This is the accepted version of a paper published in Psychology of Sport And Exercise. This paper has been peer-reviewed but does not include the final publisher proof-corrections or journal pagination.

Citation for the original published paper (version of record):


Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Creative Commons Attribution Non-Commercial No Derivatives License

Permanent link to this version:
http://urn.kb.se/resolve?urn=urn:nbn:se:gh:diva-5284
FEPSAC position statement: Mental health disorders in elite athletes and models of service provision

Conflict of interest: None
Abstract

Mental health disorders (MHD) in elite athletes is a topic that has received increased attention in recent years. The overall aim of this position statement is to enhance awareness of this important topic and to critically discuss optimal service provision for athletes who suffer from MHD. In the first part of the paper a short overview of the research on MHD in elite athletes is provided. Elite athletes seem to have comparable prevalence rates for the most common MHD when compared to non-athletic peers, but there are still many disorders that have not been investigated in athletes. Sport specific situations such as injuries, periods of overtraining and career termination may put athletes at an increased risk of developing MHD. In the second part of the paper, models of service provision for elite athletes suffering from MHD from six European countries are presented, focusing on 1) professional service providers, 2) support systems, 3) diagnostic assessment, 4) clinical treatment, 5) performance during treatment, 6) screening, and 7) education systems. It emerges that competencies, certification issues, and professional boundaries of the involved service providers, as well as the structure of the National Health Care systems differ strongly across European countries, which makes defining a golden standard difficult. In the third part of this paper, the authors provide general recommendations for athletes and coaches, clubs, federations, organizations and scholars that hopefully will inspire stakeholders to optimize their support systems.

Keywords: professional service providers, diagnostic assessment, clinical treatment, screening, education
Highlights:

- Elite athletes have a similar prevalence rate of MHD as the normal population
- There is so far a lack of knowledge on how to support elite athletes with MHD
- Service provision for MHD vary greatly across European countries
- Recommendations for how to best support elite athlete with MHD are proposed
Mental health disorders and models of service provision for elite athletes: FEPSAC position statement

Mental health disorders (MHD) in elite athletes have gotten increased attention in applied and research settings in the last years (Macintyre et al., 2017; Schinke, Stambulova, Si, & Moore, 2017). For a long time, it has been assumed that only mentally and emotionally strong athletes are able to successfully compete at the highest level, consequently limiting the attention on MHD in the world of top sports. However, the various high performance sport contexts consist of a unique range of stressors, such as competitive factors (e.g., performance expectation), organisational (e.g., travel) and personal stressors (e.g., family issues), that potentially increase athletes’ risk for mental illness (Sarkar & Fletcher, 2014; Rice, et al., 2016). Noteworthy, peak performance age in elite sports (see Allen & Hopkins, 2015) in most disciplines coincides with a period in life with a peak in the onset of adult MHD (Jones, 2013). A rising number of elite athletes suffering from MHD have been reported in media, as for example Gianluigi Buffon, Robert Enke, Sebastian Deisler, Gerd Müller, Marco Pantani, Victoria Pendleton, Michael Phelps, Hope Solo, and Jonny Wilkinson. These public cases suggest that top athletes can also be affected by MHD.

This paper will focus on MHD, defined as illnesses that can be diagnosed following the criteria of the DSM-5 (American Psychiatric Association [APA], 2013) and/or the ICD-10 (World Health Organization [WHO], 2004), which both define a threshold between disorder and non-disorder. Wakefield (2007) postulates that classifications of mental disorder are intended to guide determinations of eligibility for services or treatment decisions. However, we are aware that it is not that simple to define the threshold between clinical and subclinical conditions. According to Clark, Cuthbert, Lewis-Fernández, Narrow, and Reed (2017), setting a threshold between clinical and subclinical conditions is problematic due to the fact that a clear definition of mental disorders is still under debate, and mental disorders are
multidimensional in nature. Therefore, these authors suggest describing mental conditions on a continuum between health and illness (Clark et al., 2017). In the applied setting, this means that practitioners must be aware that athletes may not have all symptoms for a formal diagnosis of mental illness, but can still experience subclinical conditions where an early intervention would be beneficial (Roberts, Faull, & Tod, 2016). Some authors (e.g., Bär & Markser, 2013; Hoyer & Kleinert, 2010) suggest that there also exist sport-specific MHD (e.g., female athlete triad, chronic traumatic encephalopathy, mood disorders in the context of overtraining syndrome). However, research so far is too limited to draw any conclusions about the prevalence and impact of these MHD.

A recent position stand regarding the relationship between athletes’ mental health, performance and development from the International Society of Sport Psychology (ISSP; Schinke, et al., 2017) represents the growing attention directed towards mental health in sports. By bridging the topic of subclinical issues and prevention of mental ill-being, as focused on in the ISSP position stand (Schinke et al., 2017), with a focus on clinical disorders and service provision for elite athletes who suffer from MHD, we intend to advance the literature in this area.

To date, there has been a lack of information about how to set up a feasible and effective support system to manage mental health conditions in elite sports. This may limit the process of help-seeking, assessment and treatment of mental disorders for all practitioners and professional service providers. The aims of this position statement are therefore to (a) describe and compare the models of service provision for elite athletes with MHD in a number of European countries, (b) suggest future directions of research and investigation within this area, and (c) provide practical recommendations for professional service providers (i.e., applied sport psychologists, clinical psychologists, psychiatrists and other professionals involved in the athlete care setting) and sport institutions, and thereby support the decision
and commitment of the stakeholders involved in the high performance support system on how prevention, assessment, and treatment of mental disorders in elite athletes can be structured. The focus of the present paper is on elite athletes, defined as competitive-elite, successful-elite and World-class elite athletes (Swann, Moran, & Pigott, 2015). As an overall goal, this paper will hopefully enhance awareness and thereby generate greater interests and more resources focused on MHD in elite sports, and also provide knowledge about how to best support athletes.

