

## Professional and Collegiate Team Assistance Programs: Services and Utilization Patterns

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Every federal agency and most large businesses have cost-free, work site-based programs to improve employee morale and productivity through leadership consultation, training, and worker personal problem interventions [1–4]. Some professional sports organizations and university athletic departments have followed industry's lead by hiring psychiatric consultants or sport psychologists, or by offering assistance services to players, team staff, and organizational leaders [5–9].

Major league baseball (MLB) requires each of its 30 teams to have an active employee assistance program (EAP). In an effort to standardize program staffing and services, MLB's medical advisor disseminated a set of practice guidelines in 2003 [10]. The National Football League (NFL) does not require individual team assistance programs, but rather facilitates the development of assistance services to players and families by developing health plan networks of qualified local participating providers. Recently, however, the NFL's Office of Player and Employee Development created an employee assistance staff position to encourage the creation of more typical cost-free assistance programs [11]. Some Division I university athletic departments, including those at Penn State, Ohio State, Purdue, and the University of Tennessee, offer combined sport psychology and counseling services to teams and individual student athletes and coaches [12]. These services are usually in addition to those offered at student health or campus counseling centers.

To address all important areas, assistance programs for sports teams should offer a broad set of services in some or all of the following areas: substance abuse prevention, stress recognition and control, tobacco cessation, mental illness management, injury rehabilitation, performance enhancement, and cultural awareness and support [13–25]. Common core functions are the same as for

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industry EAPs, and include: (1) problem assessment; (2) short-term problem resolution; (3) referral and monitoring; (4) crisis intervention, including critical incident debriefing; (5) organization and supervisory consultation; (6) use promotion through outreach visits and educational seminars; and (7) program evaluation [1].

Team assistance programs (TAPs) are an effective way to address typically low annual behavioral health use rates for athletes and coaches [16,23,26]. A regular presence of assistance program staff at practice or before games dramatically increases annual use rates to 10% or higher. By working closely with the team's physicians, trainers, and strength and conditioning staff, TAPs generate new referrals and make follow-up visits or monitoring easier.

The University of Maryland School of Medicine's Department of Psychiatry has run comprehensive TAPs for two professional sports organizations since 1996. This same model was used to develop services at two University of Maryland, National Collegiate Athletic Association (NCAA) Division I athletic programs. This article describes the history, organizational structure, direct services, typical activities, referral sources, and use patterns over 9 years for the professional teams and 3 years for one of the university programs. Extremely high use rates of 15% to 30% annually by players and team staff were achieved through regular on-site visits by TAP staff throughout the year. Strong linkages with each team's medical staff by the group's four sport psychiatrists built trust and ensured a steady stream of referrals. By offering performance enhancement training, initial resistance to seeking assistance for problems is reduced.

## HISTORY AND PROGRAM DESIGN

### Professional Teams

In 1996, two professional sports organizations independently requested proposals for team assistance services that emphasized substance abuse prevention and early intervention for personal problems and workplace stress. One was relocating and wanted to replicate a very successful program that had high satisfaction and use rates. The other was looking to replace an ineffective program that operated exclusively by linking team members and other staff to off-site providers through telephone self-referral. Both teams eventually contracted for free, confidential services that covered all employees and family members. A general six-visit limit, including the initial intake evaluation, was established for both. Regular team assistance advisory program meetings involving the general managers, directors of player development, head trainers and team physicians, and our group's staff were held at least semiannually. At these meetings, policies were approved and trends in use were reviewed.

To ensure that the services would be actively used, both teams contracted for comprehensive services and aggressive outreach approaches. In the first year and thereafter, the assistance program staff had a strong presence at preseason training. As the playing season began, staff members made once- or twice-weekly visits to the training facilities for practice or to the stadiums before games. At each visit, staff members would interact with key members of the coaching and

medical staffs to provide consultation and solicit referrals. Group talks on various performance-related topics, such as life balance, stress control, supplement use, substance abuse, mental skills, relationships, and anger management, were given. Players and staff would often self-refer after one of these talks.

