

## Spotlight on mental health

Signs and symptoms  
of depression,  
winning at all costs,  
mood foods plus more

### **Should we take the 'S' out of 'SEM'?**

Dr J questions if sport is  
giving exercise a bad name

### **be active 2014**

Highlights, award winners,  
photos plus more

- Depression in elite athletes: are we doing enough?
- Sports trainers and depression in athletes
- Elite sportsmen and their stories of depression
- Aerobic exercise prescription for mental illness
- A look at the Glasgow 2014 Commonwealth Games Medical Program
- The keys to business success



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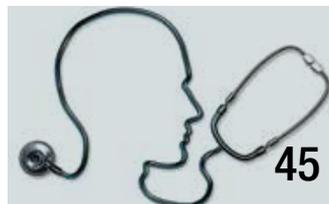
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## What a week it's been



SMA and APA representatives at the 13th Asian Federation of Sports Medicine Congress. L-R: Nello Marino, Michael Kenihan (SMA Board Member), Marcus Dripps (APA President), Margaret Qian Jing Hua (Beijing Sports University) and Cris Massis (APA CEO).

### **SMA CEO, Nello Marino talks on the importance of exercise and mental health.**

If you've reviewed a health department or health-related calendar lately you'll realise that there is a day or week dedicated to almost every health condition or healthy behaviour in existence. Having been involved with a few over my time, you get to realise that it is a very crowded calendar, in fact so crowded that there are now numerous timeslots dedicated to sometimes multiple health conditions.

Whilst it's a pity that it takes a dedicated time slot for some health conditions to be given some level of profile, it's completely understandable in the marketing saturated world we live in, where we are constantly bombarded with advertising and promotion and our own mental filtering system sifts through them like a sieve, offering attention only when warranted.

One of my first 'real' jobs was actually working on Heart Week and I had the job of being a Project Officer at the Heart Foundation in Melbourne. My role was completely focused on organising a 'walk around the block' for several

thousand office workers, culminating in a festival-like atmosphere in the then city square. Given this and having been involved directly with several others of these dedicated weeks, I'm probably a little nonplussed.

However, we've just been through Mental Health Week and I must admit to being thoroughly engaged and very impressed with some of the material that has been presented. It's probably helped having the entire ABC network dedicated to the week with the theme 'mental as' and, as a result, several mainstream programs have been genuine about carrying a mental health theme.

**"If there is one thing that Mental Health Week has reinforced, it's that exercise makes such a positive contribution to so many medical conditions, including mental health conditions."**

This may also be a reflection of how little I and presumably many others really know about mental health conditions and the genuine impact on people's lives.

**“Ultimately exercise is the glue that binds the many disciplines that make up Sports Medicine Australia.”**

Hence the importance of this issue of *Sport Health* being dedicated to exercise and mental health. If there is one thing that Mental Health Week has reinforced, it's that exercise makes such a positive contribution to so many medical conditions, including mental health conditions. Even at a very simple level the evidence on the benefits of exercise on mental health conditions are really clear (lifts mood, facilitates better sleep, increases energy levels, blocks negative thoughts, and makes you feel better connected with others).

At a more specific level we see some really strong evidence showing the benefits of exercise across the lifespan for conditions such as depression, anxiety, schizophrenia and Alzheimer's, just to name a few.

Whilst I appreciate the issue examines a wide range of mental health issues and the connection to sport and exercise, it is a salient reminder of the important role of exercise and physical activity in addressing a wide range of health conditions. Ultimately exercise is the glue that binds the many disciplines that make up Sports Medicine Australia.

**Nello Marino**

Chief Executive Officer  
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Obese children as young as 2 at risk of heart disease, stroke in later life

<http://ab.co/1zFqLNF> @HeartAust – November 11, 2014

Get up to date with everything you need to know about hydration thanks to @Ausport <http://bit.ly/1Gv8jcp> – November 7, 2014

Thank you to the presenters in tonight's Peak Performance in Football Event thanks to @opsmc! Next stop: Brisbane – October 22, 2014

Peak performance in football inj prev seminars this week with @MarioBizzini Sydney, Melb, Brisbane register <http://sma.org.au> @FIFAcOm – October 20, 2014

Got a camera and a mic? You're now equipped as a patient for telehealth @beactive2014 – October 18, 2014

**Kestrel – A better way to measure atmospheric conditions**



As I venture down memory lane a little my mind harks back to my first role with SMA as the Victorian Smartplay Program Manager; very humble beginnings! I recall working with a number of sporting organisations on trying to implement more effective ways to manage hot conditions during the summer months. This was particularly so for winter sports that usually began pre-season training or pre-season competitions during the often hottest part of the year.

At the time there was some conjecture on which measure of temperature to use and which measure would be easiest for sports to implement. Wet bulb globe temperature (WGBT) was, and probably still is, regarded as the most reliable measurement given it considers various components including ambient temperature, humidity, wind speed, sunlight and radiant heat. As you can gather, this was a complex procedure for sports wondering whether it was too hot to hold an event or at least modify their game breaks.

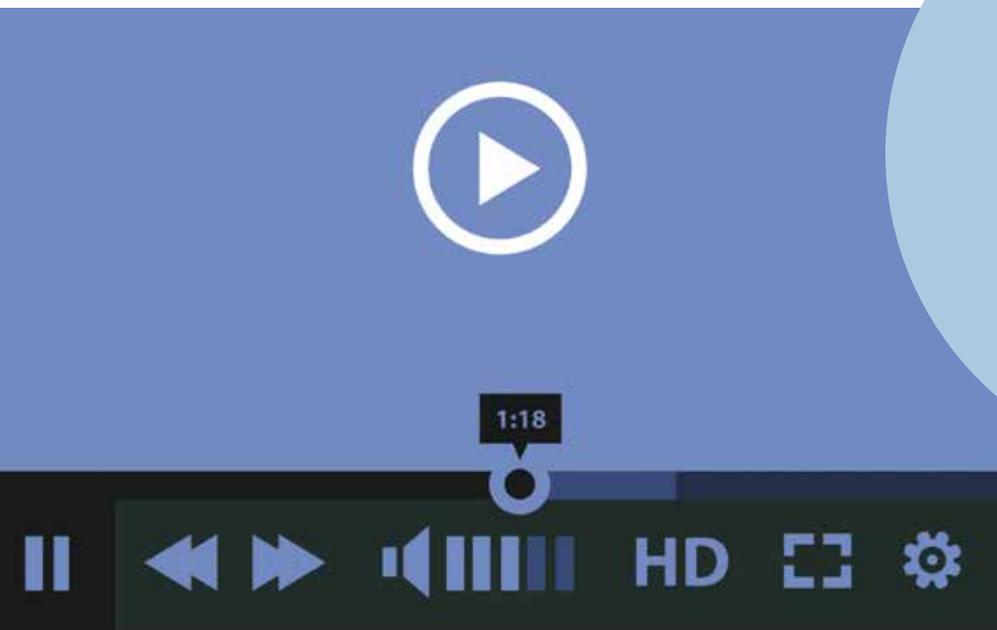
I recall at the time searching worldwide for a device that measured WGBT which was portable and easy to use.

I stumbled upon a company called Kestrel which made portable weather meters. Their products ticked all the boxes: easy to use, very portable (mostly handheld) and able to measure a wide range of weather conditions. Most important, the Kestrel meters calculated WGBT based on all the factors and provided accurate measurements locally and in real time at sporting events.

I was therefore delighted when recently approached by Kestrel, unprompted from our side, to partner with SMA. We look forward to working closely with Kestrel with the knowledge that atmospheric conditions play a very big part in the delivery of sporting events and competitions in Australia. Kestrel is a great product that can assist sporting organisations and those overseeing them to easily and accurately make important decisions on athlete exposure to extreme conditions.

For more information on Kestrel Heat Stress Trackers visit [www.kestrelmeters.com.au](http://www.kestrelmeters.com.au)

## Member news



**Member portal**

**Podcasts**

Did you miss out on reading some JSAMS articles this year? Would you like to hear the authors of some of these articles speak about their own research?

The SMA member portal has a collection of interviews with JSAMS authors which are available to download. Access a number of podcasts including the most recent, 'Exercise related hyponatremia' at [sma.org.au](http://sma.org.au)

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## SMA Research Foundation Grants

The SMA Research Foundation has been established to provide support to young postgraduate researchers engaged in sports medicine and disease prevention research.

The SMA Research Grants are designed to support research conducted by postgraduate students and postgraduate practitioners for the purpose of advancing research in sports medicine and its relationship with disease prevention.

Congratulations to the following five applications that were recently awarded SMA Research Foundation Grants of \$2,000 each for 2014.

- Celeste Coltman, University of Wollongong.
- James Devin, University of Queensland.
- Belinda Thompson, University of Newcastle.
- Steven Watson, Griffith University.
- Emma Zadow, University of Tasmania.

Further congratulations goes to James Devin who was also recently awarded the 2014 Brian Sando Clinical Sports Medicine Research Award.

## New advice to help women get active

Make sure to check out SMA's new women in sport fact sheets including:

- Nutrition for Active Women.
- Bone Health for Active Women.
- Pregnancy and Exercise.
- Exercise for Young Women.
- Exercise for Women Over 50.

Download at [sma.org.au](http://sma.org.au)



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## 5 mins with... Elroy Aguiar

2014 Asics Medal Winner and Best New Investigator Physical Activity and Health Promotion



Elroy Aguiar upon receiving his Asics Medal from Mark Doherty from Asics.

### What is your profession?

Physical activity and nutrition research. I am currently a PhD candidate at the University of Newcastle's Priority Research Centre for Physical Activity and Nutrition (PRC PAN). My PhD thesis focuses on lifestyle interventions for type 2 diabetes prevention.

### How many years have you been in this profession?

In 2008 I began working as a research assistant for Professor Robin Callister at the University of Newcastle. I was very fortunate through this position to be exposed to a range of exercise, nutrition, healthy lifestyle and human physiology research projects in both adults and children. In 2010 I completed a Bachelor of Biomedical Science (Hons) and in 2011 I commenced my PhD.

### What does your typical day consist of?

I am fast approaching my PhD submission deadline, so my lifestyle is not the most exciting thing to report on! My work day usually consists of writing and reading journal articles, with a splash of statistics. I also teach exercise physiology and biomedical science classes at the University of Newcastle, and often help with exercise and anthropometric assessments on a number of research projects.

### What is your favourite aspect of your job?

When I started in this field of research I was excited at the prospect of helping individuals improve their lifestyle and change their health for the better. This is the driving force that keeps me going through the long periods of thesis induced sedentary time.

I also love that I work with a group of incredibly intelligent, multi-talented, positive and dedicated people at the PRC PAN. We are constantly striving to push the boundaries of research in our respective fields.

### What has been the highlight of your career?

My career is still only young so I don't have a huge list of accolades... yet. The Australian Sports Medicine Federation Fellows 'Asics Medal' and the 'Best New Investigator – Physical Activity and Health Promotion' are at the top of my list.

### When, why and how did you become involved with SMA?

I have been a student member with SMA since 2012 when I first attended the SMA 'be active' conference in Sydney. The conference really opened my eyes to the broad range and quality of sports medicine research across the country.

### Can you give us an insight into the research that won you the Asics Medal this year?

My PhD research focuses on the evaluation of the type 2 diabetes PULSE Program (Prevention Using LifeStyle Education) in men at high risk for the disease. Broadly speaking there are three novel aspects to the program.

First, the PULSE Program is a self-administered lifestyle intervention i.e. *there is no face-face contact for intervention delivery*, as is the case with traditional approaches. Instead the intervention is delivered through a series of self-administered resources focused on diet modification, exercise and weight loss (The SHED-IT Weight Loss Program). Self-administered interventions are likely to cost less and also allow for widespread dissemination of the program e.g. community settings or rural/remote areas. Second, the PULSE Program is a gender-tailored lifestyle intervention i.e. the intervention resources are designed to cater for the psychological needs and preferences of men. The process improves program appeal, uptake and adherence of health messages, and ultimately may result in greater improvements in health outcomes. This approach has proven successful in previous studies from our group (e.g. The SHED-IT Weight Loss Program), but has yet to be evaluated for type 2 diabetes prevention in men. Third, the PULSE intervention is a multi-component lifestyle intervention, which targets the modification of diet, exercise (both aerobic and resistance training) and weight loss in order to improve a range of risk factors for type 2 diabetes. There is currently limited quality evidence surrounding multi-component interventions for type 2 diabetes prevention.

My research has demonstrated that the PULSE Program elicited greater improvements in weight loss, glycosylated haemoglobin (HbA<sub>1c</sub>), visceral fat area, aerobic fitness and muscular fitness compared to control treatment over six months. Furthermore, the results are comparable (at least over the short term) to gold-standard type 2 diabetes prevention trials such as the US Diabetes Prevention Program and Finnish Diabetes Prevention Study.

### What is the next step with this research?

The current trial was funded by a small grant and was therefore of limited duration (six months). The next step is to build on this evidence by assessing the long-term efficacy and cost-effectiveness of the PULSE program. We will also refine the intervention components based on participant feedback.

### Outside of work, what are you passionate about?

I spend a large amount of my spare time with a camera in hand or editing photos on my computer at home. I started photography as a hobby in 2010 and in early 2013 I started a small photography side-business. I sell landscape images and also photograph events, weddings and engagements.

### What's the best piece of advice anyone has ever given you?

Luck happens when preparation meets opportunity.

### Name four people, living or not, you would invite for a dinner party and why?

My grandparents. My family and I moved to Australia when I was four years old and I consequently missed out on spending time with them while growing up. I consider knowing where I have come from and keeping in touch with my cultural background very important to shaping who I want to be in the future.

### Favourites

**Travel destination:** This is a hard question as I have travelled quite a bit and plan to travel lots more. I'll narrow it down (with great difficulty) to the best destination I have visited (Cinque Terre, Italy) and the countries I am currently planning to visit (Cambodia and Laos).

**Sport to play/watch:** Field hockey.

**Cuisine:** I am obliged to say Indian food, especially the local cuisine of Goa (my home state), which is quite different to the rest of India.

**Movie:** Remember the Titans.

**Song:** My music collection is rather eclectic, but I'll go with 'Hearts and Bones' by Paul Simon.

**Book:** A Song of Ice and Fire by George RR Martin (AKA Game of Thrones).

**Gadget:** iPhone (simply because I use it everyday) or my Canon 5DmkIII DSLR camera with a suite of lenses.



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## Should we take the ‘S’ out of ‘SEM’: is sport giving exercise a bad name?



**Dr J considers the notion of moderate exercise divorcing itself from competitive exercise, for the sake of promoting its benefits.**

During school and whilst studying medicine I did a lot of competitive debating. By the time I got to Uni the vast majority of fellow debaters were law students. At the top level of debating, the further I went at university, the more out of my depth I was getting (i.e. the people I was debating against were getting a lot better than me). In retrospect this should not have been surprising, because I was an amateur against professionals. All of the law students were about to embark on careers of arguing for a living, whereas I was going into a health field. One of the final straws for me was getting knocked out of the Australasian University championships in the quarter finals on the debate topic, ‘That we should take the ‘Z’ out of ‘ANZUS’. I can remember which side of the debate we were on, but this point doesn’t actually matter. The whole premise of being a lawyer in the Western legal system is that you have to mount as strong an argument as possible for whatever side you end up on – what you believe in (or whether there is such a thing as right or wrong) doesn’t stop a lawyer from pushing the case of the client. It is rare indeed for barristers or law firms to take a moral stand on an issue. The most common example is that some law firms decide that they won’t accept tobacco

companies as clients (and of course this is done knowing that there will be rivals who will take this highly-profitable work).