**Short overview of the research investigating MHD in elite athletes**

While several studies report the prevalence of single mental disorders, only five studies have been conducted so far that investigated a range of MHD in elite athletes. The results are summarized in Table 1. Of these five studies, only Schaal and colleagues (2011) used clinical interviews to determine prevalence rates, whereas the other four studies relied on self-report data. Schaal et al. (2011), Gulliver, Griffiths, Mackinnon, Batterham, and Stanimirovic (2015) and Gouttebarge et al. (2017) concluded that the prevalence of mental disorders in their studies were comparable with the general population in their respective country. In contrast, the findings from Gouttebarge, Frings-Dresen, and Sluiter (2015) suggested that the prevalence of common MHD is higher in current and former male professional footballers than in the general population. A narrative systematic review by Rice et al. (2016) concluded that elite athletes experience a broadly comparable prevalence of mental disorders such as depression and anxiety compared with the general population, whereas a comparison for other mental health domains such as substance use, is less consistent. To date, a large number of disorders, such as ADHD and bipolar disorder have been overlooked in research in elite athletes (e.g., Lebrun & Collins, 2017; Reardon & Factor, 2010).

More commonly, studies have focused on investigating specific disorders in the elite athlete population, and most studies, including reviews, exist for depression and eating
disorders. The reader is guided to Wolanin, Gross, and Hong (2015) for a review on depression, to Joy, Kussman, and Nattiv (2016) for a narrative review on eating disorder, and to Rice et al. (2016) for a narrative review on mental health in elite athletes.

It has been proposed that elite sport context-specific factors such as injury, excessive overtraining in combination with inadequate recovery and career termination may increase vulnerability to certain mental disorders (see e.g., Gulliver et al., 2015; Meeusen et al., 2013; Raglin, 2001; Rice et al., 2016). Gouttebarge, Aoki, and Kerkhoffs (2016) concluded in their study that both the number of severe musculoskeletal injuries, as well as undergone surgeries during a career were positively correlated with self-reported symptoms of distress, sleeping disorders, adverse alcohol behaviour and adverse nutritional behaviour among male European professional football players. Gulliver et al. (2015) showed that injured athletes had higher levels of symptoms of depression and generalized anxiety disorders (GAD) compared with non-injured athletes. Brewer and colleagues reported problematic emotional constellations in 10-20 % of injured athletes (Brewer, Linder, & Phelps, 1995; Brewer, Petitpas, VanRaalte, Sklar, & Ditmar, 1995). For a narrative review on the impact of injury on mental health see Putukian (2016).

The sport specific effects of different levels of training load in relation to mental health was originally described in a mental health model by Morgan (1985). Specifically, athletes who managed to adapt to hard training expressed superior mental health (the “Iceberg Profile”) in comparison to athletes who failed to adapt to hard training (i.e., showed maladaptive response to training). This maladaptive condition, well known today as the overtraining syndrome, is characterised by performance impairment, accumulated fatigue, depression, mood disturbance, muscle soreness, loss of appetite, sleep disturbance and is regarded as consequence of non-functional overreaching (Halson & Jeukendrup, 2004; Kenttä & Hassmen, 1998; Urhausen & Kindermann, 2002). However, despite advancement in sport
science (see for example the joint consensus statement of the European College of Sport Science (ECSS) and the American College of Sports Medicine (ACSM) about the overtraining syndrome published by Meeusen et al., 2013), Schwellnus and colleagues (2016) concluded that monitoring training load and recovery will continue to be one of the biggest challenges to mental health and performance adaptation or maladaptation.

Several studies with male athletes from team sports showed that self-reported MHD were higher in retired athletes than in the general population (Gouttebarge, Kerkhoffs, & Lambert, 2016; Gouttebarge, Aoki, & Kerkhoffs, 2015; van Ramele, Aoki, Kerkhoffs, & Gouttebarge, 2017). Gouttebarge, Kerkhoffs et al. (2016) found that the more dissatisfied rugby players were with their career, the more they suffered from distress, sleeping disturbance, smoking and adverse nutritional behaviour after retirement. In a study by Wippert and Wippert (2008), nearly 20% of the skiers who were dismissed from the team and had to stop their career showed clinically relevant levels of traumatic stress three and eight months after termination. A recent study by Beable, Fulcher, Lee, and Hamilton (2017) showed that athletes who were still competing, but who were considering or planning retirement had higher rates of depressive symptoms than athletes who had not reflected on career termination.

Elite athletes who suffer from mental ill-being face an additional challenge to seek help due to the sport’s culture of masculine ideals, valuing strength and mental toughness, being encouraged to minimise and suppress signs of weakness and vulnerability (see Reardon & Factor, 2010), and fears of being excluded from the team or not allowed to compete (Bauman, 2016). Consequently, it has been postulated that athletes are less likely to seek help for mental disorders (e.g., Gulliver, Griffiths, & Christensen, 2012) and have less positive attitudes toward help-seeking for mental health problems (Watson, 2005) than their non-athletic peers. Several studies revealed that one of the most prevalent barriers to help seeking was
stigmatisation regarding mental illness (Biggin, Burns, & Uphill, 2017; Gulliver et al., 2012; Gulliver et al., 2015).

To sum up, research shows that elite athletes do suffer from mental disorders. Moreover, the stressors experienced by elite athletes and some specific contextual issues exist in elite sport that may trigger MHD. Given this situation, some sport organisations have started to structure models of service provision to prevent, discover, diagnose and treat MHD in elite athletes. Since the approaches of these countries are different, the following description and comparison of different structures and processes may provide guidance on how to establish best practice for dealing with MHD in elite athletes.