While at the training facility or the stadium of a team, most of the assistance program staff time was spent in the training room or conditioning areas. Many informal contacts were made with players and other team staff members who were receiving treatments for injuries or working on strength and fitness. Managers and coaches were approached casually in their offices or on the field as they prepared for practice or games. Assistance team staff also traveled periodically with the team for out-of-town games. This allowed for extensive interaction with players and team staff while traveling or at the team hotel. Front office staff members were also seen informally during team drop-in visits, or more formally during or after supervisory training or open seminars. An office for evaluation and intervention was made available near the training areas and locker room. This on-site approach worked much better than trying to get players and team staff to go off-site to private offices.

While at practices or before games, assistance staff had extensive interactions with the team's primary care physician, orthopedist, chiropractor, dentist, nutritionist, and strength staff. Because on-site TAP visits usually lasted 3 to 5 hours and occurred more than 20 times in a year, there was ample time to develop great trust by discussing topics and players of mutual concern.

### University Athletics

In 2002, a Division I university athletic department in Maryland established a TAP. A campus primary-care sports medicine physician, who also serves as the head team physician for one of the professional teams, facilitated its development using the professional TAPs as a model. The TAP coordinator (a sports psychiatrist) assembled an interprofessional staff of on-campus resources, including a sport psychologist, an eating disorder counselor, and a substance abuse counselor at the Counseling Center; a career counselor the Career Counseling Center; a former eating disorder nurse at the Women's Center; a nutrition and health promotion counselor at the Health Education Office; and a domestic violence counselor in the Abused Person Program. The director of the athletic department's academic support program was recruited to join the TAP, in the event a student athlete needed assistance with a learning disorder or attention deficit disorder. The idea that the athletic department would have a point person based in the training room to coordinate care was particularly appealing. Before the TAP's development, the Director of Sports Medicine had been frustrated with low Counseling Center show and retention rates, and with restrictions on feedback.

Once the members of the TAP were recruited, a brochure was designed and presented to sports medicine physicians and trainers. It was posted in the training room for student athletes to see. The TAP was presented annually to all coaches at a monthly compliance meeting. At the beginning of the 2002–2003

season, a letter attached to a screening questionnaire introduced the TAP to each student athlete. The TAP sport psychiatrist also met each incoming freshman and transfer student athlete while giving lectures in a required health and human behaviors course. Referrals were possible to any TAP staff member.

## STAFFING AND SERVICES

### Professional Teams

The authors' group uses an interprofessional, culturally diverse team of mental health and substance abuse experts. The team consists of three psychiatrists, one psychologist, three clinical social workers, and one certified chemical dependency counselor. Each team member is assigned responsibility for a specific service area or outreach to one of the eight teams. Six specific service areas were developed after the first few years: (1) substance abuse prevention, (2) tobacco cessation, (3) stress control for individuals and families, (4) cultural support, (5) psychiatric treatment, and (6) performance enhancement.

Substance abuse prevention is the most active service area, because most of these referrals come from league or team urine testing. In addition to the common drugs of abuse (marijuana, stimulants, opioids, cocaine, ecstasy, and phencyclidine [PCP]) testing is also done for supplements, adulterants, anabolic steroids, and alcohol. Every positive test is medically reviewed for justified use, and an intake is scheduled for confirmed positive tests. Referrals also come from alcohol or drug-related behavioral problems such as partner violence or arrests [9–11,17,19,20]. Most cases are for substance misuse or abuse rather than dependence.

Because 30% to 40% of athletes and coaches on these teams use spit-tobacco products (primarily moist snuff), tobacco cessation became an important focus. The most successful approach for case identification thus far results from linkages with the team dentist at the time of the preseason physical examination [18]. At that time, a dental assistant asks current users to fill out a form that asks about the pattern of tobacco use and indicators of nicotine dependency. If the dentist identifies an oral lesion or an “at-risk” user, then a referral is made for those wanting information or intervention.