It is not coincidence that the majority of politicians are lawyers and also expected to represent positions under instruction. In the very, very rare occasion that a politician is asked to vote on an issue based on what they believe in rather than what their party orders they call it a ‘conscience vote’. It is reserved for issues such as abortion, euthanasia and – perhaps – gay marriage. One of the politicians I debated against at school and university, Greg Hunt, apparently wrote a thesis which argued that climate change required a government response and that economically the preferred option was a carbon tax. As Environment Minister in real life one of his signature achievements has been to remove the carbon tax, obviously the opposite to what he (once) believed but what politically helped his party to wedge the opposition and gain power. Arguing cynically or as a hired gun is not confined to one side of politics: Paul Keating won what he ironically labelled the ‘true believers’ election in 1993 by opposing a GST after having previously written economic papers arguing for its implementation.

**“So those of us working in exercise medicine can genuinely feel that we are on the side of the ‘good guys’.”**



**“The side effects that you would be more likely to assault someone in the short-term, or get heart disease or cancer in the longer-term, gets brushed aside as a non-concern.”**

So I can feel good about myself (and you, as primarily health care worker readers, the same) for the fact that medicine is a science where there is an empirically-definable (but changing) right and wrong and we can and all should try to be on the lily-white side of the fence wherever possible. In our sense of superiority we need to be totally realistic that as human beings – albeit working in a health field – we are also susceptible to the profit motive and conflict of interests, as are our colleagues. Narrowing in from medicine to exercise medicine, we can again feel good about the tsunami of research showing the unequivocal benefits of exercise at both preventing and even treating the vast majority of the major diseases of our age. It is great to sit back and read jaw-dropping papers showing, for example, that exercise beats most chemotherapy at improving survival from breast cancer. So those of us working in exercise medicine can genuinely feel that we are on the side of the ‘good guys’.

**“For the sake of promoting the benefits of moderate exercise, we have to divorce moderate exercise from competitive exercise.”**

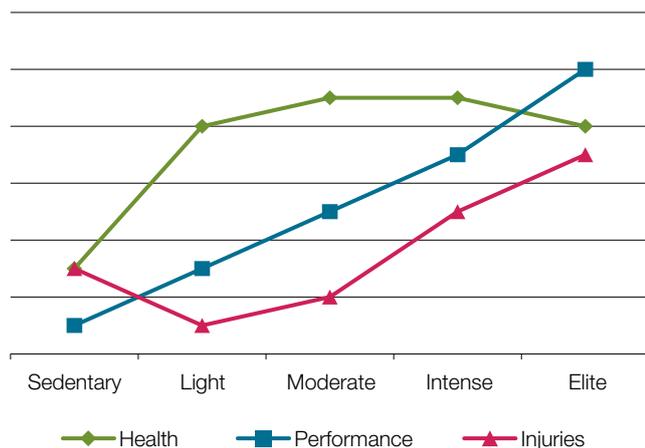
We should also remind ourselves that just because something is ‘scientifically-proven’ does not translate to immediate uptake. Although we can live on a morally-higher plane than advocacy experts, it does not follow that we can live without them. The benefits of exercise are now unequivocal. Further studies to prove this beyond even more doubt will be helpful, but not as helpful as those in the advocacy professions coming up with a successful strategy to ‘cut through’ and make the necessary changes to promote exercise even more. A couple of months ago I spoke at a symposium with Professor Adrian Bauman, who is one of the world’s leading exercise and public health researchers and he admitted to being dumbfounded as to why exercise promotion remained a ‘Cinderella’ field that is still not considered all that important given the massive potential to improve community health.

The perceptiveness amongst you may have noticed that I have been referring so far in this article to ‘exercise medicine’ and not sports medicine, which reflects the title of the piece. I might be on the verge of committing sacrilege but I want to toss up the argument – ‘Is ‘sport’ giving ‘exercise’ a bad name?’ And – if it is – should we be getting rid of the



term 'sports medicine' and replacing it, as much as possible, with 'exercise medicine', taking the 'S' out of 'SEM'?

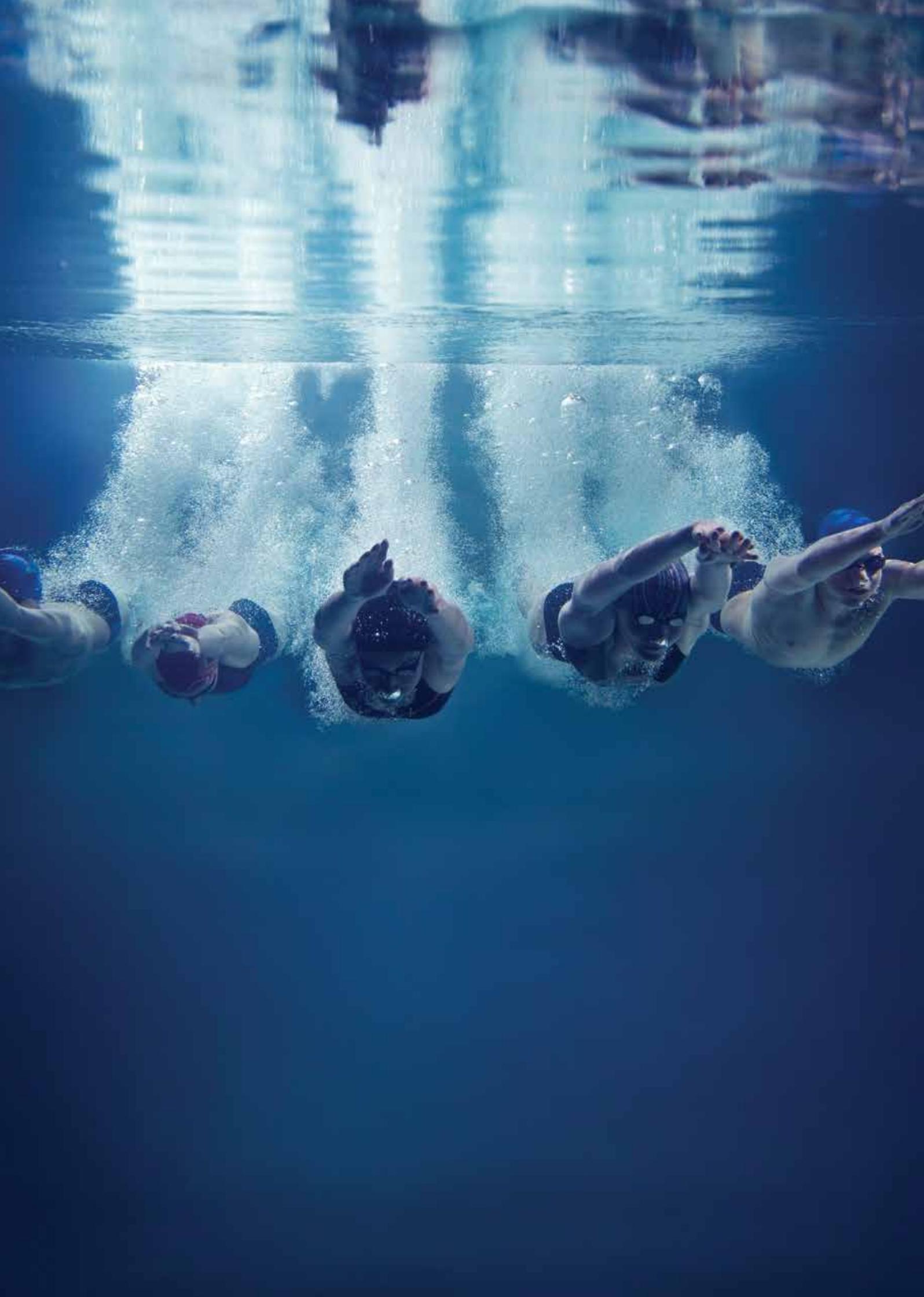
**Figure 1: Why exercise (light-moderate) is generally better for you than both sport (intense-elite) and sedentary behaviour.**



First of all, without bothering to consult the Oxford English Dictionary, let me give you my personal view on what separates exercise and sport: in a word, it is 'competition'. As soon as you are exercising in a competitive sense it becomes sport. You can of course be competing with an imagined opponent. If you decide you want to run 10 marathons in a calendar year, it is not just exercise, it is quite obviously sport as well

and you are competing with the 'alternative universe' you, who would be satisfied with doing fewer than 10 marathons in a year. Figure 1 (a ball park reference which absolutely nails the thrust of this argument) can be used to answer a number of questions:

1. Are you going to be a better runner (Performance) from training to do 10 marathons in a year, compared to less running? Absolutely yes (unless you get injured and can't run at all).
2. Are you going to be healthier (Health) than someone who runs less than this? Compared to someone who doesn't exercise at all, without a doubt. Compared to someone who moderately exercises, probably not. In fact, the strain of such intense running probably tips the heart, in particular, over the edge from peak health to slightly more at risk.
3. Are you going to be running a higher risk of getting injured (Injury)? Absolutely, and this risk is high enough that a good proportion of people who attempt such a substantial goal will wipe out all of their gains by getting an injury which could prevent running altogether, either in the short-medium term or even long-term. There are some degenerative injuries that are non-reversible and, since you only get one body you might find out the hard way that in the marathon of life you pushed yourself too hard too early and had to stop running before the finish line.



If you are a public health expert, when you read Figure 1, you want as many people as possible in the Sedentary group shifting to the Light or Moderate exercisers group to improve health outcomes, in order to reduce the risks of heart disease, stroke, cancer, depression, osteoporosis etc. As a secondary goal, you might want to also reduce the number of Intense-Elite exercises to reduce the number of injuries that need to be dealt with (and also the people who might later become sedentary because of an injury they needlessly suffered from). So from a public health perspective, the major enemy is sedentary behaviour, but 'Sport' is a less desired end point than 'Exercise'. On the surface this might seem to be splitting hairs, and sport and exercise can be reasonably combined to fight the real enemy of sloth. The problem is that, at the moment, sport and exercise in a marketing sense are Siamese twins that can't be separated and competitive sport is currently doing a good job at making exercise seem less attractive.

**“Is ‘sport’ giving ‘exercise’ a bad name?’ ... should we be getting rid of the term ‘sports medicine’ and replacing it, as much as possible, with ‘exercise medicine’, taking the ‘S’ out of ‘SEM’?”**

Performance-enhancing drugs (PEDs) are probably the worst black eye on competitive sport. Forget the percentages and how accurate the perceptions are: it is simply fact that a significant number of people now believe that a high percentage of elite and professional athletes take PEDs. It used to be that Australians neatly pigeon-holed 'cheating sports' (like cycling) and 'clean sports' (like our own football codes) and, worse still, 'clean countries' (us) and 'cheating countries' (everyone else). In retrospect that was naivety, wishful-thinking and even perhaps racism. The average sports fan now probably has a more mature attitude (that all of our 'own' athletes are the 'clean' ones. And look, Santa Claus just came down the chimney...) but sadly a slightly more cynical one as well. Just as we used to watch the Olympics 100 metres and Tour de France and enjoy the spectacle but without confidence it was necessarily a clean event, we now wonder which, if any, major sports we can have complete confidence in. I'm not suggesting that this is going to put an end to professional sport or any enjoyment that we'll have watching it, but the ideal that professional sport is a completely healthy and pure activity has been damaged somewhat. Sadly, some of this rubs off on exercise itself, even though if you are exercising for health and enjoyment rather than to 'win' then there is no need to use PEDs.

**“How can professional sport make a difference in trying to shift the culture of sport away from a ‘win at all costs’ mentality?”**

There would be damage limitation if PEDs were ONLY associated with professional sport, but perhaps the association that they now have with the amateur 'gym culture' is even worse. The trade-off for PEDs in professionals is seen as being one of performance-benefit versus risk of getting caught. The potential long-term health damage of PEDs doesn't seem to get brought into the equation. Many gym goers appreciate that, as amateurs, they won't get drug tested and are at minimal risk of criminal charge if they use PEDs and only see net upside. The goals that too many people see are competitive ones ('how much can I bench press?' or 'how big can I get my biceps?') rather than health ones. It is not confined to the gym only. There are amateur runners, triathletes and cyclists obsessed with PBs and improving their times. There are hikers who treat treks like trophies, where the Overland Track is only 'silver' because Kokoda is 'gold' and Mt Everest is 'platinum'. When you become obsessed with your own performance above anything else then PEDs actually make sense in the way you view yourself and the universe. Sadly, there are so many amateurs out there who think like this that the market of underground PED dealers and even semi-legitimate anti-ageing doctors has expanded to meet the demand. Although it is less well-known and studied, it is likely that many of the PEDs are addictive. Anything that increases testosterone is going to make you feel more competitive, and the more you feel competitive the more you would crave a drug that improves your performance. The side effects that you would be more likely to assault someone in the short-term, or get heart disease or cancer in the longer-term, gets brushed aside as a non-concern.

**“Ethically, I don't have any problem with giving a professional athlete, say, an injection of some sort (as long as it is not harmful), at their request because ‘they want to get back on the field quicker’.”**

The disease of 'win at all costs' isn't just about PEDs. Whilst we can easily understand the motivation for a professional sports team keeping a concussed player on the field (increasing the chance of winning), there are, sadly, schoolkids who try to avoid reporting symptoms of concussion because they 'don't want to let the team down' or 'don't want to miss next week's game'.



Professional sport (from the NFL down) has taken a decent hit in image in recent years because of the ‘win at all costs’ attitude. The fans are as much to blame as the administrators because of their ‘cult-like’ view of the sporting world.

Analogous to PEDs and concussion, I read a succinct article on diving in the EPL earlier this year which stated:

1. The fans of every team think that diving is a scourge of the game and should be eliminated.
2. The very same fans scream as soon as their star striker hits the turf in the penalty box, demanding that the referee point to the ‘spot’, without any consideration for whether the defender made any contact.

It is very hard to argue that this does not 100 per cent nail the point and also very hard to argue that our own football competitions don’t mirror the EPL, whether it relates to diving for penalties/free kicks, borderline supplement/PEDs program, stretching the concussion rule to the limit or finding a way to beat the salary cap on a technicality. If someone else’s team appears to be doing it, the reaction is outrage that they are getting away with it. If your team is accused of doing it, the reaction is outrage that your team could possibly be accused of something so heinous (and, by the way, where is the proof for your outrageous accusation?)