Models of service provision for elite athletes with mental health disorders in European countries

In the following section, the models of service provision for elite athletes experiencing MHD will be described as it is structured in six European countries, namely France\(^1\), Germany, Great Britain and Northern Ireland\(^2\), Hungary, Italy, and Sweden. The key aspects of the systems are reported in Table 2. Including and describing the models of all European countries would go beyond the scope of this paper. However, these six countries were selected based on purposeful sampling within the FEPSAC-community, representing Southern, Northern, Western, and Eastern areas of Europe with different cultural backgrounds. In some of these countries (Germany, Italy, Sweden) dramatic incidents with famous athletes (e.g., suicides) that attracted large media interest may have increased the interest in mental disorders in elite athletes. Nevertheless, the authors acknowledge that this is not a representative sample, and that there are other countries not involved in this overview.

---

\(^1\) In the case of France, the model adopted by the INSEP (National centre) involving about 700 elite athletes, will be presented (and subsequently referred to as “France”).

\(^2\) For Great Britain and Northern Ireland, the service provision model of the English Institute of Sport (EIS), supporting 1700 elite athletes, will be described (and subsequently be referred to as “GB & NI”).
with well-developed models. We hope that service provision models of other countries may be represented in forthcoming papers.

Professional service providers

Several professional groups are working in the field of sport psychology and sport psychiatry. However, these professional groups and the scope of their professional boundaries vary greatly in the different countries due to different regulations and certification systems. The most typical service providers will be described as they are defined in the six different countries:

- **Sport psychologist (SP):** In general, SPs are responsible for performance enhancement service, and for providing support in sub-clinical issues. SPs are licenced psychologists in many countries (France, GB & NI, Italy). In Sweden, and in Germany, individuals working as SPs have an academic education in psychology, sport science and/or sport psychology, at a Master or Doctoral level, but do not necessarily have a licence as psychologists. In Germany, there is a distinction between SPs who have an academic degree in psychology, and Sport Psychological Experts (SPEs) who have an academic degree in sport science and a further specialized education in sport psychology quality assured by the German Association of Sport Psychology (ASP). Both groups have similar functions and rights in the field of elite sport. In Hungary SPs are psychologists who hold a master degree in psychology and attended a further 2 years specialization in sport psychology.

- **(Sport) Psychotherapists or clinically trained (sport) psychologists:** In Sweden, a group of SPs are clinically trained and allowed to provide psychotherapy for clinical disorders under supervision. Thus, this specific group of SPs in Sweden
are also allowed to treat MHD, thus expanding the professional boundaries beyond the traditional role of sport psychology. In a similar vein, many SPs in Italy and Germany are also trained as psychotherapists which enables referral among professionals when a clinical intervention is needed. Other represented countries (but also in some cases in Germany) refer clinical cases to clinically trained psychologists or psychotherapists, where it is emphasised that these professionals should have specific knowledge in sports. The English Institute of Sport SPs are specifically trained in Mental Health First Aid (MHFA). The Hungarian Olympic Committee provides some professional psychotherapists as specialized support for Olympic athletes.

- Medical doctors: Psychiatrists (France, Germany, Italy, Sweden, Hungary), and/or sport medicine physicians (France, GB & NI, Italy) provide initial support for mental disorders in elite athletes. In France, GB & NI and Italy the sport medicine physician (not psychiatrists) are involved in the initial screening process, but refer to a clinical psychologist/psychiatrist for further assessment. Psychiatrists and sport medicine physicians are the only ones that are allowed to prescribe medication and thereby provide pharmacological treatment.

**Support system**

The SP is a potential first contact for an athlete suffering from mental health problems in every country investigated. The SP in GB & NI, Germany and Hungary then refers the athlete to a clinically trained person. In GB & NI all referrals are done by a medical doctor. In France, Italy, and Sweden, the clinically trained SPs can take on the treatment in the case of sub-clinical issues not requiring a psychiatric assessment, even though it is recommended in Italy to keep the role of SP distinct from the role of psychotherapist. In the case that no SP is
available, the first contact can also go through the general practitioner of the family or the sport medicine physician of the team (Germany, Italy), or through a nation-wide initiative that offers a first screening and provides a network of sport psychologists and sport psychotherapists (MentalEmpowerment.de, Germany). In Sweden, elite athletes can directly access the psychiatric clinics if they fulfil specific criteria (see below).

In some countries (Italy, GB & NI, Germany), the clinical support services are external to the sport context and run in private hospitals, affiliated to the state health care system. In France, there are psychologists in almost all regional center and national schools. Those psychologists are in charge of the compulsory interviews. In GB & NI and Italy there are no specific public national institutions or organizations that provide care services for athletes with MHD. Rather, in these countries, experts from the private sector are involved, or athletes are referred to the public health care services. In contrast, in Sweden there are two psychiatric clinics that are part of the public health care system and specifically tailored and designated for elite athletes (see below). In Germany, there is a network of 10 clinics for MHD, which offer special services for athletes. The network is connected to the field of sport practice by the nation-wide initiative MentalEmpowerment.