Stress control services focus primarily on relationships, parenting, financial and legal problems, traumatic events, and grief [13–16]. These services extend to immediate family members and even to extended family members in distant cities, especially if a team member is worried and distracted. Marital or relationship strain, with or without partner violence, is common. Staff provides couples counseling and support following relationship strain, aggression, or breakups. Because many players and team staff have infants or school-aged children, parenting issues such as discipline or learning often surface. Spouses travel or move frequently, and are often alone in distant cities without adequate support networks. Losses of family members or close friends are more difficult, because of geographic separations and a strong shared sense of family that teammates and coaches develop.

Cultural support services developed because of the high percentage of foreign-born players in baseball. Today 30% or more of players on most teams are Latinos. Communication, acculturation, and complex family problems are addressed. Our group has a Dominican-born psychiatrist who translates all presentations and documents into Spanish. He travels frequently to the developmental leagues in the Caribbean to meet younger players, so that he can interact with them over several seasons in order to facilitate assimilation and acculturation.

Mood, anxiety, sleep, impulse control, and attention deficit disorders are the most common problems in this population [23]. Psychiatric evaluation and treatment is provided on-site at the training facility. Careful attention is paid to the use of alcohol, stimulants, and steroids, because these are common inducers or exacerbators of insomnia, nervousness, inattention, and irritability [21,22]. Psychotropic medications are chosen carefully, and the dosages are adjusted slowly in order to avoid negative effects on temperature regulation, sweating, level of alertness, or fine motor coordination [27]. Stimulants for attention deficit disorder must be prescribed with caution, and only after a rigorous diagnostic evaluation, so as to avoid their misuse as performance-enhancing substances [21]. Because of the concern about medication side effects, nonmedication approaches such as time management, positive sleep hygiene, relaxation training, meditation, massage, and biofeedback are often used first.

Many professional athletes are reluctant to discuss personal problems, even if on-site assistance is readily available. They will, however, readily engage in discussions of strategies to improve performance in practice and games. After several years of offering more typical problem-based assistance, the authors' group added mental toughness training services [12]. One of the assistance team's psychiatrists, along with clinical social workers who had strong backgrounds in stress medicine and clinical hypnosis, sought additional training in sports psychology. They began to offer biofeedback-assisted skills training for relaxation, concentration, attentional shifting, visualization, intensity regulation, goal setting, positive self-talk, and precompetitive routine development [28]. Although initial meetings start with a mental skills focus, discussions commonly drift to lifestyle and stress barriers to peak performance.

### University Athletics

The staff consists of a sport psychiatrist and psychologist; a nutritionist; substance abuse, career, and domestic violence counselors; and an eating disorder specialist. The TAP sport psychiatrist is available on-site in the training room for an afternoon each week. He sees student athletes for performance enhancement, stress reactions, relationship difficulties, substance use prevention, mental health concerns, sleep and attention problems, and partner violence. Other TAP staff members focus on substance abuse prevention, nutrition, disordered eating, women's issues, and team motivation and mental skills training.

Student athletes, trainers, sports medicine physicians, the chiropractor, coaches, and academic support staff have access to the sport psychiatrist's

schedule. Records are kept in separate folders locked in the director's office. Athletes understand that access to these is limited to the TAP and sports medicine staffs. TAP notes are written with as much discretion as possible. The trainers write prescribed medications and dosages in the general medical record. Only one athlete refused treatment because of this arrangement, and she was given a referral to a preferred provider in her insurance network.

Appointments are scheduled on Wednesday afternoons in 1-hour sessions for intakes and half-hour sessions for follow-ups. The schedule is usually full. No-shows are limited by training staff reminder calls on Wednesday mornings. Some urgent problems are dealt with over the phone. The sport psychiatrist works with teams on performance enhancement, mental skills, positive self and team talk, and communication skills or conflict resolution between teammates and coaches in early morning, evening, or weekend times.