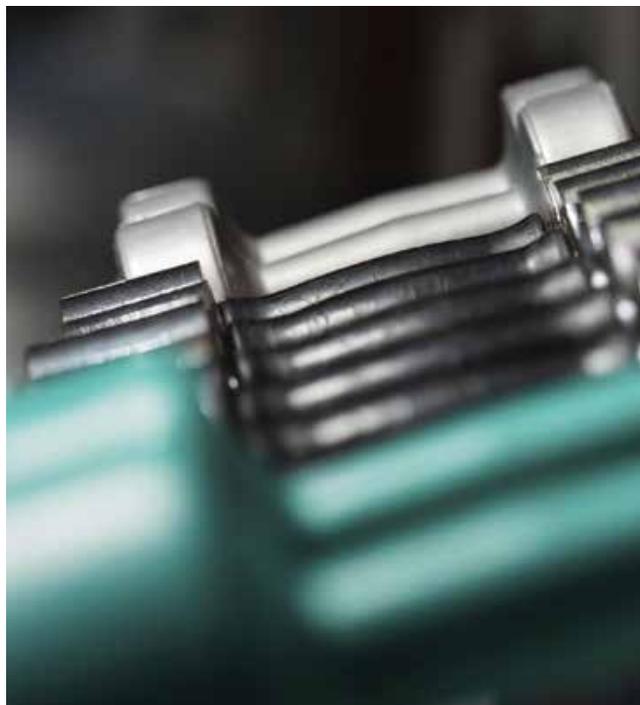
**“... at the moment, sport and exercise in a marketing sense are Siamese twins that can’t be separated and competitive sport is currently doing a good job at making exercise seem less attractive.”**

How can professional sport make a difference in trying to shift the culture of sport away from a ‘win at all costs’ mentality? One innovation that makes sense would be institution of a ‘sportsmanship’ or ‘fairplay’ table/ladder alongside the actual competition table. Two of the world’s most prominent leagues have actually taken this progressive step, the EPL and the IPL. The problem is that very few sports fans could tell you who actually won the ‘Fairplay’ Awards last year or any other year, because the leagues to date give them very little publicity. The catch 22 is that the criteria for these awards to date – in my opinion – are wrong and until the leagues get them right then no one will take them seriously. In the EPL last season, Liverpool won the Fairplay Award, on the back of enterprising attacking play (which is a major criterion). The player who contributed most to the win was probably Luis Suarez, who happened to have been one (of many) serial divers in the EPL and also happened to have been the only serial biter in the EPL. If you want to make the Fairplay Award a serious venture,

then you need to penalise suspected diving so much that a team can decide between winning a few suspect penalties per year or winning the Fairplay Award, but not both. If a team wants to indulge a serial biter, or wife-beater or past PED-user or underworld-associater or sports-gambler because he happens to be a very good player (or coach/support staff member), then they can enhance their competitive results by doing so, but they should never win the Fairplay Award until that person has been cast aside. The IPL Fairplay Award was won by Chennai, and ditto for all of the above given that they won the award in the same year they fended off accusations of match fixing. It would be nice if Fairplay Awards actually meant enough that they too could be stripped at a later date. For example, team X won the Fairplay Award five years ago but, in hindsight, the fact that Dr Ferrari was their Head of Performance that year means we probably need to strip the award, even if we can't prove beyond reasonable doubt that Dr Ferrari was giving them EPO that season.

**“We need to collectively peel back the competitiveness of sport... if we want the population to have the health benefits of exercise without the harms that excessive competition can bring.”**

What can health professionals do to make a stand with respect to amateur athletes? The obvious angle is, as examples, to discourage PEDs and tell players with concussion to take a rest from sport for their own good. The less obvious one, but that needs doing, is to encourage people to be LESS competitive when competition is leading to more harm than benefit. Ethically, I don't have any problem with giving a professional athlete, say, an injection of some sort (as long as it is not harmful), at their request because 'they want to get back on the field quicker'. The treatment may or may not be evidenced-based (depending on the substance and diagnosis). However the desire to 'get back on the field quicker' is a rational one for a professional athlete. If the injection is, at worst, a placebo, then it potentially does have some use. However for an amateur athlete the ethical framework may be different. If someone has early knee osteoarthritis and wants an injection because they 'have to' run another marathon or 'have to' play in the soccer finals or 'have to' be able to leg press 200kg so that they can show their face in the gym, then the compliant style of medicine may be not what is called for. The trouble is that it is easier to just do the injection and escort the patient back into the waiting room than it is to try to spend half an hour suggesting that maybe they should be listening to the limits that their body is



straining against. Once a patient is addicted to the 'winning is everything' or 'bigger, stronger, faster and more is always better' it is very hard to convince them otherwise. Trying to do the right thing quite commonly will mean they walk out the door dissatisfied and find the practitioner who'll just give them what they ask for.

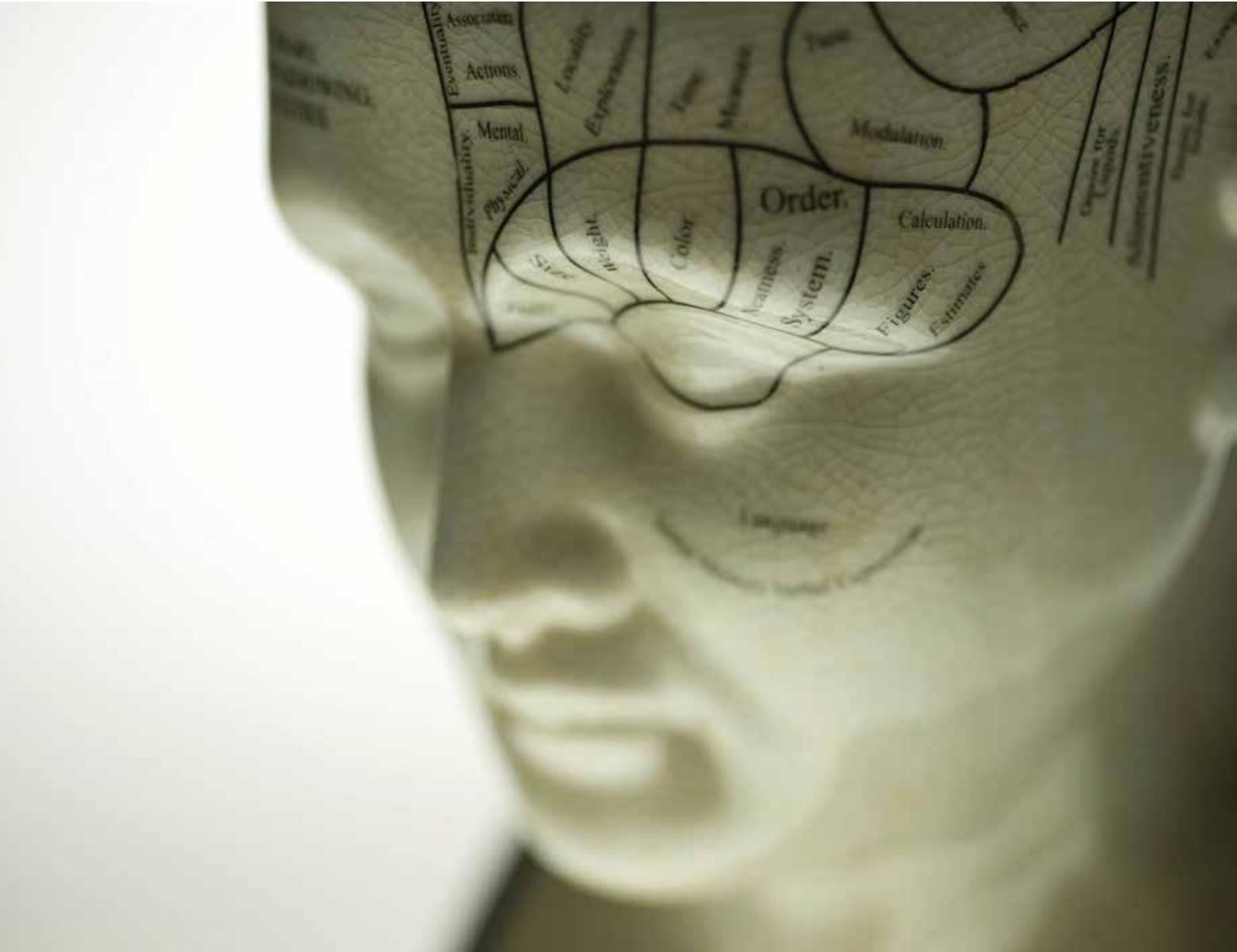
**“Performance-enhancing drugs are probably the worst black eye on competitive sport.”**

However the culture change needs to happen. For the sake of promoting the benefits of moderate exercise, we have to divorce moderate exercise from competitive exercise. Because the problem with competitive exercise – sport – is that if your opponent is doing 'x' then you feel the obligation to try to do 'x+1' to win the competition. That is a necessary aspect of elite and professional sport, but a performance arms-race is not the track that amateurs should be going down. We need to collectively peel back the competitiveness of sport (i.e. make it more about the exercise and less about the competition) if we want the population to have the health benefits of exercise without the harms that excessive competition can bring.

**Dr J**

The opinions expressed in Dr J are the personal opinions of the author.

## Spotlight on depression



***Sport Health* chats to *beyondblue* about depression: what it is, signs and symptoms and who can help.**

In any one year, around one million adults in Australia experience depression. While we all feel sad, moody or low from time to time, some people experience these feelings intensely, for long periods of time and sometimes without any apparent reason. Depression is more than just a low mood – it’s a serious condition that has an impact on both physical and mental health; however it is treatable and effective treatments are available.

**“In any one year, around one million adults in Australia experience depression.”**

### **What causes depression?**

While the exact cause of depression is not known, a number of things can be associated with its development. Generally, depression does not result from a single event, but from a combination of recent events and other longer-term or personal factors.

## Life events

Research suggests that continuing difficulties – long-term unemployment, living in an abusive or uncaring relationship, long-term isolation or loneliness, prolonged exposure to stress at work – are more likely to cause depression than recent life stresses. However, recent events (such as losing a job) or a combination of events can ‘trigger’ depression in people who are already at risk because of past bad experiences or personal factors.

## Personal factors

- **Family history** – Depression can run in families and some people will be at an increased genetic risk. However, this doesn’t mean that a person will automatically experience depression if a parent or close relative has had the illness. Life circumstances and other personal factors are still likely to have an important influence.
- **Personality** – Some people may be more at risk of depression because of their personality, particularly if they have a tendency to worry a lot, have low self-esteem, are perfectionists, are sensitive to personal criticism, or are self-critical and negative.
- **Serious medical illness** – Having a medical illness can trigger depression in two ways. Serious illnesses can bring about depression directly, or can contribute to depression through associated stress and worry, especially if it involves long-term management of the illness and/or chronic pain.
- **Drug and alcohol use** – Drug and alcohol use can both lead to and result from depression. Many people with depression also have drug and alcohol problems. Over 500,000 Australians will experience depression and a substance use disorder at the same time, at some point in their lives.

## Changes in the brain

What happens in the brain to cause depression is not fully understood. Evidence suggests it may be related to changes in the levels or activity of certain chemicals – particularly serotonin, norepinephrine and dopamine – which are the three main chemicals related to mood and motivation that carry messages within the brain. Changes to stress hormone levels have also been found in people with depression. Research suggests that behaviour can affect brain chemistry – for example, long-term stress may cause changes in the brain that can lead to depression. Changes in brain chemistry have been more commonly associated with severe depression rather than mild or moderate depression.

It is important to remember though that everyone is different and it’s often a combination of factors that can contribute to a person developing depression. It’s crucial to note that you can’t always identify the cause of depression or change difficult circumstances. The most important thing is to recognise the signs and symptoms and seek help.

## Signs and symptoms

Depression affects how people feel about themselves. A person may be depressed if, for more than two weeks, he or she has felt sad, down or miserable most of the time or has lost interest or pleasure in usual activities, and has also experienced several of the signs and symptoms across at least three of the categories below.

It’s important to note that everyone experiences some of these symptoms from time to time and it may not necessarily mean a person is depressed. Equally, not every person who is experiencing depression will have all of these symptoms.

### Behaviour

- not going out anymore
- not getting things done at work/school
- withdrawing from close family and friends
- relying on alcohol and sedatives
- not doing usual enjoyable activities
- unable to concentrate.

### Thoughts

- ‘I’m a failure’
- ‘It’s my fault’
- ‘Nothing good ever happens to me’
- ‘I’m worthless’
- ‘Life’s not worth living’
- ‘People would be better off without me’.

### Feelings

- overwhelmed
- guilty
- irritable
- frustrated
- lacking in confidence
- unhappy
- indecisive
- disappointed
- miserable
- sad.

### Physical

- tired all the time
- sick and run down
- headaches and muscle pains
- churning gut
- sleep problems
- loss or change of appetite
- significant weight loss or gain.

To provide more insight, *beyondblue* have developed a quick, easy and confidential checklist, the **Anxiety and Depression Checklist (K10)** at [www.beyondblue.com.au](http://www.beyondblue.com.au)



## Types of depression

There are different types of depressive disorders. Symptoms can range from relatively minor (but still disabling) through to very severe, so it is helpful to be aware of the range of disorders and their specific symptoms.

### Major depression

Major depression is sometimes called major depressive disorder, clinical depression, unipolar depression or simply depression. It involves low mood and/or loss of interest and pleasure in usual activities, as well as other symptoms previously mentioned. The symptoms are experienced most days and last for at least two weeks. The symptoms interfere with all areas of a person's life, including work and social relationships. Depression can be described as mild, moderate or severe; melancholic or psychotic (see following).

### Melancholia

This is the term used to describe a severe form of depression where many of the physical symptoms of depression are present. One of the major changes is that the person can be observed to move more slowly. The person is also more likely to have a depressed mood that is characterised by complete loss of pleasure in everything, or almost everything.

### Psychotic depression

Sometimes people with a depressive disorder can lose touch with reality and experience psychosis. This can involve hallucinations or delusions, such as believing they are bad or evil, or that they are being watched or followed. They can also be paranoid, feeling as though everyone is against them or that they are the cause of illness or bad events occurring around them.

### Antenatal and postnatal depression

Women are at an increased risk of depression during pregnancy and in the year following childbirth.

The causes of depression at this time can be complex and are often the result of a combination of factors. In the days immediately following birth, many women experience the 'baby blues' which is a common condition related to hormonal changes, affecting up to 80 per cent of women. The 'baby blues', or general stress adjusting to pregnancy and/or a new baby, are common experiences, but are different from depression. Depression is longer lasting and can affect not only the mother, but her relationship with her baby, the child's development, the mother's relationship with her partner and with other members of the family. Almost 10 per cent of women will experience depression during pregnancy. This increases to 16 per cent in the first three months after having a baby.

## Bipolar disorder

Bipolar disorder used to be known as 'manic depression' because the person experiences periods of depression and periods of mania, with periods of normal mood in between.

Mania is the opposite of depression and can vary in intensity – symptoms include feeling great, having lots of energy, having racing thoughts and little need for sleep, talking fast, having difficulty focusing on tasks, and feeling frustrated and irritable. This is not just a fleeting experience.

Sometimes the person loses touch with reality and has episodes of psychosis. Experiencing psychosis involves hallucinations or having delusions.

Bipolar disorder seems to be most closely linked to family history. Stress and conflict can trigger episodes for people with this condition and it's not uncommon for bipolar disorder to be misdiagnosed as depression, alcohol or drug abuse, Attention Deficit Hyperactivity Disorder (ADHD) or schizophrenia.

Diagnosis depends on the person having had an episode of mania and, unless observed, this can be hard to pick. It is not

uncommon for people to go for years before receiving an accurate diagnosis of bipolar disorder. It can be helpful for the person to make it clear to the doctor or treating health professional that he or she is experiencing highs and lows. Bipolar disorder affects approximately two per cent of the population.

## Cyclothymic disorder

Cyclothymic disorder is often described as a milder form of bipolar disorder. The person experiences chronic fluctuating moods over at least two years, involving periods of hypomania (a mild to moderate level of mania) and periods of depressive symptoms, with very short periods (no more than two months) of normality between. The duration of the symptoms are shorter, less severe and not as regular, and therefore don't fit the criteria of bipolar disorder or major depression.

## Dysthymic disorder

The symptoms of dysthymia are similar to those of major depression but are less severe. However, in the case of dysthymia, symptoms last longer. A person has to have this milder depression for more than two years to be diagnosed with dysthymia.