In France, GB & NI, Germany, Italy, and Sweden, a specific group of athletes get access to specific private or public support: In France, all high-level athletes (carded athletes) by law since 2006 have an annual compulsory interview with a clinical psychologist or a sport medicine physician (see for more details below), and can request consultations during the year when in need for psychological support. In GB & NI, all funded athletes receive private medical healthcare which provides parity of care for physical and mental health, where the latter is in accordance with the National Institute for Clinical Excellence (NICE) guidelines of 8-12 therapy sessions and up to 28 days inpatient care. Through its Mental Health Referral Programme (MHRP) the EIS provides secondary care services to their athletes through
referral to external psychiatric and clinical psychology support services. Appropriate contact within the bounds of confidentiality is maintained between the external providers and the EIS in order to maximize support for the athlete in their sporting environment both during and after the referral process. This may include case conferencing, specific relapse prevention strategies and context specific education for the external providers. In Germany, a network of 10 clinics for mental disorders exists which offer special services for athletes. This network was founded by the Sport Psychiatry section of the national scientific association for Psychiatry (DGPPN) and is connected to sports by the nation-wide initiative MentalEmpowerment which was founded in 2011. MentalEmpowerment links the clinic-network directly to athletes, coaches, and sport clubs and coordinates with sport organizations and the German Association for Sport Psychology (ASP). In addition, MentalEmpowerment supervises a network of private psychotherapists and psychiatrists who are particularly skilled in working with athletes. Furthermore, applied sport psychologists at the national Olympic centers are connected to MentalEmpowerment and its network service. In Italy, athletes involved in military and state corps groups (currently 530 athletes) follow the general rules of military corps consisting of among others an annual compulsory examination including evaluation and support for mental health problems. In addition, for Olympic athletes there is a specific multidisciplinary private service in Rome at the Institute of Medicine and Science in Sport, Center for Olympic preparation “Giulio Onesti”, in which the athletes and the National Sport Federation have access to a supplementary medical service that includes outpatient psychological and psychiatric services. In Sweden, two newly opened psychiatric clinics link the public health care system and the elite sports organisations (represented by The Swedish Sports Confederation) and provide ambulatory psychological and psychiatric support for elite athletes. To get access to these clinics, athletes need to be above 18 years of age and a current, or recently retired member of a national team. The Hungarian Olympic Committee provides
just a small number of professionals (psychologists/psychotherapist) as specialized support for all the athletes across country.

**Diagnostic Assessment**

France, GB & NI, Germany, Hungary, and Italy do not have a standardized assessment process for elite athletes. Instead, the content of the assessment is decided on a case-by-case basis (France, Germany, Italy), or on a sport and individual basis (GB & NI). France has a standardized process when it comes to the yearly mandatory interview, which is further described under the screening section. In Germany, there are regional processes in different states (e.g., Brandenburg, North-Rhine-Westphalia) providing standardized screening diagnostic, such as the Patient Health Questionnaire-2 (PHQ-2; Blom, Bech, Högberg, Larsson, & Serlachius, 2012) or the World Health Organization Well-Being Index (WHO-5; Löwe et al., 2004). In Italy, the supplementary service for Olympic athletes involves a semi-structured interview based on Symptom Check-List-90 (SCL-90; Derogatis & Savitz, 2000) and a psychophysiological assessment with bio-neuro-feedback equipment and other private services use the Cognitive Behavioural Assessment (CBA-Sport; Sanavio, Berolotti, & Michielin, 1997) and specific diagnostic tools (e.g., Beck Depression Scale, Anxiety inventory). In contrast, in Sweden the assessment procedure is standardized at the two psychiatric clinics. Initially the psychiatrist performs a clinical assessment supplemented with a structured diagnostic interview for the most relevant psychiatric disorders (M.I.N.I. International Neuropsychiatric Interview; Sheedan et al., 1998), plus a clinical assessment (Clinical Global Impression Scale; Busner, & Targum, 2007). When needed, blood samples and a somatic status will be done. In addition to the assessment by the psychiatrist, the licensed psychologist assesses the athlete with a focus on functional behavioral analysis. Furthermore, clinical established and validated self-assessment scales covering anxiety,
depression, alcohol use, neuro psychiatric functioning as well as sport specific performance scales, supplemented with targeted scales for certain conditions can be applied when needed (see table 2).

**Clinical Treatment**

All authors agree that treatment of clinical disorders in elite sports should (a) include evidence-based methods, (b) be conducted by well-educated specialists (i.e., officially skilled and qualified in psychotherapy and/or clinical psychology), and (c) be conducted by persons who have a thorough knowledge of the nature of high performance contexts. Regarding the latter, different methods have been mentioned to secure the contextual knowledge of the treating staff: (a) the treating person is also educated as a sport psychologist (often the case in France, Italy, Sweden; sometimes the case in Hungary and Germany); (b) a person coming from clinical psychology/psychotherapy and/or psychiatry has gone through further education in sport science and the various high performance sport contexts (France, Germany); (c) the treating person has their own background in elite sports (though not a sufficient criteria in some countries, e.g., Germany); (d) the treating person sampled broad working experience with this specific group, which is sometimes the case in France; or (e) the clinical psychologist/psychotherapist and the SP keep up communication during the treatment (GB & NI). An interesting approach in Germany is that psychiatrists/psychotherapists and SP form dyads and develop their skills through peer learning (while cooperatively treating/counselling athletes). Another important aspect when it comes to treatment of elite athletes is to consider the specific life circumstances of this group (e.g., irregular daily schedule, travels, competitive demands, etc.) which need to be addressed in treatment planning.

The only treatment approach that is included in all countries is Cognitive Behaviour Therapy (CBT). Some countries (GB & NI, Sweden) emphasize the use of more recent
treatments stemming from CBT, such as Acceptance Commitment Therapy (ACT) and Mindfulness. Whereas these treatment approaches are the only ones adopted in Sweden, the other countries use different treatments based on the presentation and the respective specialism, such as systemic approaches, psychodynamics, humanistic, integrated procedures, and EMDR. In all countries, if needed pharmacological treatment is initiated and supervised by a psychiatrist.

**Performance during treatment**

Performance issues will always be an integral topic of discussion when treating elite athletes with mental disorders. A common approach when it comes to performance during treatment is to take a decision on a “case-by-case” basis. Depending on the kind of disorder and the severity of the symptoms, the team around the athlete needs to take a decision if participation in training and competitions is justifiable from a medical point of view. Performance issues are especially sensitive when treating eating disorders, mainly because low weight may enhance performance in some sports and because eating disorders involve an increased health risk and have been shown to be contagious in adolescent populations (i.e., potentially affecting teammates’ health and performance; Eisenberg, & Neumark-Sztainer, 2010; Fletcher, Bonell, & Sorhaindo, 2011). The IOC consensus statement (Mountjoy et al., 2014) presents a risk assessment model for sport participation, where it emerges that athletes with serious mental health problems (e.g., diagnosed with anorexia nervosa or athletes with extreme weight loss techniques) must be prevented from any sport participation. Another decision that must be taken is if an eventual sport psychology intervention should be continued alongside a clinical treatment, or if it is better that such an intervention be paused for the duration of the treatment. Optimally, all such decisions are taken collaboratively.
between the different service providers involved (i.e., SP, clinical psychologist, psychotherapist, psychiatrist), the athlete and his/her coach and/or significant other.

