MANAGING MENTAL HEALTH EMERGENCIES IN ELITE FOOTBALL

FEATURE / TIM ROGERS

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Emergency is not a word or situation that many in football would necessarily associate with mental ill health. However, psychiatric symptoms can cause a range of situations in which a player or coach is in a situation of imminent risk. This may be through behaviour caused by intense personal distress or suicidal intention, through self-neglect or even situations in which others are at risk. Mental ill health can cause physical health emergencies too; for example through extreme changes in eating or drinking (including in the context of eating disorder). These situations can all constitute emergencies where immediate intervention is required.

Stigma is universal to society's experience of mental ill health. In football, there are various reasons why stigma can be felt more acutely. Teams of players, in particular in the men's game, can feel an expectation not to engage in help seeking or to avoid the appearance of weakness. They may fear the impact of confiding about their mental health upon team selection, employability or transfer value. This may make emergencies more likely, more severe or more complex to address.

Suicidality or serious self-harm can arise in a variety of mental disorders but is most characteristic of major depressive disorder. Moments of serious sporting injury or loss of athletic identity due to retirement (transition) out of sport are those periods when footballers are most at risk. Rarely, situations of public humiliation or sentencing for a criminal offence can be the precipitant. A common myth about suicide is that asking or enquiring about suicidal thoughts can cause such an emergency. It cannot. If a sustained change is apparent in someone, suspected thoughts of hopelessness or suicidal intention can be asked about

sensitively: "sometimes people get to feeling that they cannot go on; do you ever think like that?".

Disordered eating occurs much more commonly among footballers and coaches than is recognised or treated. These conditions are often found to have the highest mortality ratios of all conditions. Immediate risks among those with eating disorder usually arise because of related physical health issues such as electrolyte abnormalities, arrhythmia or sudden collapse.

Psychosis is the inability to distinguish real thoughts and experiences from those caused by certain mental illnesses, including schizophrenia, bipolar disorder or a number of substance use disorders often related to cannabinoids (skunk), amphetamine (speed) or crack cocaine. Those with mental ill health are more likely to be at risk to themselves than to hurt others in these situations. Abnormal beliefs (such as delusions), hallucinations (such as 'hearing voices') or manic excitement can create a range of risks. Nihilism in depression can prevent someone from eating or drinking. Disinhibition in abnormal elation can cause sexual exploitation or other risk-taking behaviour that requires an immediate intervention. Psychosis can precipitate a situation in which a footballer is assaulted by others who feel threatened or fearful of the way in which they are behaving.

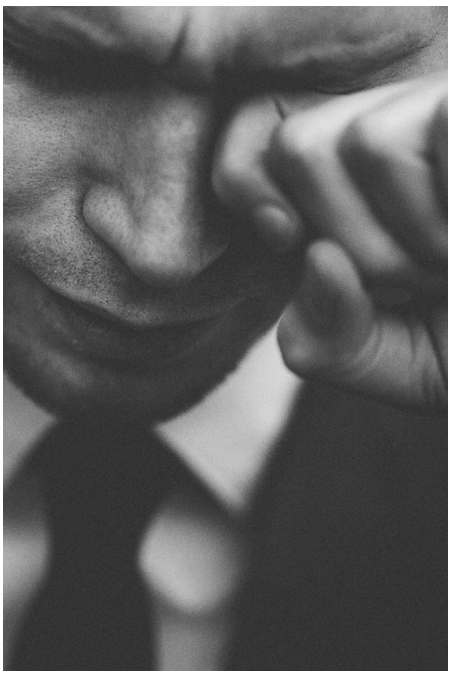
Substance use, alcohol withdrawal and other factors (including head injury, HIV or fluid mismanagement) can cause delirium. This is an abrupt onset neurocognitive disorder characterised by confusion and fluctuating conscious level. The challenge is often in recognising delirium for what it is and enabling treatment of the underlying condition. The player is often not able to give a good history that can explain the presentation. This is an uncommon emergency in football.

Acute severe anxiety as experienced in panic disorder may appear to represent a mental health emergency when, in fact, this is simply a high degree of emotional distress. Anxiety symptoms are often the most frequently experienced psychiatric syndromes among footballers. They are eminently treatable.

Gambling problems might not be expected to be discussed in a conversation about mental health emergencies. Gambling is a behaviour that is recognised to develop, in many, into a psychiatric syndrome of dependence. Footballers are among those who experience immediate risks related to gambling disorders. These can be due to: their greater financial resources; their differential 'special' treatment by private bookmakers; their assumptions about "being good at" predicting scores; their deeply ingrained habit of competing and chasing losses. Footballers with gambling addiction can rapidly run up huge losses that place their immediate welfare or that of their family at risk, threaten relationships or precipitate self-harm or suicide (including in the absence of major depressive disorder).

Managing a mental health emergency should begin with information gathering and a careful assessment. Next of kin, teammates or others may be able to provide this. A working diagnosis is important. If feasible, rating scales may help indicate the severity or nature of the mental health problem. It is necessary to understand the history of risk, important recent events or stressors and what the nature, imminence and severity of current risk is. This can inform decisions about managing the emergency, including what sources of support and what safety plans can be put in place. It is useful to understand how the person ordinarily copes in difficult situations. Appropriate medical investigations or substance use testing can be helpful.

First of all, ensure the immediate safety of the environment for the player, coach or yourself. It is right to promote autonomy where feasible, such that a person can make their own safe choices or share in the responsibility for seeking help, keeping themselves safe where possible. If not, contact emergency services or provide emergency healthcare as needed. If away from home or travelling, consider whether a local intervention is needed before travelling further. Do not avoid seeking help because of being away or on tour. Seek advice if you need to, including from a sports psychiatrist. If waiting for this, take steps to restrict access to means of harm. Reassurance, checking in and staying in contact can reduce suicide risk whilst other care and treatment is put in place. Direct the player or coach towards other sources of support, which may be appropriate from team medical staff, teammates, coaching and support staff or even in a hospital setting. If not making direct contact with '999' emergency services, each area will have an emergency crisis mental health service or emergency duty social work team available to address mental health emergencies around the clock. Well prepared teams and organisations may have made a mental health emergency action plan in advance, setting out the process that would be followed and the relevant contact people and details who would offer assessment and management. The Mental Health Act (1983), safeguarding legislation and duties of care apply to those in football as they do elsewhere. Have a system in place for reflecting upon, reviewing and learning from untoward events such as a mental health emergency. Football has some key sources of support, including through the Professional Footballers Association 'PFA' and Sporting Chance. Many professional clubs would offer their athletes bespoke packages of expert care where needed, such as through Cognacity Wellbeing.



Three Clinical Pearls

- Mental ill health is common: it exists in your club. Foster a culture where everyone can speak about it or admit to not feeling ok without risk.
- This kind of psychologically safe environment allows early intervention, time to seek expert advice and reduces the risk of unwanted outcomes.
- Mental health care treatment reduces the associated risks but so does asking, keeping in contact, being open and discussing.

Key references
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