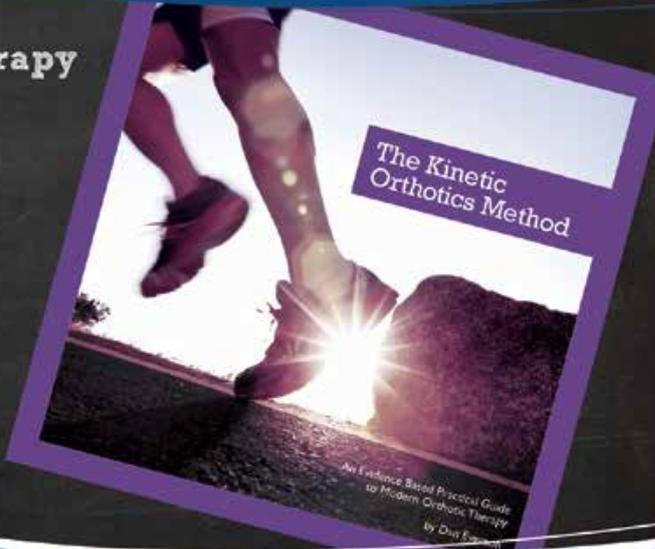


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## Seasonal Affective Disorder (SAD)

SAD is a mood disorder that has a seasonal pattern. The cause of the disorder is unclear; however it is thought to be related to the variation in light exposure in different seasons. It's characterised by mood disturbances (either periods of depression or mania) that begin and end in a particular season. Depression which starts in winter and subsides when the season ends is the most common. It's usually diagnosed after the person has had the same symptoms during winter for a couple of years. People with SAD depression are more likely to experience lack of energy, too much sleep, overeating, weight gain and carbohydrate cravings. SAD is very rare in Australia and more likely to be found in countries with shorter days and longer periods of darkness, such as in the cold climate areas of the Northern Hemisphere.

## Treatments for depression

There is no one proven way that people recover from depression. However, there is a range of effective treatments and health professionals who can help people on the road to recovery.

There are also many things that people with depression can do for themselves to help them recover and stay well. The important thing is finding the right treatment and the right health professional for an individual's needs.

### Psychological treatments for depression

Psychological treatments (also known as talking therapies) help people with depression to change negative patterns of thinking and improve their coping skills so they are better equipped to deal with life's stresses and conflicts. Psychological therapies may not only help a person to recover, but can also help to prevent depression reoccurring.

### Medical treatments for depression

The main medical treatment for depression is antidepressant medication. There is a lot of misinformation about antidepressant medication and while there is no simple explanation as to how it works, it can be very useful in the treatment of moderate to severe depression (and some anxiety disorders).

### Other sources of support

Some other sources of support are: family and friends, exercise, diet, support groups, online forums, relaxation training and e-therapies.

Everyone needs to find the treatment that's right for them. Just because a treatment has been shown to work scientifically, it doesn't mean it will work equally well for every individual. Some people will have complications, side effects or find that the treatment does not fit in with their lifestyle. It can take time, strength and patience to find a treatment that works.

## Recovery and staying well

Recovery can take time. As well as getting treatment underway, the person has to find new ways to manage, and live with, the changes and challenges of having depression. While psychological and/or medical treatment can help with a person's recovery, there are many other ways people can help themselves to get better and stay well. Following are some practical tips on how to manage depression.

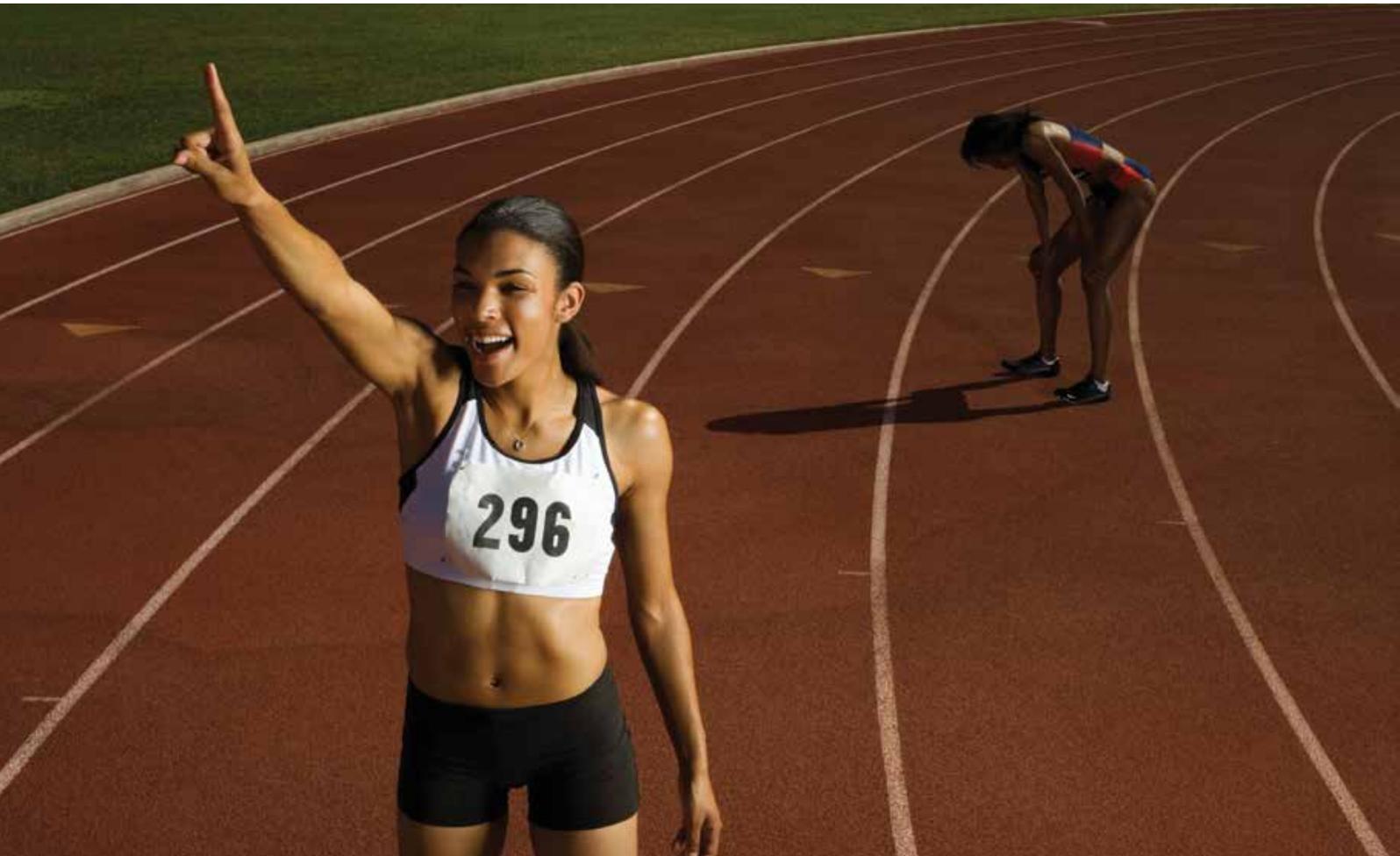
- Learning new ways to reduce and manage stress.
- Maintaining a healthy lifestyle – eating well, exercising, getting enough sleep, avoiding harmful levels of alcohol and other drugs.
- Trying to avoid or manage common triggers (family and relationship problems, financial difficulties, changes in living arrangements, changing jobs or losing a job, having other health problems and using alcohol and other drugs).
- Knowing the warning signs (getting up later, finding it hard to concentrate, skipping meals and eating unhealthily, having disturbed sleep, feeling irritable, stressed and teary, withdrawing socially or wanting to spend a lot of time alone).
- Getting over setbacks. When people relapse, it can be easy for them to fall into the trap of thinking that they will never feel well again. However, it's important to understand there are ways of moving through this stage.

## Where to get help

Depression and anxiety can go on for months; even years, if left untreated, and can have many negative effects on a person's life. Whatever treatments are used, they are best done under the supervision of a GP or mental health professional. If you have taken the first step and enlisted the help of your GP or another health professional, there are additional things you might like to try to get your recovery underway. Just remember that recovery can take time, and just as no two people are the same, neither are their recoveries.

**For information on depression and anxiety and where to get help, visit [www.beyondblue.org.au](http://www.beyondblue.org.au) or contact the support service on 1300 22 4636.**

## Winning at all costs: The psychological impact



**Eugene Aidman, Tracey Veivers, Stephanie Hanrahan and Jeff Bond, all Members of the Australian Psychological Society's College of Sport & Exercise Psychologists National Executive Committee look at the rationale behind athletes' doping decisions.**

Winning at all costs. Has it crept into the psyche in Australian sport? There is no doubt that finding ways to enhance performance is an essential ingredient of competitive sport. Athletes, coaches and support professionals are on a constant lookout for the latest technology, better equipment, improved technique and training regimes, and advanced recovery protocols. Nevertheless, one group of performance enhancement methods stands out as broadly unacceptable. Most sports governing bodies expressly prohibit doping, with the World Anti-doping Agency (WADA) acting as an

international watchdog authority, supported by a network of national agencies and testing laboratories. The advances in anti-doping testing have so far failed to stem its fairly widespread use. The questions of detection and prosecution are losing their primacy to the questions of prevention, including psychological drivers behind the doping practices – from perceptions and attitudes and to decision making and specific choices athletes make.

**“Recent events in the world of cycling and indeed in various football codes in Australia emphasise the potential significance of the pressure that athletes might experience at the hands of unscrupulous clubs, coaches, leading athletes and medical and sports science professionals.”**

Harold Abrahams' gold at the 1924 Olympics 100-metre sprint stood out as an exemplar of very early professionalism, due to his commitment to systematic training and the hiring of a coach. Although highly controversial at his time, it is standard practice now. Activities once unacceptable (e.g. being coached or trained) have become the norm. The athlete's body is now seen as a highly specialised 'tool' that is continuously improved for maximal performance. Scientists constantly seek ways to improve sports performance. Athletes are encouraged to seek every possible way to improve their performance, including specialised training, hi-tech equipment and apparel, scientific and medical support, including the use of nutritional supplements. Being a high performing athlete is a profession that requires dedication, long-term commitment, and sacrifice.

**“Winning at all costs. Has it crept into the psyche in Australian sport?”**

The commercialisation and professionalisation of sport have replaced its politicisation during the Cold War era – but the resulting hyper-pressures remain and keep distorting its original core values. The ever-increasing premium on winning keeps raising the temptation to risk athletes' health and reputation and to potentially violate the principles of fair play.

Although there are many ways to put strain on health during an athletic career (e.g. excess training, injuries, disordered eating), the greatest concern to sport governing bodies is the chemical alteration of athletic performance. As sports participation swells, the variety and use of doping agents continues to increase and now extends beyond professional sport to amateurs and even young people who are physically active. Some studies suggest that agents such as anabolic steroids are also used by non-sports-practicing individuals and fitness centre visitors.

Except for nutritional supplement contamination or inadvertent use of a medicine containing a banned substance, accidental use of doping is highly unlikely. It requires deliberation, planning, and commitment; and is influenced by a host of protective and risk factors. In the course of their careers, athletes, with the support of key stakeholders, regularly set goals and make choices regarding the way by which these goals are to be achieved. The intriguing question here is what compels athletes to risk their health or reputations for outstanding sports performance and what factors make athletes vulnerable to doping at which point of their careers.



Competitive athletes are at an increased risk from exposure to doping offers by external and perhaps even internal agents and from their own temptation to experiment to find a quick fix (e.g. for recovery particularly from injury) or that performance edge.

**“Psychologists and educators have known all along that no amount of incentives can match intrinsic interest in breeding excellence.”**

The degree of rationality in doping decisions is highly debated. Economic models of doping mainly assume that athletes' decisions and actions are driven by economic rationality. They consider doping as a special case of a *prisoners' dilemma* game where two players must learn to trust each



other to develop a winning strategy, while the tactics of abusing the other's trust remain attractive for short-term gains. The players have no visibility of each other's actions – they can only guess them and feel their impact. As a result, suspected actions have consequences for both actors, and the best collective strategy is difficult to reach due to the lack of trust for the other player's decisions and their actual or suspected actions. This type of dilemma is what an athlete is faced with when striving to succeed at an international level where suspicions can fly right, left and centre about the state of fair play. The widely preferred and best case scenario in sport would be to compete at doping-free events. However, the widespread suspicions and speculations about other athletes' possible actions and their suspected doping behaviours have the potential to bias most athletes in favour of doping. Game-theoretic modelling suggests that the majority of competitors are likely to see doping as their best option and, under certain circumstances, the only feasible strategy to ensure winning to gain all of the associated economic benefits and status/recognition rewards.

Although theories and models of doping behaviour have ignored individual dispositions toward doping when it comes to decision making, they emphasise the importance of a broader situational context, within which decisions are not only made on individual preferences but in consideration of others' actions. Existing behavioural doping models have made attempts to incorporate personality, decision making rationality, and situational context, including peer group and subculture influences.

**“... the greatest concern to sport governing bodies is the chemical alteration of athletic performance.”**

The life-cycle model of doping use distinguishes numerous stages and exit points providing opportunities for behaviour change, relative to doping use. The interplay between facilitating and inhibiting systemic and personality factors is analysed, in conjunction with the continuous influence of situational factors. The resulting doping attitudes combined with subjective norms (i.e. perceived social pressure to engage or not to engage in a behaviour), influence intentions to use doping. These influences differ across the stages of athlete development, as are the developmental dynamics of the attendant vulnerability factors that make some athletes more vulnerable to engaging in doping than others, and at some time periods more than the others.

**“... the widespread suspicions and speculations about other athletes' possible actions and their suspected doping behaviours have the potential to bias most athletes in favour of doping.”**

Further, there is no reason to expect fundamental differences in the cognitive or motivational process involved in an athlete's decision cycle whether it deals with acceptable performance enhancement or doping methods. Psychologically, there may be little distinction between accepted and prohibited means of performance enhancement. Both need a sustained, motivated, goal-directed action. The difference is brought about by the current convention of the sport and whether or not the method is deemed to be acceptable or unacceptable in it.

When we consider the findings from meta-analyses of motivational research we can see where the decision to dope in sport might gain traction. If we accept that there are three key motivational drivers that might explain human behaviour – achievement, affiliation, and autonomy – doping in sport can be partially explained by the effects of these three drives on decision making. If the athlete and coach believe that doping will fast track achievement, then it might become an attractive option to choose. If doping occurs in a team situation (e.g. Lance Armstrong's U.S. Postal cycling team), it might be attractive to those athletes driven by a need for affiliation and identification with the team to choose to participate in the activity. Similarly, those athletes driven by a need for autonomy may choose to take part in doping activities because they see it as a fast track to celebrity status and levels of respect that permit them to make autonomous decisions, both on and off the field.

This life-cycle model identifies vulnerability factors across the stages of athlete development with the view of informing the design of anti-doping assessment and intervention. The model suggests that, instead of focusing on the actual engagement in prohibited performance enhancement practices, deterrence strategies are likely to be more effective if they (a) target the influencing factors at the appropriate stage and (b) identify groups of athletes and their respective career stages that pose particular risks of engagement in doping practices. This strategy enables effective intervention by targeting specific risk factors and expectancies.