**Screening strategies to detect mental health problems**

France has a rather unique system for screening athletes with the mandatory interview. Since 2006, every athlete on the high level national list (which includes both athletes at INSEP and athletes in the regional centers) must, by law, do a specific interview with either a sport medicine physician or a clinical psychologist, once a year. Below is a short description of this process at INSEP: For athletes over 15 years, the interview will start with the M.I.N.I. (Sheedan et al., 1998), investigating 17 psychopathological categories such as anxiety disorders and depressions. For athletes under 15 years of age an adapted test is used, namely the French version of the Multiscore Depression Inventory for children (MDI-C; Berndt & Kaiser, 1996). This part of the interview is done at the initial assessment; in the ensuing years, only the second part is implemented. The second part consists of an open discussion with a self-created guide that includes topics such as prior contact with psychologists/psychiatrists, school and/or employment situation, family and social environment, sporting life and mental aspect in high level sport, and personal life. All interviews are concluded with the option (or a specific demand of the athlete him- or herself) of a follow up, which is classified as either “prevention”, “care” or “help towards performance”. Finally, depending on the (eventual) demand from the athlete, and the psychologist’s conclusion and/or diagnosis, a referral to the most appropriate professional is done.

In all other countries (GB & NI, Germany, Italy, Sweden), there is no systematic, comprehensive, and nation-wide system implemented that aims to detect mental disorders in elite sport. However, in Germany, there are some regional processes (especially in elite youth sport), in which short screening instruments, such as e.g., PHQ-2 (Blom et al., 2012) and
WHO-5 (Löwe et al., 2004) are applied with the purpose of detecting psychosocial problems at an early stage; in case of suspicious results further interviews are conducted by trained persons. Though there is currently no formal screening process across GB & NI, the EIS staff (including over 250 sport science, medicine and operational staff) have 4000 face to face contact hours with athletes each week so are well positioned to identify early signs and encourage athletes to seek help. In the past, in Hungary, there was a National systematic screening among elite athletes, which has been cancelled for the last couple of years and it is now under revision.

**Education system**

In France and Hungary, most of the education regarding clinical psychology in sport will take place by working in the field, internships and /or taking part in workshops and conferences, meanwhile in some university degrees, sport issues will be included. In GB & NI, as part of the BPS Stage 2 training to become chartered and registered with the Health Care Professional Council (HCPC), SPs have training in awareness, detection and referral for clinical issues. All EIS sport psychologists are trained in Mental Health First Aid. In Germany, the initiative MentalEmpowerment in cooperation with the German Association for Sport Psychology (ASP) offers programs for further education for SPs /SPEs and psychotherapists/psychiatrists. For the first group, the main aims of these programmes are to increase awareness of mental health problem, to handle and interpret screening results correctly, and to discuss treatments in subclinical cases. For the second group, specific knowledge about the stressors and circumstances in elite sport is provided, as well as information on sport specific diagnostic tools. In Italy, private educational organisations (accredited by the Ministry of Education) provide further education for psychotherapists in sport issues and for SPs in clinical issues. However, to be registered as psychotherapist it is
compulsory to complete the 4-years specialization program after a Master degree in psychology. In Sweden, since 2009 there is an educational initiative that aims to improve the connection between performance enhancement and clinical support in order to provide a broader sport psychology support system and to decrease the need of referral to other professionals. For this purpose, the Swedish Sports Confederation designed a specific CBT-program that focuses on elite athletes, in collaboration with academia.

Recommendation for practice and research

The synthesis of the literature on MHD in elite athletes, the analysis of the systems of service provision presented in that paper, as well as the authors applied experience working in this field resulted in recommendations for research and practice, directed toward athletes and coaches, clubs, federations, organizations and scholars. These recommendations will hopefully inspire stakeholders to optimize their mental health support systems in order to develop a healthy and safe environment for those athletes performing at the top level.

1) Education and help-seeking behaviour

a) Education of athletes, coaches, and high performance directors about symptoms of different mental health conditions is a key point to normalize, prevent and/or detect mental health problems in athletes. Educating professionals in relation to the different high performance sport contexts has been proposed as an important facilitator for help-seeking (Gulliver et al., 2012). Different programs have been developed in the sport context (see for a review Breslin, Shannon, Haughey, Donnelli, & Leavey, 2017).

b) Organize specific seminars for medical and sport psychology professionals involved with athletes, investigating and defining the issue of the blurred threshold between
diagnosable clinical conditions and subclinical conditions and its relation to athletes’ wellbeing and performance.

c) Normalizing and validating the issue of mental disorders and vulnerability in high level sports is an important step that staff and sport organizations can do to destigmatize the topic in that population. Providing information that professional assessment and treatment is often successful, especially when seeking help early, is important information that needs to be taught to athletes, but also to professionals and organizations in elite sports. Providing the comparable example regarding how to act and manage typical overuse injuries, i.e., try to intervene at an early stage to prevent more serious enduring problems, may serve as an analogy that would resonate with many elite athletes.

d) All behaviours that will facilitate help-seeking when athletes suffer with mental illness should be reinforced. Common facilitators of help-seeking include social support, encouragement from others, positive relationship with service staff, confidentiality, time for therapy sessions, integration into athlete life, positive past experiences, ease of expressing emotion and openness (see e.g., Putukian, 2016). A healthier and more sustainable environment will develop when athletes feel comfortable and free to ask for help, without any negative consequences for their career, and can receive professional assessment and treatment.