As with the professional athletes, many student athletes are reluctant to seek treatment unless initially asking for performance enhancement. The one notable exception is the self-referrals that come in after the "disordered eating" lecture given in health education class by the sport psychiatrist each semester. Athletes usually walk in the following week with a chief complaint of "I think I have an eating disorder."

Sessions with the sport psychiatrist involve the use of one or more of the following therapeutic techniques: performance enhancement training; diagnostic screening; motivational interviewing; cognitive behavioral therapy; talk therapy; work on stress and time management, including proper sleep hygiene; substance use prevention; and careful, conservative medication management. All those requesting treatment are seen.

## PROGRAM USE

### Professional Teams

The overall annual use rates for both organizations are impressive, averaging nearly 20% for baseball and 15% for football. The use rate is computed by adding the number of different employees or family members seen in a year and dividing by the total number of employee family units in the organization. The authors' group averaged 7.2 visits per intake in football, and 2.7 visits for each individual seen in baseball. The maturity and long-term nature of the NFL substance abuse program and a greater numbers of complicated family cases among football team staff explains this difference. All four major target groups (players, team staff, front office, and family members) were solidly represented in most years.

Players represent the largest percentage of those seen, averaging just more than 70% for baseball and 50% for football; however, they make up 50% and 43% of the total number of employees, respectively. This active use is not surprising, because the most attention was given to player services. The percentages of team staff of the total of those seen were about equal for baseball and football (13% versus 14%), but more family members were seen in football than baseball (21% versus 7%). Supervisory referrals were more common in



support services. These expansions led to 30% more clubhouse visits. The increased availability allowed more players to easily access services for relationship concerns and their mood and anxiety disorders.

The high use rate for 2003 has tragedy as a partial explanation. In spring training, a major league team player died unexpectedly of ephedrine-related heat stroke after collapsing on the field the day before. In the days, weeks, and months that followed, many players and team staff sought assistance for grief and anxiety. More than 30 individuals received grief counseling or therapy for recurrent waves of emotion that surfaced each time the death received additional publicity. The assistance program arrived within 24 hours to assist the organization's response to the loss. Four team members stayed 5 days, and along with a baseball chaplain, helped organize several clubhouse meetings for the players and staff, and a memorial service. In addition, support services were provided to the player's and spouse's families. In addition to increased workload from the player's death, this was also the busiest year ever for substance abuse prevention. Stimulants and alcohol were seen more often than before as the organization adopted a more aggressive approach to urine drug testing, with teams being tested five rather than four times that season. Our staff members also wondered whether the stress of the loss resulted in heavier drinking.

In football, the player and family member use rates have fluctuated from year to year. In the first 5 years, substance abuse prevention intakes were more common for players, whereas in the past few years psychiatric disorder and performance enhancement visits have increased. The decline in substance abuse intakes follows a policy shift in football and other professional sports to sanction first before sending for counseling or rehabilitation. This is especially true when players test positive for performance enhancing substances such as anabolic steroids or stimulants. The reasons for increased psychiatric disorders in recent years are not entirely clear, except that we are seeing more cases of attention deficit disorder and depression. Many of these athletes were diagnosed in college, and some came to the team already on medications. Performance enhancement service use has also increased recently. This is because of an increased general interest in this service among younger players. Many more are being exposed to mental skills training in college, and are interested in continuing this work. In addition, we have placed a stronger emphasis on tracking the emotional and behavioral adjustment of injured players. During prolonged rehabilitation periods, some players are electing to work on mental skills improvement (Table 2).

Family member use rates have also varied significantly from year to year. Most of these cases involve spouses or adolescent and young adult children of team or front office staff. The head team physician or trainer refers them. The most common reasons for referral are mood, anxiety, somatization, or substance use disorders. Front office staff have also been regular users of the group's services over the years. One of the team physicians, who also serves as the primary care provider to these staff, makes most of the referrals. Tobacco cessation, family stress, and generalized anxiety are the most common problems.