Psychologists and educators have known all along that no amount of incentives can match intrinsic interest in breeding excellence. This intrinsic interest – ‘for the love of it’ – is what



makes you practice mega-hours with no respect for any external evaluation or reward. And these mega-hours get overlooked by much of the general public. Practice doesn't make for a good media story, and it takes retirement for our superstars like Andrew Gaze to admit that there is no substitute for it. An average Jo Bloggs' lack of first-hand experience with regular training makes athletic success all too easy in his or her eyes. It is hard to reconcile – especially for the inexperienced – the astronomical earnings many sporting stars enjoy with their love for their sport. Remuneration in professional sport is a big issue. How often do we hear envious remarks along the lines of, “If only I earned THAT much, it'd be so easy to be the best”? The best response to such a remark is a reminder that the only way to ‘earn THAT much’ is to enjoy doing it ‘for nothing’.

One can only surmise that with the progressive reduction in institutional doping brought about by increasing global surveillance and detection systems, that perhaps the continuing evolution of ‘quick fix’ expectations now typical in many societies (e.g. dieting) has contributed further to increased temptation by athletes to speed up their elite sport career development, to get them back on the field quicker after injury or a non-selection break, or to win at all costs sooner rather than later.

**“The ever-increasing premium on winning keeps raising the temptation to risk athletes’ health and reputation and to potentially violate the principles of fair play.”**

Recent events in the world of cycling and indeed in various football codes in Australia emphasise the potential significance of the pressure that athletes might experience at the hands of unscrupulous clubs, coaches, leading athletes and medical and sports science professionals. Athletes early in their professional careers are particularly susceptible to the influence of significant authority figures in sport and may naively ‘follow the leader’ in agreeing to be involved in attempts by teams to gain a competitive edge.

The doping dilemmas most athletes face at various stages of their career are profound. The advances in anti-doping deterrence policies, such as out-of-competition and retrospective testing, make them ever more challenging and offer no ‘silver bullet’ solution. Penalties and other forms of negative reinforcement remain the core of these policies, offering little support for positive reasoning against doping use. As a result, individual athletes may need all the help

they can get in making this critical, career-defining decision and maintain that delicate balance between their long-term, life goals and the lure of fast-track success. Among those who can lend a professional hand with this, are sport psychologists who can assist in diagnosing individual athlete's vulnerabilities and develop their resilience through individual counselling and promoting constructive attitudes and behavioural norms within the culture of sporting environments. Members of the Australian Psychological Society's College of Sport and Exercise Psychologists are recognised for their specific qualifications and years of experience, with their expertise uniquely relevant to the field of sport and exercise psychology, including the doping dilemma.

**“Psychologically, there may be little distinction between accepted and prohibited means of performance enhancement.”**

## Where to find a Sport and Exercise Psychologist

Sport psychologists can be contacted through the Australian Psychological Society website ([www.psychology.org.au](http://www.psychology.org.au)) and its College of Sport and Exercise Psychologists website ([www.groups.psychology.org.au/csp/](http://www.groups.psychology.org.au/csp/)). You can also find them through respective state or territory institutes and academies of sport.

### About the authors

**Eugene Aidman**

**Tracey Veivers**

**Stephanie Hanrahan**

**Jeff Bond**

All Members of the Australian Psychological Society's College of Sport & Exercise Psychologists National Executive Committee.

## DO YOU NEED A SIDE OF CARBS WITH YOUR EXERCISE?

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## Mood foods: More than just performance



**Helen Duong, Accredited Sports Dietitian gives us insight into ‘Positive Performance Nutrition’ and how an athlete can work to put this into practice.**

Although science and our understanding of the links between food and the brain are constantly evolving, and occasionally subject to debate, it cannot be denied that food has the ability to enhance or impair mental state or quality of being.

As a practitioner in sports nutrition, a captivated observer and student of colleagues who have been championing person-centered, weight inclusive and non-diet approaches ahead of me I’ll aim to give colour and depth to what I have observed as the two main components of ‘Positive Performance Nutrition’. I hope this draws attention to the fact that nutrition is more than a classic means of providing energy and building materials to the human body. Dietary habits/eating patterns, and how we relate to food, counsel and support our athletes, will have a profound effect on mood, sense of well being and ultimately play an integral role in optimising athletes’ potential.

**“... how an individual approaches, relates and behaves around food is what can truly enhance or impair mental state or well-being.”**

### Part 1: Positive Performance Nutrition: Mood foods – The mechanics

The first component of positive nutrition starts with a thorough understanding of the basics of healthy eating. A practical starting point when it comes to foods to enhance well-being, cognition and mood for healthy athletes is the Australian Dietary Guidelines. For any athlete, it is important they achieve this baseline first and foremost before the additional needs of exercise and adaptations are addressed. Here is a brief overview of how a variety of each core food group contributes to boosting mood and improving cognition.

**Grains:** Aim for mostly wholegrain, high fibre varieties.

Key nutrients: Carbohydrate, protein, dietary fibre, B group vitamins, Vitamin E, Iron, Zinc, Magnesium and Phosphorus.

- Soluble fibres in oats (B-glucan) or psyllium are known to stimulate hunger suppressant hormones (e.g. cholecystokinin) and also contribute to extending subjective satiety, therefore promoting a sense of wellbeing.
- The starch component of low GI carbohydrates is linked to an increase in insulin to optimise transport of glucose across the blood brain barrier, therefore promoting feelings of alertness and vitality.

**Dairy:** Aim for low fat varieties. Enjoy yoghurts, milks and cheeses in moderation.

- Rich source of tryptophan: an essential amino acid precursor of the neurotransmitters serotonin and melatonin. These neurotransmitters are linked to feelings of well-being and happiness as well as playing a role in restfulness and drowsiness. This supports better quality sleep and provides optimal recovery conditions.
- Rich source of calcium: involved in the conversion of tryptophan to melatonin and enhances restfulness.
- Yoghurt is rich in probiotics that enhance the good bacteria inside of our bodies that play a role in many of our immune system functions and have been linked to mood and mental well-being.

**Vegetables and fruit:** Aim for a wide variety of colours and types.

- Red, yellow and orange coloured vegetables rich in vitamins and antioxidants can help neutralise free radicals that have been produced during metabolism.
- Dark green leafy vegetables are a source of folate that has a role in DNA replication and regeneration.

**Lean protein foods:** Aim for those rich in omega 3 – oily fish, eggs, lean meats, soy and linseed (flaxseeds).

- With Docosahexaenoic acid (DHA) being the most abundant fatty acid in the cells of brain matter, general consensus points to a key role in learning, memory and mood.
- As the human body is not efficient in synthesizing DHA, the consumption of omega 3 rich food could work to support brain development and perception of wellbeing.

## Part 2: Positive Performance Nutrition: Food moods – Mindfulness and winning behaviours

It could be argued that once an athlete consumes the right food, optimal health, wellbeing and mood will automatically follow suit. This is partially true, however as nutrition practitioners, we know that a truly healthy and mood boosting diet is not just the physical food itself, but how an individual approaches, relates and behaves around food is what can truly enhance or impair mental state or well-being.

The second component of positive nutrition is the emotional and 'Intuitive Eating' features of dietary behaviour. 'Mindfulness' or 'Mindful Eating' is a collective term that best describes these habits for optimal well-being and performance.

'Mindful Eating' is the act of being properly engaged, present and free of judgment during any eating occasion. Practising curiosity, appreciation, and wholehearted engagement of the senses of smell, taste and texture, helps clear space in an athlete's mind, which then leads to an unobstructed ability to focus and take effective steps towards achieving nutrition goals.

**“...nutrition is more than a classic means of providing energy and building materials to the human body.”**





**“When internal and external intuitive skills are combined and practiced within nutrition programs, this forms an athlete’s optimal performance nutrition ‘lifestyle’.”**

A key feature of Mindful Eating particularly relevant to the athlete is the ability to ‘think mindfully’. Often perfectionistic or high self-expectations (key traits that may have separated elite athletes from the rest of the pack) could be an athlete’s downfall if they become obsessed or too restrictive in their approach. An example of a negative critical thought could be: “I think my coach is going to drop me from the squad, he hasn’t said it to my face, but it’s because I think I’m too big, I am not good enough. I don’t look like the other guys in the team, so I’m going to skip breakfast so that I can lose weight. Coach will be really happy with me when I lose weight”. This example has many types of unhelpful thinking that sport psychology colleagues could write volumes on, but as a Mindful Eating tip, observing and understanding that a thought is just a thought, not a fact, means that it does need to be acted on or sway emotions. Incorrect negative thoughts can trigger overeating or stop athletes from adequately feeding their hunger or what their bodies need to optimise recovery and therefore become more damaging than beneficial.

When we equip athletes with an ability to practice mindfulness, and positively reinforce and reward desired behaviors, we are effectively tapping into the athlete’s schema of ‘wanting-to-please’ (themselves, their coach, their team, their country).

Mindfulness therefore is an integral component to healthy eating that truly boosts a person’s mood.

**Now that we know what the two branches of ‘Positive Performance Nutrition’ look like, how does an athlete work with an Accredited Sports Dietitian to put this into practice?**

Once a structured and nutritionally adequate meal plan is devised, practical ‘Intuitive/Mindful Eating’ practices can be trained using eating awareness diaries that explore ‘Intuition’ (sense of ‘just knowing’) on two levels:

1. ‘Internal Intuition’: awareness of physical signals of hunger and fullness and thought processes.
2. ‘External/environmental intuition’: the physical food environment and social influences on eating choices.

Internal intuition could be an athlete’s ability to read and recognise their own unique physical and emotional sensations

or triggers to eating to identify when they are truly hungry or full. Athletes can learn to mindfully ‘check-in’ with their hunger through using scaling systems (how hungry am I on a scale of one to ten?) and link situations and circumstances to their subsequent food choices. They could also practice attentive eating by focusing just purely on the act of eating with no distractions. With an enhanced awareness, an individual learns how to eat until they are satisfied, leaving themselves neither ‘stuffed’ or ‘starving’ and ultimately learning to trust their body’s responses. Mindfulness can help amplify the volume of the body’s cues and thus lead to greater feelings of satisfaction and achievement. Mindfulness in an athlete is ultimately about acknowledging, observing, accepting and choosing when to buy-into beliefs and learning when it is appropriate to let them go for the purpose of optimising performance.

**“Mindfulness therefore is an integral component to healthy eating that truly boosts a person’s mood.”**

External intuition describes an ability to recognise the features of differing environments (supermarkets, restaurants, eating while on holiday) and the general and flexible rules of thumb around meal preparation and social eating. Meal planning, recognising ‘risk’ situations (i.e. at parties or functions), food label knowledge, cooking abilities and shopping strategies are skills that assist people to eat with confidence, flexibility, joy and moderation no matter what environment they find themselves in.

When internal and external intuitive skills are combined and practiced within nutrition programs, this forms an athlete’s optimal performance nutrition “lifestyle”.

Finally, because emotional experiences and perceptions of self will be unique and individual, it is important to remember to always keep a person-centered approach to dietary planning and counselling. To minimise harm and anxiety around eating plans and performance plans, it is important to keep message delivery, language and reference to food emotionally neutral and function focused. As athletes become aware of their individual experiences and unique body cues, they are empowered with self awareness and therefore are more likely to be resilient and joyful in their eating habits and become less likely to suffer poor dietary food choices or disordered eating in the long term.

**About the author**

**Helen Duong**

Accredited Sports Dietitian

## be active 2014 recap



**Sport Health gives you all the highlights from this year's be active 2014 conference.**

### Overview

This year's be active 2014 conference in Canberra was a huge achievement. Over 550 delegates enjoyed the combination of three conferences which offered a mix of sports medicine, sports science, sports injury, and physical activity clinical and research content. Professor Stuart Biddle kicked the conference off presenting the study of physical activity and sedentary behaviours with a focus on multi-disciplinary approaches to health behaviour change. He ensured he kept the audience entertained with his engaging presentation and witty repertoire.

He joined a long list of insightful keynote presenters including Dr Darren Burgess, Dr Tim Gabbett, Professor Paul Hodges, Dr Andrew McIntosh, Professor Jill McNitt-Gray, Professor Neville Owen, Associate Professor Catrine Tudor-Locke and our Refshauge Lecturer, Winthrop Professor Daniel Green.

**CPurdam @CPurdam**



**"Congrats @beactive2014 outstanding conference! Great international and local contributors. Well done all #beactive14"**

**Christian Barton @DrChristianBarton**



**"#beactive14 @davidopar hamstring injury risk factors of age and previous injury may be modulated by eccentric strength"**

This year we were blessed with a plethora of high calibre presentations and presenters, although it did make it hard when it came to awards time! Congratulations to Elroy Aguiar from the University of Newcastle who took out the major prize of the Asics Medal for the Best Paper Overall for his research into diabetes prevention.

The social calendar was also a much talked about highlight, with delegates enjoying catching up with old friends while making new ones over dinner, poster sessions and drinks throughout the week.

**Sean Docking @SIDocking**



**"Paul Hodges – "pain is not in the tissues, threat is in the tissue" local tissue changes cannot be discounted #beactive14"**

Sports Medicine Australia would like to thank all conference partners, trade exhibitors, speaker and session sponsors, award sponsors and our lanyard sponsor for their involvement in be active 2014. Most notably we are grateful for our Major Partners Asics and the Heart Foundation. SMA also owes thanks to the Conference Chairs; ACSMS Conference Chair, Kay Copeland; NPAC Chairs, Associate Professor David Dunstan and Professor Jo Salmon and NSIPC Conference Chair, Dr Dara Twomey; and their respective Conference Committees.

**Karim Khan @BJSMBMJ**



**"Massive congratulations to @SMACEO on program at #beactive14. Great value for clinicians the world over"**

All Conference abstracts will be published online as a supplement to the *Journal of Science and Medicine in Sport*. More details about this Journal, including subscription information can be found at [www.jsams.org](http://www.jsams.org).

We hope all those who attended be active 2014 were stimulated by the program and took pleasure in the typically social event, and we look forward to seeing you in Sanctuary Cove on the Gold Coast for the Asics Sports Medicine Australia Conference.

**Simon Rosenbaum @simon\_rosenbaum**



**"Australia committed to reducing inactivity by 10% 2025...guidelines on there own won't make any difference – Dr Trevor Shilton #beactive14"**

## Awards

Congratulations to all be active 2014 award winners.