2) Sport-specific approach in detecting and treating MHD in elite athletes

   a) Further research is needed investigating whether there are sport-specific MHD. In a next step, defining specific diagnostic criteria for such disorders would be required.

   b) A thorough examination is needed to check the validity of existing diagnostic instruments for elite sport (including screening instruments for mental health problems). Likewise, it is welcomed to develop sport-specific instruments.
c) It should be explored if there is a need for and validity of contextualizing specific treatment protocols for common disorders in elite athletes within the context of elite sport (e.g., a protocol for anxiety disorders with regard to performance anxiety, or a protocol for eating disorders taking into account the initial performance enhancing effect of weight loss).

d) Developing and enhancing treatment protocols for athletes suffering from specific sport-related problems such as overtraining, psychological reactions to injuries and career termination is another important issue. For example, overtraining syndrome is typically treated with rest only while neglecting any form of psychological intervention, despite mood disturbance being a central part of the syndrome.

e) Focus should be put on sport-specific situations that athletes may experience, and which may increase the likelihood of developing MHD, such as (a) severe and/or repeated injuries or concussions, (b) excessive training with insufficient recovery, or (c) career termination. Staff working with athletes who may fall into these categories should monitor them carefully, initiate a conversation with the athlete, and, if necessary, refer to appropriate service providers if they have the suspicion that an athlete’s wellbeing is compromised. In terms of monitoring, standardized procedures need to be established in appropriate institutions with suitable processes (e.g., as an additional part of medical checks during rehabilitation).

f) When referring, training, and developing ensure that all mental health service providers have a good understanding of the nature of high performance sports and can discuss and relate clinical treatment to performance issues.

g) The simple knowledge of psychotherapeutic and psychiatric care is not sufficient unless the professional is trained in and experienced in the various high performance sport contexts (e.g., being aware of the specific life style elite athletes have; having
knowledge of the specific behaviours associated with performance that might be considered as abnormal in the general population but are desirable and very prevalent in elite sports, such as extensive training hours or “making weight”). A possible way is to increase cooperation and multidisciplinary team care between coaches, SPs, psychotherapist, and psychiatrists while treating an athlete.

3) Clear pathway and signposting by institutions and stakeholders:
   a) It is important that athletes have both knowledge about what support is available as well as actual access to the support (see e.g., Gulliver et al., 2012). To establish a highly visible and easily accessible Mental Health Referral Program (MHRP), as it has been done at the EIS, can contribute to a good utilisation rate by the athletes, and alongside this an increase in education for the medical support team and a reduction in stigma around mental health. For countries that are considering how to improve their services, they may want to utilise education packages (e.g., Mental Health First Aid, workshops on promoting good mental health, multidisciplinary case formulation) for members of the support team and the use of multimedia sources (including old-fashioned posters and flyers) to promote the service.
   b) Make an effort to align mental health support across all different sport organizations (various NGB’s, Paralympic and Olympic support systems, etc.) and with the more traditional medical model that already exists in sports medicine.

Conclusions

MHD in elite athletes is a topic that has received increased attention in recent years. In this position paper, several models of service provision for elite athletes with MHD have been presented, stemming from six European countries. Due to the fact that competencies, certification issues and professional boundaries of the involved service providers (e.g., SPs,
psychotherapists, psychiatrists, sport scientists with further qualification) differ considerably between European countries, it does not make sense to define a gold standard on how to organize the support system. Rather, the models presented in this paper should be considered as a way to increase understanding for and stimulate reflections on optimal support in one’s own country, based on the contextual situation.

It is our hope that this article initiates a discussion about optimal service provision in the field of clinical sport psychology, and stimulates the exchange between different countries and organization – perhaps by regular mental health summits. Finally, we hope that other countries or organizations both across Europe and across other continents will add to this discussion and provide information about their system, also involving other stakeholders such as members of the national health and sport ministries, and members of national Olympic committees and of national sport federations.

Acknowledgments: The authors want to thank Zsanett Bondar for her effort to gather information about the Hungarian system
References


psychology position stand: Athletes’ mental health, performance, and development.

*International Journal of Sport and Exercise Psychology, 1-18.*

doi:10.1080/1612197X.2017.1295557


doi: 10.1016/j.psychsport.2014.07.004


<table>
<thead>
<tr>
<th>Authors</th>
<th>Country</th>
<th>Year</th>
<th>Sample</th>
<th>N</th>
<th>Age (M)</th>
<th>Sport</th>
<th>Method</th>
<th>Prevalences all (females, males)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gouttebarge et al.</td>
<td>Netherland</td>
<td>2017</td>
<td>Current and retired male and female Dutch elite athletes</td>
<td>485</td>
<td>27.3 (current)</td>
<td>Different individual and team sports</td>
<td>Online questionnaire containing demographic variables, variables regarding retirement, injury, surgeries, adverse life events, career dissatisfaction, social support, and self-report questionnaire (for distress, anxiety/depression, sleep disturbance, eating disorders, and adverse alcohol use)</td>
<td>Current athletes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50.7 (retired)</td>
<td></td>
<td></td>
<td>Distress ‡ 26.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anxiety/depression ‡ 44.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sleep disturbance ‡ 22.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adverse alcohol use ‡ 6.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Eating disorders ‡ 32.1%</td>
</tr>
<tr>
<td>Gouttebarge, Aoki, Ekstrand, Verhagen, Kerkhoffs</td>
<td>Finland, France, Norway, Spain and Sweden</td>
<td>2015</td>
<td>Male professional players</td>
<td>540</td>
<td>27</td>
<td>Football</td>
<td>Online questionnaire containing demographic variables, variables regarding injuries and surgeries, and self-report questionnaires (for distress, anxiety/depression, alcohol consumption) respectively single questions (for smoking and sleeping disturbance) or several questions (for nutritional behaviour).</td>
<td>Retired athletes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Distress ‡ 15.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anxiety/depression ‡ 37.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sleep disturbance ‡ 24%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adverse alcohol behaviour ‡ 10.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Smoking ‡ 3.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adverse nutrition behavior ‡ 58.2%</td>
</tr>
<tr>
<td>Gouttebarge, Frings-Dresen, &amp; Sluiter</td>
<td>Australia, Ireland, Netherlands, New Zealand, Scotland, USA</td>
<td>2015</td>
<td>Male professional players</td>
<td>149</td>
<td>27</td>
<td>Football</td>
<td>Paper and electronic questionnaire containing demographic variables and self-report questionnaires (for distress, burnout,</td>
<td>Current athletes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Distress ‡ 10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Burnout ‡ 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anxiety/depression ‡ 26%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Low self-esteem ‡ 3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adverse alcohol behaviour ‡ 19%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Smoking ‡ 7%</td>
</tr>
</tbody>
</table>
anxiety/depression, self-esteem, alcohol consumption) respectively single questions (for smoking) or several questions (for nutritional behaviour).