**Table 2**

TAP service volumes and utilization patterns for football: 1997–2004

Football	1997	1998	1999	2000	2001	2002	2003	2004
Intakes	21	22	29	23	33	36	44	28
Visits	207	253	305	206	219	248	262	246
Athlete utilization								
Rate	13%	9%	18%	16%	25%	14%	28%	20%
Job class								
Player	11	08	15	11	21	12	24	17
Team staff	02	06	04	03	03	06	06	05
Front office	02	05	04	04	02	06	05	01
Family	06	03	06	05	07	12	09	05
Total intakes	21	22	29	23	33	36	44	28
Referral type								
Self	08	11	21	17	22	28	37	25
Supervisory	13	02	08	04	11	08	07	03
Primary problem								
Sub prevention	13	05	09	06	14	09	08	02
Relationships	06	08	06	02	07	13	10	04
Performance	—	—	02	04	03	01	13	10
Stress/psych	02	09	10	09	06	09	11	09
Career	—	—	01	—	02	—	—	—
Tobacco	—	—	—	02	—	03	02	03
Other	—	—	01	—	01	01	—	—
Cultural support	—	—	—	—	—	—	—	—
Grief	—	—	—	—	—	—	—	—

### University Athletics

Only individual sessions with the sport psychiatrist in the training room office are in the use data. Neither formal sessions with other TAP members nor informal advice by the sport psychiatrist are included. Unlike the professional TAPs, the university TAP is focused only on student athletes. Service data for 3 years are found in [Table 3](#).

Most referrals were self-referrals, followed by referrals from trainers, team physicians, and coaches. Some athletes were seen repeatedly. In fact, 22 athletes initially seen in 2002–3 were seen again in 2003–4. A total of 69 different student athletes were seen over 3 years. Visits averaged five per intake, although some athletes were seen once or twice and others more frequently. No significant gender use rate differences were noted. Few athletes were seen in 2002 because

**Table 3**

University TAP service volumes and use rates: 2002–2004

Year	Intakes	Visits	Total athletes	Use rate
2002 (3 mos)	6	10	354	1.7%
2002–2003	43	224	328	13.1%
2003–2004	47	201	322	14.6%

the sport psychiatrist's time was used primarily for staff recruitment, presentations, and coaches' meetings.

Identifying a primary problem for individual athletes was not always possible. Therefore, if athletes had two or more significant problems, each was included in the common problem list in **Box 1** below. Interestingly, two athletes had three problems together—"the overdoer triad," which includes an eating disorder, obsessive compulsive disorder, and exercise dependence [29].

## STRATEGIES

There are few published articles describing practical strategies to increase athletes' use of lifestyle management, stress control, mental health, or substance abuse prevention services [7–9,13,16,18,23]. Even fewer can be found for sports psychiatry/psychology and sports medicine linkage strategies, except in the area of injury rehabilitation [5,7,24,30–32]. This is despite the fact that some sports

### **BOX 1: TOTAL PRESENTING PROBLEMS: 2002–2004\***

- Performance enhancement (23)
- Stress reaction to injury/rehabilitation (9)
- Depression (9)
- Attention deficit disorder (8)
- Substance use (7)
- Eating disorders (7)
- Post-concussive syndrome (4)
- Obsessive compulsive disorders (4)
- Stress reaction to break-ups (3)
- Generalized anxiety (3)
- Grief (3)
- Domestic violence (3)
- Exercise dependence (3)
- Learning disorder (2)
- Insomnia (2)
- Panic disorder (2)
- Bipolar disorder (2)
- Anger management (2)
- Dysthymia (1)
- Social phobia (1)
- Specific phobia (1)

\* Some athletes had more than one presenting problem.

medicine staff are not comfortable with diagnosis and intervention in these areas [33]. Finally, the authors were only able to locate one published report of a sports-specific EAP, and this was in the horse racing industry, for jockeys and back stretch personnel [9].