### The Australian Sports Medicine Federation Fellows Awards 2014



#### ASICS Medal – Best Paper Overall

##### Elroy Aguiar

*Improvements in weight, HbA1C and fitness following lifestyle intervention: The PULSE trial for type 2 diabetes prevention in men.*

#### ASICS Best Paper – Clinical Sports Medicine

##### David Opar

*Nordic hamstring exercise weakness is a risk factor for hamstring strain injury in elite Australian football: a prospective cohort study.*

#### ASICS Best Paper – Exercise and Sports Science

##### Adam Semciw

*Quadratus femoris emg function while running and walking in healthy adults.*

#### ASICS Best Paper – Injury Prevention

##### Caroline Finch

*A new classification scheme for coding, analysis and reporting of the incidence and impact of subsequent sports-related injury.*

#### ASICS Best Paper – Physical Activity and Health Promotion

##### Genevieve Healy

*Potential impacts on cardio-metabolic risk biomarkers of reducing sitting time by increasing standing and stepping.*

#### Best New Investigator Physical Activity and Health Promotion

##### Elroy Aguiar

*Improvements in weight, HbA1C and fitness following lifestyle intervention: The PULSE trial for type 2 diabetes prevention in men.*

#### ASICS Ken Maguire Award for Best New Investigator

##### Ebonie Rio

*Clinical implementation of isometric exercise for patellar tendinopathy: Is it successful on the road?*

#### John Sutton Award for Best New Investigator – Exercise and Sports Science

##### Craig McNulty

*Influence of increment magnitude and exercise intensity on VO<sub>2</sub> kinetics, time to steady state and tissue oxygenation.*



#### Sporting Injuries NSW Award for Best New Investigator – Injury Prevention

##### Christina Ekegren

*The facilitators and barriers to implementing injury surveillance systems alongside injury prevention programs.*

#### Wendy Ey, Women in Sport Award

##### Geeske Peeters

*The influence of long-term exposure and timing of physical activity on new joint pain and stiffness in mid-age women.*

#### Best Poster – Clinical Sports Medicine

##### Lachlan Garrick

*Validation of visual rating criteria for single leg squat performance in asymptomatic runners.*

#### Best Poster – Exercise and Sports Science

##### Luke Perraton

*Quadriceps and hamstring strength, control and activation after anterior cruciate ligament reconstruction: relationship with new function.*

#### Best Poster – Injury Prevention

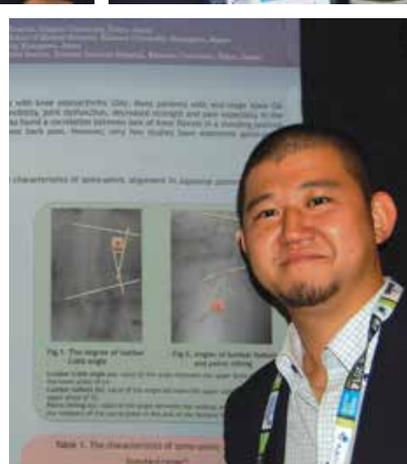
##### Lyndon Krause

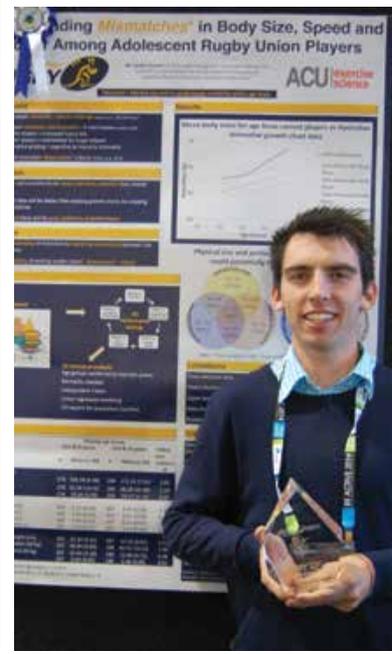
*Understanding mismatches in body size, speed and power among adolescent rugby union players.*

#### Best Poster – Physical Activity and Health Promotion

##### Jason Bennie

*Total and domain-specific sitting time among employees in desk-based work settings in Australia.*





Stuart Biddle @stuart\_biddle



“Did I stir it up in Canberra #beactive14? High intensity exercise is not a viable public health strategy!”



### ASMF Fellows

During the Conference the ASMF Fellows enjoyed a wonderful evening at the ASMF Fellows Dinner, held at The Deck at Regatta Point.

Congratulations to the following four SMA members who were awarded Fellowship:

- Professor Garry Allison
- Professor Andrew Cresswell
- Alex Donaldson
- Trish Wisbey Roth

These inductees now join an esteemed group of Professional members that have made great contributions to SMA and the sports medicine industry.



Jennifer Hatt @HattJennifer



“Elly Fletcher presenting sit to stand desk interventions in schools. Making school not boring. She received a standing ovation. #beactive14”

Jodie McClelland @JodieMCClelland



“Only 65% of people return to pre-injury level sports after ACL reconstruction. @clare\_Adern @DrKateWebster #beactive #latrobe”

SMA News @sma\_news



“Media release: Wii can’t fix couch potato kids #beactive14 research by Prof. Leon Straker shows”

### Media recap

From unhealthy sponsorship in sport, to mobile learning in the classroom, through to the association between children’s mental health and participating in organised sport, there were a number of be active 2014 research presentations that made media headlines during the conference.

**Online articles:** 521 outlets.

**Print articles:** 60 outlets including the *Sydney Morning Herald*, *The Canberra Times*, *Herald Sun*, *Daily Telegraph* and *Courier Mail*.

**Radio interviews:** 20 interviews.

**TV appearances:** The ABC Midday News, Channel 10 news, Channel 7 news and Channel 9 news.

Many thanks to all of the be active 2014 keynote speakers and presenters who participated in media opportunities during the conference – particularly those who completed early morning radio interviews without complaint! To keep up to date with all things SMA media and news related, follow @sma\_news on Twitter.

Stephanie Filbay @StephFilbay



“Don’t underestimate the importance of sleep duration and quality, in preventing injury and optimising athletic performance #beactive14”

Save the date: Asics Sports Medicine Australia Conference

October 21–24, 2015, Sanctuary Cove, Queensland.

O C T O B E R 2 1 - 2 4 2 0 1 5

# Sanctuary Cove

QUEENSLAND

*Save the Date!*



**ASICS**  
**SPORTS MEDICINE AUSTRALIA**  
**C O N F E R E N C E**

## A profile of depression: Ben Tune



**Queensland and Australian rugby union player and *beyondblue* ambassador, Ben Tune shares his story of depression and recovery.**

In 1996, Ben played for the Queensland Reds in their inaugural Super 12 season and made his debut for the Australian Wallabies against Wales. Ben spent more than a decade playing international level rugby where he scored 24 tries in 46 tests for the Wallabies, including a try in the 1999 Rugby World Cup final against France. He was named in the Queensland Rugby Team of the Century in 2001 and the Wallabies Team of the Decade in 2006. He retired from the Queensland Reds at the end of the 2007 Super 12 season.

Hearing about the death of young North Queensland Cowboys player Alex Elisala in 2013, Ben decided to share his story about his suicide attempt in 2009 and the depression he had been experiencing, through a heartfelt article in Queensland's *Sunday Mail*. "As a parent, I couldn't think of anything worse than outliving your children so when I read about Alex, it made me think about how his parents must be feeling. It made me reflect on my experiences and I felt compelled to say something on the off chance it might help raise awareness of the issues and reduce the stigma attached with talking about mental illness."

**“I isolated myself from family and friends, was not worried about the consequences of my actions when normally I would be, and drinking and taking drugs to excess.”**

The story received worldwide coverage and Ben was surprised by the response. “My privacy is very important to me, however the seriousness of the issue meant it was a gamble I decided I was willing to take. The support and empathy people showed me about my experiences meant it became a positive experience. I would encourage others to speak up about their journey, but you have to be in a good space before trying to help others, otherwise you can end up hurting your own progress.

Going by the incredible number of responses I received, it is obvious to me that mental illness touches most people in some way.”

Looking back, Ben now realises he was experiencing depression before he retired from professional rugby. He experienced regular ‘down days’, but said the endorphins and adrenaline from training and playing helped keep him in a good frame of mind. “On days when we didn’t train, I’d struggle, feel sad and would have trouble even getting out of bed.”

Once his rugby career finished in 2007, Ben threw himself into several business ventures, which kept him extremely busy. Surgery for rugby-related injuries also saw Ben develop a dependency for prescription painkillers. By the end of 2008, with the encouragement of his wife at the time, Ben visited his GP where he was diagnosed with the symptoms of depression. However, Ben wasn’t ready to deal with the diagnosis. “I didn’t want to be put in the category of a professional athlete who couldn’t cope when they retired, because I’d done so much to prepare for life after rugby.”

Some of the symptoms Ben experienced including feeling lethargic, getting upset for no obvious reason and finding no joy in the activities he normally would. “I isolated myself from family and friends, was not worried about the consequences of my actions when normally I would be, and drinking and taking drugs to excess.”

In 2009, Ben hit rock bottom and was hospitalised after his suicide attempt. “For the first time, I recognised the seriousness of my illness and sought treatment for it. I had managed to convince myself that my friends and family had no idea what I was going through and even if help was

available, the trek out of the darkness seemed insurmountable. I was utterly void of feelings, which led me to hurt the people I cared about the most. When you have no intention of living much longer, consequences just don’t seem as important.”

Ben spent six weeks in hospital, working through his dependency on prescription pain killers and commencing anti-depressant medication in conjunction with intense therapy to work through his issues. “For me, medication on its own wasn’t the answer. I encourage people to talk to a specialist to get their thoughts and emotions out in the open, so these thoughts can be processed rationally.

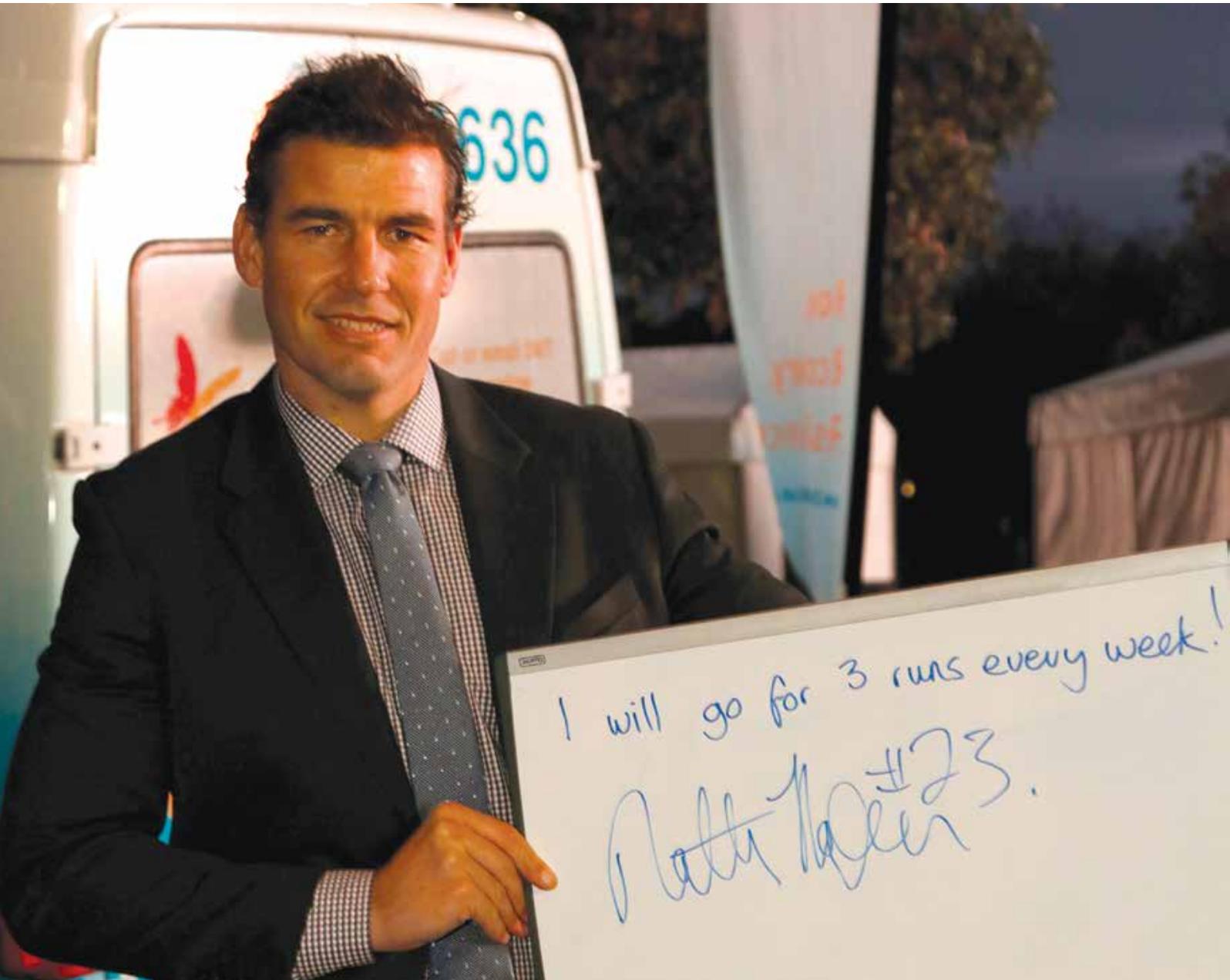
Finally, after a week or two, my head started to clear and the newly prescribed medication began to kick in. I started seeing things clearly and thinking rationally for the first time in a long time. It has taken five years of really struggling, hitting rock bottom and then building myself back up, to get to the point where I felt comfortable enough to talk about my experiences. I encourage people to see their GP as soon as possible to discuss your symptoms. The earlier you acknowledge something isn’t right, the sooner you and your doctor can look at dealing with it. The best way for me to describe the illness is to compare it to a weed. If you see it early, it’s easier to deal with. If you ignore it, it just keeps growing and growing so it can get out of control and becomes harder to deal with.”

Ben has said that nowadays he is relatively content and can actually get excited about the future. “I never say I’m cured of my depression... I am just in remission.” Ben said knowing his triggers and managing issues early is the key. “I rarely drink, and if I do it’s never a lot, I haven’t touched a prescription painkiller in over three years, religiously take my medication, and regularly see my doctor. All these things, along with the support of my father (my mother passed away in 2009), two amazing big brothers and a small group of very loyal mates have meant that although the journey back to reality has been arduous, I haven’t always done it alone.”

Ben encourages people who are concerned about a partner, family member or friend to help make them aware that they don’t seem to be their ‘normal’ selves. “Point out how their behaviour has changed while letting them know they are loved, cared for and not alone. I think it is important to help people see the problem for themselves. It wasn’t until I acknowledged my illness that I truly became committed to doing something about it.”

Source: *beyondblue*

## A profile of depression: Nathan Thompson



**Former professional AFL footballer and *beyondblue* ambassador, Nathan Thompson shares his story of depression and recovery.**

Nathan Thompson was a professional AFL footballer, playing a total of 179 AFL games – 119 at Hawthorn from 1998 to 2004, and 60 with the Kangaroos from 2005 to 2008. In 2004, Nathan spoke publicly about his experience of depression and since becoming an Ambassador for *beyondblue* has played

an important role in raising community awareness about the prevalence of the illness. Nathan currently works as a media commentator for the Channel 9 Sunday Footy Show and Today Show, SEN radio, AFLlive and Sportsday. He is married with a young family. Nathan shares his story.

"I think I'd known for years that something wasn't right, but I never thought it was depression. I felt like I 'should' be happy. Here I was – a successful AFL footballer, a great career,

strong, fit and healthy. But I wasn't. I wasn't mentally healthy – and that is just as important as anything else. I had constant negative thoughts about myself. I'd go to bed at night and I couldn't sleep. I would stare at the roof and ruminate over things – mainly everyday stresses or thoughts that we all have, but I couldn't switch them off. I'd end up shaking and in a lather of sweat. I'd finally get to sleep, but then I'd have to get up to go to work – so I was exhausted and tired all the time. When I was at my worst, suicidal thoughts were a day-to-day proposition for me. I didn't think I was ever actually going to hurt myself – but I just couldn't stop the thoughts. I'd spend the whole day thinking about it and then at night, I'd break down and fall into a heap."