<table>
<thead>
<tr>
<th>Gulliver et al.</th>
<th>Australia</th>
<th>2014</th>
<th>Athletes competing at least at the national level or above</th>
<th>224</th>
<th>24.9</th>
<th>24 different individual and team sports</th>
<th>Adverse nutrition behavior $^a$ 26%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schaal et al.</td>
<td>France</td>
<td>2011</td>
<td>Junior and senior elite athletes</td>
<td>2067</td>
<td>18.5</td>
<td>36 different individual and team sports</td>
<td>General psychological distress $^d$ 16.5% (20.3%, 12.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Depressive symptoms $^i$ 27.2% (30.5%, 23.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anxiety symptoms $^i$ (GAD) 7.1% (10.2%, 3.8%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Social anxiety symptoms $^i$ 14.7% (15.3%, 14.2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Panic disorder symptoms $^i$ 4.5% (5.9%, 2.8%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Eating disorder symptoms $^i$ 22.8% (32.2%, 12.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Any mental health problem $^i$ 46.4% (53.4%, 38.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anxiety disorders $^e$ 8.6% (11.3%, 7.1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anxiety disorders $^b$ 12.1% (15.8%, 10.1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Depression $^e$ 3.6% (4.9%, 2.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Depression $^b$ 11.3% (16.3%, 8.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Eating disorders $^e$ 4.9% (6.5%, 4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Eating disorder $^b$ 7.5% (11.2%, 5.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sleep problems $^e$ 21.5% (23.9%, 20.2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sleep problems $^b$ 26.6% (30.3%, 24.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Abuse or dependency $^b$ 4.1% (4%, 4.2%)</td>
</tr>
</tbody>
</table>

*Note. $^a$ = point prevalence, $^b$ = lifetime prevalence, $^c$ = one-month prevalence, $^d$ = six months prevalence, $^e$ = current prevalence, defined as within the last 6 months; $^f$ = prevalence ranging from “during last four weeks” to “during past week”.*
### Table 2

**Models of service provision for elite athletes with mental health disorders in different European countries.**

<table>
<thead>
<tr>
<th>Country</th>
<th>Professional service providers</th>
<th>Support system</th>
<th>Diagnostic assessment</th>
<th>Clinical treatment</th>
<th>Performance during treatment</th>
<th>Screening strategies to detect mental health problems</th>
<th>Education system</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB &amp; NI</td>
<td>Chartered SPs provide Mental Health First Aid as well as support for non-clinical and performance issues. Sport medicine physicians are able to refer to psychiatrists and clinical psychologists.</td>
<td>All athletes eligible for an Athlete Performance Award (approximately 1700) have private medical insurance for both physical and mental health. The EIS has a Mental Health Referral Pathway which enables athletes to get access to privately funded psychiatric and clinical psychology support. The support provided to the athletes follows the NICE recommendations about mental health including outpatient and inpatient support.</td>
<td>EIS medical doctors will make a clinical assessment with regards to referral for mental health support. Any EIS practitioner can share concerns about an athlete with an EIS medical doctor. All practitioners are cognisant of psychological wellbeing and mental health.</td>
<td>This will vary dependent on the diagnosis. In general, this may be CBT, but there is also use of ACT, mindfulness, EMDR and other therapeutic approaches.</td>
<td>This is on a case by case basis. With consent case formulation is shared back with the sports doctor and SP. With consent maintenance and other information on how to support the athlete back in their sporting environment is also shared.</td>
<td>This will vary across sports. There is no national system but individual sports will do screening which will be led by the medical doctor in conjunction with the SP.</td>
<td>All EIS SPs are Chartered Sport Psychologists and HCPC registered. As part of this training there is a focus on an awareness of clinical psychology issues, an ability to notice signs of clinical issues and also the ability to have a referral network. In addition, EIS SPs are trained in Mental Health First Aid. The EIS medical doctors as part of their training have education on mental health. All EIS practitioners are educated on the Mental Health Referral Pathway.</td>
</tr>
</tbody>
</table>
- Sport medicine physicians
  “Screening” and “Assessment”
- Psychiatrists
  - If mental health issues after the interviews (or if come up at another time-point of the year), the athletes at INSEP can ask for a consultation with one of the psychologists at INSEP and also can be addressed to the psychiatrist by the psychologist - usually same system for most of Regional centres (Creps)

screening processes

- Decision based on experience and “case by case” taking into consideration the symptoms, the disorder, and the treatment process

- National list will have an interview every year
  - At INSEP:
    - In the first interview: Mini (for athletes above age 15), and MDI-C (for athletes under age 15)
    - In all interviews: open discussion based on a self-created guide about personal life, familial and social environment, former contacts with psychologist, school/employment, athletic life, mental aspects of high level sport

- Decision based on experience

Germany

- SPs/SPEs for non-clinical or sub-clinical issues
- Psychiatrists (clinical educated Psychologists or Psychiatrists) for clinical issues in cooperation with SPs