Over the past 9 years the authors' group provided comprehensive behavioral health and performance enhancement services for two professional teams and more recently for two Division I athletic programs. These TAPs were modeled after typical, aggressive-outreach EAPs seen in industry [1,3,4]. We have been able to achieve high use rates and develop solid sports medicine linkages through a number of different strategies. We believe that the following ten strategies are essential for good outcomes.

### Provide Services On-Site

Regular attendance at off-season fitness sessions, preseason training camps, practices, and games allows for longitudinal interactions with players, coaches, and sports medicine personnel, and the development of trust. The training room is a good environment for brief interactions about lifestyle concerns and performance. More in-depth discussions often follow. Use flows from a physical presence and a "walking around" style of interacting. Collaborative relationships with sports medicine personnel are built from case reviews and discussions about substance prevention, sport psychiatric, and performance topics.

### Hire a Diverse Staff

The stigma associated with mental illness, substance abuse, or lack of mental toughness makes many athletes reluctant to seek assistance [23,26]. A staff that is diverse in gender, ethnicity, professional discipline, and competencies allows for team members and staff to have a choice. The experience of the authors' group has been that it is hard to predict which athlete will be attracted to which provider, because these decisions are often made on the basis of appearance, culture, or perceived competency. We try several times each year, but especially during preseason, to expose players and coaches to our entire staff. After every such meeting each staff member gets approached.

### Connect with Preseason Physicals and Injured Athletes

The preseason physical evaluation is a good time to ask about past or current concerns with sex, stress, anxiety, aggression, substances, tobacco, depression, or performance. A recent review by Joy et al [34] recommends that inquiries of this sort become standard practice. The authors have helped revise or construct screening questions in these areas for inclusion in preseason and postseason physicals. Supportive interactions with injured athletes are also important. Severe athletic injuries, especially those requiring surgery or prolonged rehabilitation, often produce emotional distress and lowered self-esteem [35,36]. Return-to-play and retirement decisions relating to injury, especially head injury, are now more clinically, socially, politically, and legally complicated [37-39]. Consequently, an expert panel of sports medicine physicians recently rec-

ommend that return-to-play processes be formalized, and that psychosocial issues be routinely addressed [37].

### Give Prevention Talks

Staff members from the authors' group regularly give brief 10 to 20-minute pre- and in-season talks to athletes and coaches. Tying the topic to athletic performance is critical to getting their attention and stimulating discussion. The most popular topics are supplements, alcohol, tobacco, stress, and mental skills training. Our group's sport psychiatrists stay current on athletic performance, and on psychoactive drugs and supplements such as amino acids, creatinine, prohormones, stimulants, and androgenic steroids [40–42]. Our staffers often collaborate with the team's sports nutritionist and strength and conditioning staff when preparing these talks. After every prevention talk, our group gets active discussion and requests for further assistance.

### Offer Tobacco Cessation Services

The adverse health effects, the inconvenience of using, and pressure from family, teammates, and the league cause athletes and coaches to be very interested in tobacco cessation. Our group's staff members routinely distribute quitting guides [43] or collaborate with the team dentist during preseason physicals to assess and intervene [18]. In addition, the team's primary care sports medicine physicians routinely ask about use, and support quitting by referring athletes to our program. Studies have shown that brief interventions can reduce spit-tobacco use in athletes [44]. Our experience has shown that athletes and coaches do better if they can find effective substitutes for their tobacco. These have included nicotine and non-nicotine gum, candy, herbal dips, aromatic hardwood branches, plastic cigar tips, and others. Continuous monitoring, encouragement, and craving coping strategies are needed to prevent slips or relapses.

### Offer Performance Enhancement Services

The authors' group has modeled these services after the approaches recommended by Dorfman and Kuehl in *The Mental Game of Baseball* [28]. Our staff members work collaboratively with the player and coach to identify major barriers to performance (ie, divided attention, negative self-talk, poor emotional control, pregame arousal, inability to let go of mistakes). We develop goal-oriented improvement plans and monitor progress over a season. We ask athletes to systemically record information about thoughts and emotions (positive and negative) during competition, using a mental training log as recommended by Porter [45]. We review these and our plan every three to five games, teaching relevant basic mental skills along the way. We often identify and resolve high-stress situations or other problems in the course of this work.