These issues came to the forefront in 2004 while Nathan was Vice Captain of the Hawthorn Football Club. "I'd had a pretty bad year health-wise. It got to the point where my health was terrible. I would turn up to games hoping I would actually break my leg so I didn't have to keep going on. I couldn't see how I could actually tell someone how bad my thoughts had become. It got to the point where I didn't feel strong enough to keep going and I was concerned that I was going to hurt myself – I no longer had the strength to deal with it. I felt so ashamed – I thought 'I'm a strong person, I can get through this', but I felt so weak and tired all the time. I'd just had enough. I was at training one night when I collapsed – I broke down and I couldn't get off the bench. The coach took me into his office and said 'right, tell me what's going on?' And I pretty much just told everything to him – all the thoughts I was having and the danger I was in. He was amazing and told me my health was more important than the game and the club, and said he would support me in any way he needed to.

He was a football coach, not a psychologist, so he probably found it hard to know what to do. But when he saw me break down at training, he made my health a priority. I owe him a lot of gratitude for the way he dealt with it."

Nathan telling his coach was the first step in starting to talk about what he was experiencing and he went home that night and told his partner and family. "The next day, the football club held a press conference. I wanted to be honest with everyone and I thought if I tell the whole world, I have nothing left to hide. I was such a confused person at the time – I had no idea why I was feeling the way I was, but I didn't think it was depression. I'd be lying if I said I wasn't embarrassed.

"Telling my family, friends, team and the public was a great first step. But it's not like telling people made me feel better – relieved yes, but not better. I felt like I had let a lot of people

down. It was a pretty tough day, but I got through it. I was diagnosed with clinical depression. It has been an interesting road to recovery. One of the most important things I have learnt is the necessity of taking control of my own health. Sometimes we wait and hope that someone is just going to fix us. But it's a journey and you are the one that has to take the first step".

**"It got to the point where my health was terrible. I would turn up to games hoping I would actually break my leg so I didn't have to keep going on."**

"I have seen a psychologist and psychiatrist and I now understand a lot more about my own makeup. Because I understand it better, I can cope better. I certainly know when I am struggling and I can start putting things into place a lot quicker to stop me from letting my health slip. When I left football in 2007, I had time to reflect on those five years of being depressed, have a good look at myself and think about how I wanted to take care of my health and set some long-term goals. I really worked on being healthy and confident. I've been working with *beyondblue* as an Ambassador for several years. I speak to people throughout Australia about my personal experience and my journey to recovery, to help eradicate the stigma and encourage people to look after their mental health – because it's just as important as physical health.

"It's important we understand that depression is really common – there are so many people who are struggling with the same problems. If we create awareness about depression and get rid of this stigma, then it will become OK for more people to talk about it and then more people will talk earlier, seek help earlier and hopefully not reach the point where they break down. If something isn't right, find out what's going on. Be proactive with yourself and go and see a doctor or talk to someone you trust. I never did – and my health and my life were dangling on a knife's edge.

"Depression is an illness, but it's one that you can get help for – and recover from. If you are struggling, don't be afraid to admit it. Sometimes you have to put up your hand and say I need help."

Source: *beyondblue*

## The keys to business success

To help make the most of your business, *Sport Health* brings you the following business insights.

### Brand versus logo?

Brought to you by Papercut



A logo is the most visual connection anyone has with a product or company. Through repeated impressions, the audience makes a visual connection with the logo. However, logos are only part of an overall 'graphic language' being the Brand. A Brand is the collection of all things an audience will experience – the touch points, and how all those elements work together. For example the logo, colour palette, image style, graphic elements, typeface, tag line, placement, treatment or any other connection the audience has – defines the brand.

A brand gives your business:

- **A face** – which is incredibly important for service businesses. The brand helps make what you're doing more real, and more tangible.
- **A set of visuals** that you can use to help communicate to your clients. Many people are visual learners, they remember what they see, better than what they hear or read.
- **Consistency in marketing**, so that each 'impression' – or viewing – of your brand adds up and creates more memorability and recognition.
- **A professional appearance**. People like doing business with others who look organised and professional.
- **A framework** for creating additional marketing materials. You're no longer starting from scratch, branding provides a map of what your pieces should look like and how to progress from there.
- **A big business presence** – and big business impact. A well-constructed brand makes you look bigger than you are – even if you're a solo person business.
- **The confidence to market**. If you're timid about marketing, an impressive brand can make getting the word out easier, because you want to show it off!
- **Confidence from your clients**. If they see that you have invested in creating a brand, and spent the time to think about your intentions, this gives them confidence that you can deliver the services/products.

- **A strategy**. Branding begins with strategy – examining your business's differentiators and target audience. This strategy guides your marketing and business growth.
- **Organisation**. A good brand has to be organised – in the thought behind it; the way that it grows and the way it's created and presented.

If you create a visually interesting brand, that professionally communicates to your best clients, and tells the story of your business, and then use those components in an organised and consistent way, your business's materials will stand out from your competition.



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## Content, content, content!

Brought to you by Sportpeople Pty Ltd



While we all know that old real estate saying... location, location, location, there's an equally apt saying that relates to a successful job advertisement... content, content, content!

Sportspeople rigorously monitors the job advertisements listed at the Sportspeople Jobs Market, measuring the vital metrics such as the number of views and applications for each job. While there are measurable differences for many roles based on tangibles such as the profile of the employer, remuneration, location and nature of employment (whether the role is full-time or part-time/casual), one of the biggest shifts corresponds directly to the quality and amount of information within the job advertisement itself.

That is, where all other things are equal including the basics such as salary and qualifications, those jobs with detailed information appear to solicit a greater viewing audience and more relevant applications. Not surprisingly, jobs with little or no information within the advertisement receive fewer applications and less views overall.

So, here are a few tips to getting the best results when you are advertising a job:

1. Make sure the Position Title describes the job's functional responsibilities. For example avoid calling it a 'Manager' if it is really at a 'Coordinator' or 'Administrator' level.
2. Display the salary whenever you can and research other similar roles currently being advertised to determine whether your salary is at an appropriate market level. For example, if you have a Trainer role paying \$20 per hour and there's another ten Trainer roles paying \$50 per hour, you may need to shift your expectations. Candidates self-screen and are more likely to view and express an interest in a role if salary is publicly stated.
3. We operate in a highly competitive marketplace with lots of similar scaled businesses offering similar opportunities. You need to ask yourself, "What makes this job better than the next?" Your job advertisement builds and reinforces your brand and the more meaningful information you have available for job seekers, the more quality applications you will likely receive.

4. Provide a short background about the employer – where the job sits in the organisational structure, main objective of the job, who the role reports to, how long you've been in business and so on.
5. Clearly list the qualification and/or experience prerequisites. The more specific the selection criteria, the less likely you are to receive unsuitable applicants.
6. Your story extends beyond the job advertisement itself – your website (in particular your career section) and other mediums including YouTube and social media all play a part in building the story about who you are and why someone would want to work for you.

There are of course a number of mandatory fields within each Sportspeople Jobs Market advertisement, designed to ensure each job contains the basic, required information for a job seeker. However, if you want the best result from your job advertisement make sure you provide plenty of content, telling the story and selling the opportunity.



Sportspeople is a leading recruitment agency and job board operator in the sport, fitness and aquatic sector. For more information visit [www.sportspeople.com.au](http://www.sportspeople.com.au)

## The three types of social networks and what to post on them

Brought to you by Klout



Use these simple guidelines to understand each type of social network, how they can serve you, and what kind of content we recommend you post.

### Personal networks (Facebook, Instagram, Google+)

This social network exists to help you stay connected with existing relationships by sharing important moments with friends.

**What to post:** These networks thrive on personal content, e.g. milestone, interesting articles, location based check-ins.

- Keep content positive as it boosts engagement and sharing.
- Keep it short. Offer something, but don't give it all away.
- Use images to improve engagement.
- Tag your friends to help boost the exposure of your content.
- Be personal and most importantly, be you.

### Content sharing networks (Twitter, Instagram, Google+, Pinterest)

Often used to have larger scale conversations, they are the best place to build new relationships and grow your audience organically.

**What to post:** Use a combination of personal and professional content to show more dimensions of your personality and different aspects of your life.

- Include interesting statistics and facts to pull in your readers.
- Use tagging functionalities to include relevant people in your posts and start discussions.
- Include topically relevant hashtags in your posts to help their reach.
- Include a clear call to action as it helps your audience know what you want them to do.
- Allow others to see who you are and find your profile.



### Shared interest communities (LinkedIn)

These are community-oriented, informative by nature, and driven by both professional and personal interests. They are often used to learn about a skill, showcase things they've learned, or stay connected with professional contacts.

**What to post:** These networks tend to have a healthy combination of personal and professional content.

- Ask questions and share your experiences.
- Allow others to see who you are and find your profile.
- Social media is a great way to discover interesting people, but the real magic happens when you meet someone in person.

*Sport Health* would like to thank Klout, klout.com for supplying this editorial.

## Depression in elite athletes: are we doing enough?



**John Crampton, Sport Psychologist from Performance Enhancement Systems advocates for embedded professional psychological support *throughout* the athlete's career.**

### Clarifying the issue

It seems that every week we hear press reports of yet another high profile athlete going public with a story of personal challenges faced during their career. This coverage would suggest there is a widespread mental health problem in elite sport in Australia.

Taken at face value the press coverage appears to indicate that depression, anxiety and substance abuse/addiction is endemic to the Australian elite sporting environment. The content and style of the coverage also suggests that the problem is growing.

Is this really the case, or are we actually just seeing an increasing preparedness for athletes to talk about their career experiences? Is it possible that the elite sport population has a similar percentage of mental health issues to other population sectors, yet the coverage of high-profile athletes revealing their challenges makes it appear to be a bigger issue?

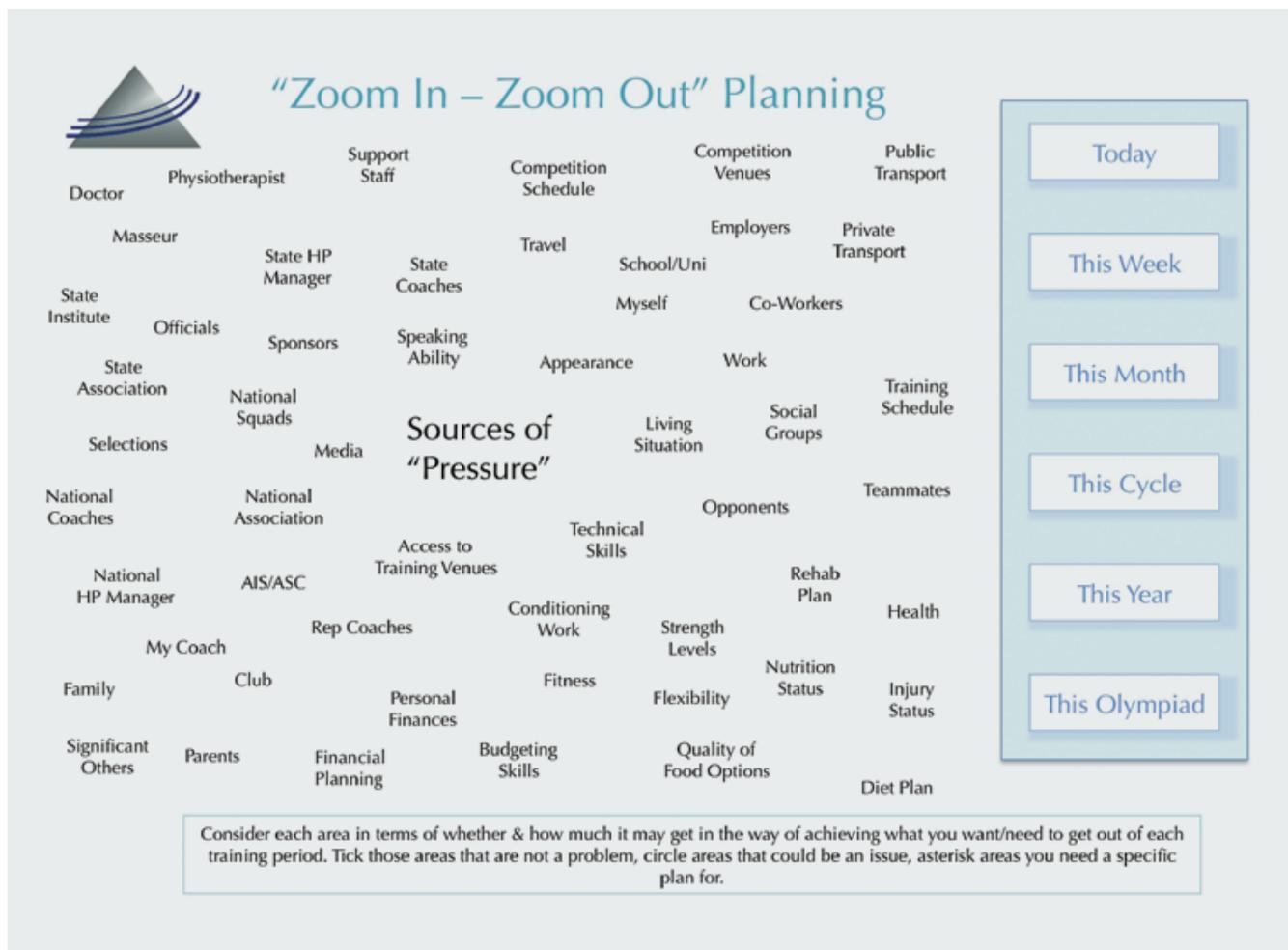
Any discussion about the causes of these mental health issues in sport tends to move into the eternal debate about what

we should be expecting of our elite performers. Does sport create mental health issues? There is plenty of evidence to the contrary. In fact the entire debate about school sport and the role of exercise in the maintenance of health in general populations is based on the premise that sport has many beneficial aspects.

On population terms we should be expecting a percentage of athletes to have their coping skills challenged at some stage of their career. The demands of contemporary elite sport argue for programs that ensure aspiring athletes 'know what they are in for', and that elite sport organisations should foster programs aimed at supporting athletes throughout their career.

This is the real issue – what we are doing as a group of science/medicine professionals to ensure elite athletes cope, survive and are able to perform consistently. Do sporting administrators understand the issues well enough to be able to justify and allocate the necessary resources and facilitate the necessary cultural changes?

**“The likelihood of sporting organisations listening to this call for support throughout the athlete's career depends largely on key decision makers and the organisational culture that is driven by key leaders in the business.”**



**“The goal of monitoring programs is to gain an understanding of what each individual athlete requires to properly focus on their job and to produce a high standard of performance.”**

### Are we doing enough?

Is it ok to just offer counselling when the apparently inevitable personal crisis is reached? Is it inevitable that elite athletes finish their careers with regrets? Is it inevitable that elite athletes suffer depression and anxiety throughout their careers, often to the point of debilitation?

Our experience says the answers are a resounding no, no and no! Our system is not managing the risks to athletes’ wellbeing adequately. Simply offering resources around the time an athlete retires is not contemporary risk management.

### Monitoring coping

The New South Wales Institute of Sport (NSWIS) Athlete Management Services (AMS) group addressed these kinds of issues in the lead-up to the Sydney Olympic Games with some specific programs and non-traditional resource allocations. The ‘Sources of Pressure’ system allowed athletes to monitor their own changing state of mind and personal feelings of competency. Through systematic formal and informal contact AMS staff assisted athletes to better predict and cope with various aspects of their training and competition schedules during their three to four year Olympic campaigns (along with the use of the ‘Campaign Planning’ tool and various assessment systems used to facilitate the establishment of an individual performance/stress profile).

This system provided ‘proof of concept’ that effective relationships can be formed in athlete support programs that grow in value during an athlete’s career. When these support

relationships are based on trust they can provide educational opportunities, monitoring and advisory services, a schedule and challenge planning service, and a system of cross-referrals within a small multi-disciplinary team. Their value to the athlete is significant. The philosophy was ‘how are you going – what are we planning to do about x – ok this is what we need to do to get ready/get back on track’.

