 for never, 1 for less than monthly, 2 for monthly, 3 for weekly, 4 for daily or almost daily]

5. How often in the past six months have you devoted a great deal of your time to getting, using or recovering from cannabis? [score 0 for never, 1 for less than monthly, 2 for monthly, 3 for weekly, 4 for daily or almost daily]

6. How often during the past six months have you had a problem with your memory or concentration after using cannabis? [score 0 for never, 1 for less than monthly, 2 for monthly, 3 for weekly, 4 for daily or almost daily]

7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children? [score 0 for never, 1 for less than monthly, 2 for monthly, 3 for weekly, 4 for daily or almost daily]

8. Have you ever thought about cutting down, or stopping, your use of cannabis? [score 0 for never, 2 for yes but not in the past six months, 4 for yes during the past six months]

Scoring: Questions 1-7 are scored on a 0-4 scale. Question 8 is scored as 0, 2 or 4. Points are summed to give total score.

Interpretation: Scores of 8 or more points indicate hazardous cannabis use. Scores of 12 or more indicate a possible cannabis use disorder for which further intervention may be required.

APPENDIX F CONTINUED

SCREENING TOPIC:
SLEEP APNEA

Measure: STOP-BANG Questionnaire

Reference: Yang Y, Chung F. A screening tool of obstructive sleep apnea: STOP-Bang questionnaire. Sleep Med Clin 2013;8:65-72. [24]

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
2. Do you often feel tired, fatigued, or sleepy during daytime?
3. Has anyone observed you stop breathing during your sleep?
4. Do you have or are you being treated for high blood pressure?

Scoring: All "yes" answers receive a score of 1. Question scores are added to produce a total score (range 0-4), with extra points added for BMI >35, male gender, age >50 and neck circumference >40 mm. This allows a total score of 0-8.

Interpretation: Maximum score is 8. Total score of 3 or more indicates risk for sleep apnea. Higher scores indicate greater probability of sleep apnea. Individuals with scores of 3 or higher should be evaluated by a sleep specialist.

SCREENING TOPIC:
INSOMNIA

Measure: Insomnia Severity Index (ISI)

Reference: Bastien C.H., Vallieres, A, Morin CM. Validation of the Insomnia Severity Index as an outcome measure for insomnia research. Sleep Med 2001;2:297-307. [25]

1. Please rate the current (i.e., last two weeks) SEVERITY of your insomnia problem(s).
    a. Difficulty falling asleep
    b. Difficulty staying asleep
    c. Problem waking up too early
2. How SATISFIED/dissatisfied are you with your current sleep pattern?
3. To what extent do you consider your sleep problems to INTERFERE with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?
4. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?
5. How WORRIED/distressed are you about your current sleep problem?

Scoring: All items are scored on a 0-4 scale. Question 1: 0=none, 1=mild, 2=moderate, 3=severe, 4=very; question 2: 0=very satisfied, 4=very dissatisfied; question 3: 0=not at all interfering, 1=a little, 2=somewhat, 3=much, 4=very much interfering; question 4: 0=not at all noticeable, 1=a little, 2=somewhat, 3=much, 4=very much noticeable; question 5: 0=not at all, 1=a little, 2=somewhat, 3=much, 4=very much. Item scores are summed.

Interpretation: Maximum score is 28. Scores of 0-7 indicate minimal or nonexistant insomnia. Scores of 8-14 indicate possible insomnia that likely does not meet diagnostic threshold or mild insomnia. Scores 15-21 indicate moderate insomnia. Scores 22-28 indicate severe insomnia. Higher insomnia scores are associated with onset and recurrence of depression and anxiety disorders. Notably, most mental health treatments are often ineffective for insomnia. Thus high insomnia scores that do not decrease with other mental health treatments warrant referral to a sleep specialist.

APPENDIX F CONTINUED

SCREENING TOPIC:
ADHD

Measure: Adult ADHD Self-Report Scale (ASRS-v1.1) Screener

Reference: Adult ADHD Self-Report Scale-V1.1 (ASRS-V1.1) Symptoms Checklist. World Health Organization 2003 [26]

NOTE: As with all mental health concerns, it is important to facilitate a specialty referral to establish an ADHD diagnosis; by doing so, the clinician with expertise in assessment of these issues can effectively rule out other explanations for attention difficulties, including, but not limited to, disordered sleep, overtraining, anxiety, depression, stress and poor time management. It is important to note that although ADHD can develop in emerging adults, it is primarily a developmental disorder with childhood onset.

Select the response option that best describes how you have felt and conducted yourself over the past six months.

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?
3. How often do you have problems remembering appointments or obligations?
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?

Scoring: Response options are never, rarely, sometimes, often and very often. For each of questions 1, 2 and 3, assign one point to a response of sometimes, often or very often. For each of questions 4, 5 and 6, assign one point to a response of often or very often. Sum all scores.

Interpretation: A score of four or more indicates that symptoms may be consistent with Adult ADHD, and a follow-up consultation with a health care provider can determine whether a further evaluation is appropriate.

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