### Provide Critical-Incident Stress Management Services

Sports organizations occasionally experience traumatic events or unexpected tragic losses. Several recent ephedrine-related deaths in football and baseball are

examples. Critical incidents such as these have the potential to disrupt individual or team functioning. Organizational leaders are expected to respond to such challenges by offering comprehensive support services for all employees. TAPs with critical incident stress management or traumatic grief expertise will likely be called on for planning and direct assistance during and after a critical incident [46,47]. The authors' group was involved in such a critical incident in 2002. The existence of a positive working relationship with the team's management, coaches, and players made the initial response more effective. Longitudinal follow-up of many individuals for a year was necessary. Key lessons learned were: (1) know the organization and its people; (2) get involved within 24 hours; (3) collaborate with a chaplain; (4) work in pairs and debrief regularly; (5) create a formal support plan with the general manager, manager, and team physician; (6) facilitate role definition, especially for a media spokesperson; (7) establish linkages with the league's medical advisors; and (8) give extra support to the medical and conditioning staff.

### Know Something About Fitness and Supplements

Over the last decade, supplement use by professional and collegiate athletes has increased dramatically [22,40,41]. Although it is true that most athletes are looking to gain a competitive advantage, they are still concerned about false claims, long-term side effects, and contamination. It is therefore possible to engage many in active discussions of these issues. Current factual information about policy and the risks and benefits is most helpful. Whether presented in preseason talks or in printed materials that are posted in the clubhouse or locker room, coaches and players are interested. Collaboration with the team physicians, trainers, strength staff, and nutritionists is necessary to ensure a consistent message. The more knowledge TAP staff have about exercise physiology, cardiovascular fitness, and speed, strength, and flexibility training, the more credibility they will have with supplements.

### Think About Sleep, Jet Lag, Chronic Fatigue, and Burnout

Professional and collegiate sports training and competition are now year-round ventures. The notion of an "off-season" is a thing of the past. It is therefore critical to monitor athletes for sleep and stress recovery. Military studies have demonstrated that approximately 6 hours of continuous sleep a night are needed for ongoing operational effectiveness. Long seasons can bring on chronic mental and physical fatigue and poor sleep, because of chronic injuries and performance pressure. Travel adds to the demands of competition, especially if it crosses two or more time zones or if circadian rhythms are disrupted [48,49]. In the last few years, our team's medical staff have received more requests for short-acting sleep medications. We have responded to this trend by conducting in-depth evaluations by TAP psychiatrists for repeat requestors. In these evaluations, we look for poor sleep hygiene, excessive stimulant or alcohol use, high stress levels, or sleep mood or anxiety disorders that might explain the insomnia.

### Reach Out to Family Members

Professional and collegiate athletes, team staff, and front office personnel work long hours and have frequent or prolonged family separations. Marital and relationship stability, parental support, and parenting may consequently suffer. The authors' group has found it useful to reach out to spouses, significant others, parents, and children. Many teams have organized gatherings of these groups. Formal presentations about TAP services or stress control topics often lead to new referrals. In addition, the authors' group actively involves key family members in new evaluations or ongoing assistance. For our professional teams, we have established national and international networks of certified assistance program providers who can respond quickly to crises by providing comprehensive evaluations and brief treatment.

### SUMMARY

TAPs that are on-site and link strongly with the medical staff can increase stress control and behavioral health services use. Although there are few sports EAP studies documenting a positive impact on performance, there are many in industry [1–3]. TAPs that offer free, comprehensive services to all team and front office staff members are most likely to have successful outcomes. Adding mental skills training to the service menu is attractive to players and coaches, and can be extended to the organization's executives and management staff. More descriptive papers of model programs and studies on TAP cost-effectiveness and performance outcomes are needed.

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