- First contact to the supervising SP/SPE (e.g., regional Olympic centres) if this is existent
- Additional support from specialized networks (e.g., the nation-wide initiative “MentalEmpowerment” with first screening oriented interview, general counselling and guide in finding regional experts/therapists)

- No sport-specific standard (standard of the therapeutical associations when clinical diagnostic is concerned)
- Depends widely on the supervising SP/SPE or therapist
- PHQ-2 and WHO-5 as good practice examples

- Focus on subclinical strategies (e.g., stress management, improvement of resources)
- Clinical approaches depending on the expertise of the supervising person; mostly CBT and systemic

- No gold standard
- Depending on the supervising team (coach, SP, therapist)
- If possible, athlete is kept in his or her typical environment (including training procedures), referral to a clinic if necessary

- No systematic screening is done on a national level
- Regional solutions exists in which short screening instruments are used to early detection of psychosocial problems
- Further education for psychotherapists in sport issues and for SPs/SPEs in clinical issues
- Psychotherapists: focus on knowledge about stressors and circumstances in elite sports
- SP/SPE: focus on understanding and
Hungary - SPs for non-clinical or sub-clinical issues
- Psychotherapists (clinical educated Psychologists or Sport Psychologists) for clinical issues

- There is no National Institution to provide specific care services for athletes with mental health issues.
- Currently there is an interest in Hungary in establishing the first Organization of Sport Psychologists.
- The Hungarian Olympic Committee provides just a small number of professionals (Psychologists/ Psychotherapist) as specialized support for all the athletes from the country.
- No standardised diagnostic screening or assessment
- At present, professionals are working on elaborating a plan for a standardized assessment system in Hungary to improve many aspects of Sport Psychology in Hungary
- This varies dependent on the diagnosis and on the clinical approaches of the specialist and also regulated by the expertise of the supervising person
- No specific guidelines
- Dependent on the athlete’s issue (type of disorder) and on the group of supervisors
- No national system for screening
- There has been a standardized screening system in Hungary for elite athletes which has stopped a couple years ago.
- At the moment, there is an interest in developing a screening system in Hungary for elite athletes.

Italy - SP for non-clinical or sub-clinical issues

- No specific National Institution or Organization provides specific care
- No standard structured assessment nor a treatment and therapy depend strongly on the kind of disorder and
- Depends strongly on the health surveillance for athletes in Italy is

3 The Italian tradition of the military and state corps sports groups deserves a specific mention. Sports groups are sections of the military and police corps that handle sports activities, including competitive sports activities, for their members. They are usually affiliated with the CONI accredited sports federations and are active in both national and international sports competitions. There are currently 530 elite military athletes. The agreement signed between CONI and Ministry of Defense has contributed to the development of 11 sports groups under the Armed Forces, Military Corps, Police Corps and others (Italian forest service fire brigade and Firefighters). Elite athletes in these...
Clinical Psychologists, Psychotherapists or Psychiatrists for clinical issues in cooperation with SP services for athletes with mental health disorders, neither specific programmes for this issues in sport context (a part the clinic service of the Institute of Sport Medicine at the CONI “G. Onesti” Centre in Rome. - Athletes with Mental health issues turn to psychotherapists or psychiatrists by themselves, in case they decide to seek specialized support - The first contacts are typically the general practitioner (family doctor) of the Community Care Service who evaluates the problems and, in case, addresses the patient to an Institutional Psychiatric Service; further contacts for athletes are coaches (who usually have a network with external specialists) or the SP of the Club when available within the staff.

Swedish Sports include three main organizations (The Swedish Sports Confederation, the Swedish Olympic Committee, the A standardised diagnostic screening performed by both a psychiatrist and kind of the athletes’ issues and on the expertise of the specialist who is supposed to work with them - Typical psychotherapy treatment entails CBT, psychodynamics, integrated techniques - If needed: pharmaceutical interventions supervised by psychiatrists severity of symptoms - In case of slight symptoms, the athlete may continue working on mental preparation with a SP - In case of clinically relevant issues or symptoms physically disabling (e.g. significant weight loss in the anorexic athlete) the SP’s intervention is interrupted to give priority to the treatment of clinical issues guarantee by the national law. The medical examination comprises a psychophysical anamnesis and assessment mainly devoted to cardio-ventilatory and physical evaluation. The screening process is compulsory conducted once a year for each athlete - There are no national services to screening mental health and wellbeing issues.

Sweden - Clinical psychologists - Psychiatrist

groups follow the general health rules of the military corps and every year there is a compulsory qualify examination that include also the evaluation and support for mental health problems. In the Military groups normally there is the support of both sport psychologist and clinical psychologist that normally use MMPI-II and other instruments for the assessment.
- SPs with clinical education

Swedish Paralympic Committee (each with employed SPs with a clinical education to provide sport psychology services to elite athletes. Subclinical issues exceeding performance enhancement issues are treated by these employees. In cases of more serious clinical disorders, athletes belonging to a national team (or having recently retired) and being over 18 years of age can access one of the two Clinics for Mental Health in Elite Athletes in Stockholm and Malmö. These clinics are a collaboration between the Swedish health care system and the Swedish Sports Confederation, where SPs with a clinical education, and licensed psychologists and psychiatrists with knowledge of the different high performance contexts take care of the athletes.

A licensed psychologist. Assessment includes M.I.N.I., CGI, PHQ-9, HAD, EQ5D, AUDIT, ASRS, performance, AAQ. If appropriate, specific measurements for specific diagnoses are added. Mindfulness, according to the most evidence based treatment for the specific disorder at hand. In some cases, pharmacological treatment in combination with CBT.

- Each case is discussed in the multidisciplinary treatment team with special attention to the relationship between treatment, sport specific training and competition.

Note. SP = Sport Psychologists; SPE: Sport Psychology Expert; ASP = German Association of Sport Psychology; CONI = Italian Olympic Committee; BISp: Federal Institute for Sport Science (Germany)