AMS took on the responsibility of monitoring athlete welfare and being proactive in the provision of support, advice and direction. Resource decisions were based on developing and directing ‘service potentials’ to individual cases.

## Duty of care

Contemporary elite sport agencies are charged with ensuring that they provide the necessary duty of care for a range of aspects of the elite athlete’s lifestyle – not just on the field. This duty of care must be adequately resourced to ensure considerations of big ticket items such as ‘at-risk’ athletes, the impact of selections, career stalling injuries, relocation/significant life changes, family members, substance abuse, relationships, medical issues and eating disorders.

There is a growing trend for elite sporting organisations to operate to a ‘recognise issue’ and ‘offer counselling’ approach in the name of demonstrating the necessary duty of care. Unfortunately this offer is often made well after the underlying issue and behaviour patterns have become well ingrained and in many cases habitual.

Organisations are responsible for ensuring the availability of qualified professionals and the assessment systems required to adequately ‘recognise the issue’. This can be expensively sourced externally for an individual or amortised as a staff cost across a large group of individuals.

**“There is considerable evidence that we are not doing enough to support our elite performers in the Australian sport system.”**

The concept of ‘offering counselling’ provides an interesting philosophic dilemma. Do we impose leadership/guidance/control on athletes throughout their career or do we provide them space, assuming that they are managing themselves adequately? Should we be actively involved in their life ‘on and off the field’? If we become aware that things are going wrong, do we just ask if they need or welcome help, or should we be actively taking over daily management of their schedules and campaigns?



There is certainly long-term evidence of the value of proactive monitoring arising from the coaching styles and philosophies of professional coaches such as NRL legend Wayne Bennett. Bennett stands out for his concern for the development of the person ahead of the weekend’s result.

The ‘offer counselling’ approach may appear to be covering duty of care for an organisation but it does not go far enough in the provision of contemporary support for elite and developmental elite programs.

There are many groups who have become well known for their provision of post-crisis care – Beyond Blue, Lifeline, Black Dog Institute, St Vincent’s CRUFAD, South Pacific Private Hospital, Headspace, ANU’s Mood Gym, etc.

With this proliferation of specialist groups available to provide support for athletes experiencing personal crises there has become a tendency to overlook the frontline defences that have existed within the Australian elite sport environment for over 30 years – the professional sport psychologists (see the APS College of Sport & Exercise Psychologists).

## The Australian Institute of Sport (AIS) Sport Psychologist Duty Statement

From inception, the AIS recognised the need to provide support for athletes and coaches outside of the performance environment. A 1984 AIS Sport Psychologist Duty Statement included this responsibility: “to oversee the psychological care and wellbeing of athletes and coaches, and to assist in their psychological preparation for competition”. Unfortunately there were several issues in the performance of those duties: the overlapping roles of various support professionals, differing opinions about service philosophies, and differing perceptions about final responsibility for athlete management.



## Support program models

Central to the tendency for organisations to look to external groups to provide one-stop assessment and treatment services post-crisis is the potential cost-savings in not having in-house professionals involved in monitoring the well-being of athletes and coaches.

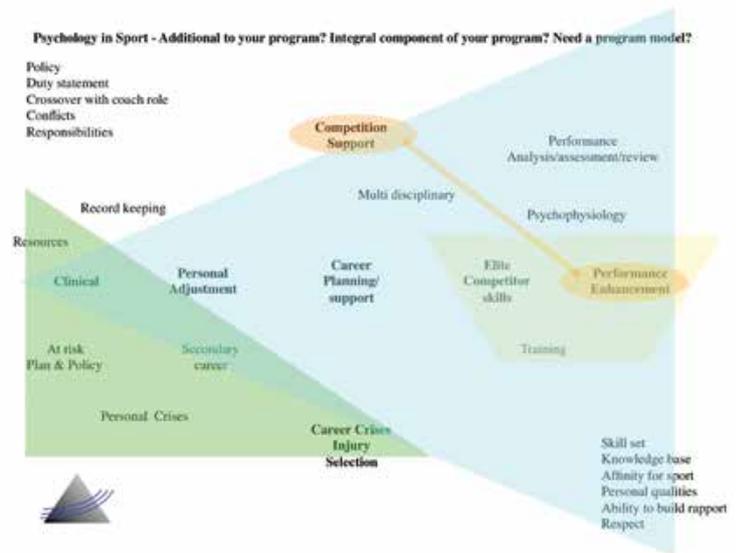
Curiously, an often-expressed attitude against the need for sport psychology professionals on staff in elite organisations was the defensive “there’s nothing wrong with me!” The irony of this belief system is that the before-mentioned press coverage seems to be saying that despite the protestations there possibly was.

### “Does sport create mental health issues?”

While the long-term stigma about openly dealing with mental health issues appears to be changing, the psychological first-aid providers of choice are usually not the highly professional sport and exercise psychologists who work in Australian sport. This is counter-intuitive and confusing, perhaps driven by some very out of date views of what psychology in sport entails.

To provide some clarity to the role of the sport psychologist in the systematic monitoring and primary care giving in athlete welfare/mental health, let’s consider the wide range of areas covered by the professional psychologist working in sport.

Psychological applications in sport range from clinical services through to performance enhancement assistance, with several ‘stops’ in between. Sport psychologists are not just clinical in approach, nor are they just about performance enhancement. The blue and green shaded areas in the diagram above indicate typical resource demand in elite programming – the ‘service potentials’ that need to be resourced.



**“With this proliferation of specialist groups available to provide support for athletes experiencing personal crises there has become a tendency to overlook the frontline defences that have existed within the Australian elite sport environment for over 30 years – the professional sport psychologists.”**

There are some internationally acknowledged models that have embraced these concepts – the original AIS Sport Psychology Program, and more recently the AMS model from NSWIS circa 1996–2000.

The NSWIS AMS model for the Sydney Olympiad was developed in response to the predictable challenges presented by the high visibility, high expectation environment that was to confront our local athletes. AMS delivered custom-made support programs for individuals via what would now be called a relationship management approach.

AMS sought to understand their level of investment, their typical patterns and approaches to schedule challenges, their level of preparedness for dealing with a high public profile, and their ability to perform in high expectation environments.

In one of its operational roles AMS looked specifically to provide an educational/advisory program aimed at minimising risks relating to selection for the Sydney Games. Resources were allocated to the maintenance of effective working relationships with athletes so they benefitted from mentoring, scenario and strategy planning.



## Athlete Management Services

AMS is the elite program service & training division for NSWIS, operating as a combination of an HR group & a professional management company. The AMS model combines sport psychology, career & education support, and coach professional development to create a support group capable of servicing the needs of contemporary elite sport programs.

NSWIS has assembled a multidisciplinary team that can deliver professional & personal development training & support services to athletes, coaches and others more efficiently than separately operating groups.

AMS provides a "one-stop" support group for coaches and athletes across the full range of areas involved in the management & enhancement of elite sport lifestyles.

AMS provides support for 3 aspects of the High-Performance Athlete/Coach's career

AMS is proudly sponsored by:

To perform well in each of these "careers" requires the same set of skills, attitudes & mentalities: *organisation, focus, purpose, desire, priority planning, resilience, dedication, perseverance, refined talent*

AMS staff & consultants assist program coaches to get the environment right for scholarship athletes

AMS programs & services aim to identify & manage the many distracting sources of pressure that can adversely affect an athlete's performance

The AMS Team custom-make training & support programs for each athlete (in conjunction with NSWIS Program Service Plan & coach / sport priorities)

**Interview / Assessment**  
for all athletes

TAIS Biofeedback Performance Survey | New Directions Aptitude Tests Interests & values

**Athlete Database**  
management file for each athlete / sport

**Campaign Plan**  
for targeted athletes

**Service / Training Needs**  
are identified

confirmed by Coach | responsibilities allocated by Team Leader

**Action Plan**  
for each athlete/sport program

Delivered at Homebush or on-site at training camps & competitions through

Individual Meetings | Team Meetings | Specialist Training Programs

monitored by Coach Meetings

**Athlete Service Model**

It takes at least 5 years to become an overnight success ....

Athletes are encouraged to plan their career in "CAMPAIGNS" - specific build-ups to major events

2000	2001	2002	2003	2004	Issues for inclusion:
19	18	20	21	22	competitions
World Games	Athl Olympic	Athl Olympic	Athl Olympic	Athl Olympic	skill changes
	World Games	C'World Games	can for Olympic Games		lifestyle changes
		World Games			medical adjustments
					equipment opportunities
					training potential
					opportunity cost

The emphasis in athlete servicing cycle changes over a 4 year elite athlete preparation cycle (eg an Olympiad)

AMS provides other support services to NSWIS athletes & coaches

- SportsCode
- Speakers Bureau
- Media Skills Training
- Athletes' Commission
- Tour & Training Diaries
- High-Tech Training Room
- At-Risk Athlete Management
- Educational Program Development
- Training Camps & Competition Support

The AMS Team brings together extensive skills & experience (we call these **training potentials**) in performance psychology, management consultancy, coach professional development, information technology, coaching, educational support, teaching, international competition, marketing & public relations, media, travel, team preparation, time management, graphic design, home economics

AMS also utilises consultants who bring expertise in media training, public speaking, financial planning, study skills, exam skills, nutrition, travel skills, computer applications

AMS Team Leader	John Crompton	295
Athlete Career Adviser	Jenny Luff	294
Sport Psychologist	Michael Martin	293
Athlete Career Adviser	Donella Burridge	297
Sport Psychology Intern	Troy Baker	291

AMS prepared support programs for each Games Team contender as final selection time approached. Many of the athletes involved would not have been aware of the extent of monitoring and planning that was being done on their behalf.

This planning was necessary to ensure that resources (staff time and training room facilities) were held in reserve for the local or in-house support of athletes struggling with the challenges as they built into significant 'sources of pressure' loads.

### The 'At Risk Athlete'

The at risk strategy was presented to the Australian Olympic Committee (AOC) at one of the gatherings of the various member National Sporting Organisations (NSOs) early in 2000 with a view to offering a structure that each sport could base their final preparation upon. Very few of the NSOs present were adequately resourced to be able to monitor and fully support athletes who were approaching a rare career landmark – a home Olympics.

Not all athletes reacted to the pressures of the selection process for the Sydney Olympics in the same way – some had difficulty coping with the possibility of missing selection, and some responded poorly to injuries, etc that are an inevitable part of a major campaign.

Each stakeholder organisation should develop and resource contingency plans for how to best support these potentially 'at-risk' athletes before and after the time of final team selection.

At that stage we were seeing a groundswell of genuine concern for athletes' wellbeing in the context of high expectation, high visibility competition campaigns. The knowledge and understanding required to structure an appropriate support program was in its infancy in Australian sport.

**For example**

Should make team

Likely to make team – good chance

Outside chance to make team - relatively late in career

Outside chance to make team - relatively early in career

"Miracle" required to / if make team

2012 & beyond squad

Have campaign plan / career plan beyond 2008 ?

Have plan only up to final selection events ?

Have put all eggs in one basket ?

Track record of reacting poorly to selections / political issues within sport

Have family / support staff with track record of complicating issues around / after selections

Have track record of performing poorly at key selection / major events

*This athlete may be under significant pressure to perform at selection events (from themselves, their family, media, etc), and if they get injured or perform below standard at key events may "come down in a heap", make unwarranted comments, feel frustrated at the effort put in, have to deal with the "big empty" of having nothing more to train for, etc*

*What support systems are available ? Can anything be done to brief the friends and family about the pressures ? Should the athlete be encouraged to monitor and deal with the stress of selection better ? Incorporate "breaks" into weekly plans ?*

**“On population terms we should be expecting a percentage of athletes to have their coping skills challenged at some stage of their career.”**

In the intervening years we have seen the growth of the Players' Associations, concern for the athlete's alternative career, the incorporation of education into training schedules, group based assessment systems, and campaigns for the greater concern for an athlete's mental health.

The goal of monitoring programs is to gain an understanding of what each individual athlete requires to properly focus on their job and to produce a high standard of performance.

Major events within a campaign plan provide invaluable additional insights into an athlete's ability to cope and adjust.

This post-event debrief is as much a way to evaluate the quality of the lead up planning and monitoring prior to a major event as it is a systematic way to keep track on subsequent emotionality, mood and state of mind.

The operating environment that is elite sport is most likely to remain highly pressurised, and characterised by increasing scrutiny and expectations of high performance standards. Our duty of care needs to be resourced in keeping with contemporary support principles as opposed to efforts focused mainly on organisational duty of care.

### Organisational culture

The likelihood of sporting organisations listening to this call for support throughout the athlete's career depends largely on key decision makers and the organisational culture that is driven by key leaders in the business.

UK group Lane4 has a succinct way of looking at what they regard as the four key drivers of organisational culture.

Put a % next to each area to represent how important each driver is to management and the organisation as a whole. If Wellbeing and Innovation are considered less important than Processes and Achievement then it is likely that organisation will be an 'offer counselling' style of operation.

If Innovation and Wellbeing are considered central to the achievement of staff and organisational goals, then that organisation will already embrace the concept of 'monitor and support'. Just as culture development is a proactive process for management, formulating a solution for the issue of long-term athlete wellbeing requires pro-active strategies and resources.

<b>Athlete Details</b> Name Event Result	<b>Background Notes</b> Were expecting to medal Were expecting to make final Were expecting to be competitive Was looking to learn lots / gain experience / see what they could do Had no expectations / were concerned about how competitive they would really be	<b>Performance</b> Performed much better than expected Performed above expectations Performed according to expectations Performed below expectations Performed well below expectations Performance hampered by injury Injured & had to withdraw during competition	<b>Emotional Control / Lifestyle Management</b> Focus Interpersonal Style Family Situation Experience
<b>High Profile</b> Recognizable Team Member (ing Hockey) Unknown	<b>High Expectation</b> Good performance, a task, level up their team Should do well No Expectation	<b>Had great load up &amp; everything was right for these</b> <b>Had good lead up &amp; things worked well</b> <b>Had adequate / OK lead up and had to make some adjustments</b> <b>Had disrupted lead up &amp; major issues at Games</b>	<b>No distractions</b> Family issues Friends Relationships Relationships within team Disrupted other team member affects performance Trained
<b>Current Emotional State</b> No Reaction Moody Frustrated	<b>How Assessment</b> Anxious Angry Depressed Unstable	<b>Injured &amp; had to withdraw before competition</b>	<b>Gold</b> Silver Bronze Finalist Semi-Finalist Competed in heats / preliminaries Trained
<b>Recommendation</b> No Action    Monitor    Interview    Refer    Relocate    Remove from Village    Refer to SPS-SAS			





## Stop press

Recent announcements by some national football codes about moving towards a medical monitoring program in 2015 indicate a continuation of the current 'big brother' programs. This monitoring is to involve periodic health checks and blood tests. This kind of program does not go far enough to monitor and support athlete lifestyles through their career.

The AIS has recently announced a rebadged ACE program, called 'Personal Excellence', purporting to assist athletes to "identify their unique path with a responsible and professional approach to all aspects of their sporting career and life". This would appear to better embrace the principles of the AMS program as discussed here. Why has it taken so long to make these changes?

**"Our system is not managing the risks to athletes' wellbeing adequately."**

**"... the psychological first-aid providers of choice are usually not the highly professional sport and exercise psychologists who work in Australian sport."**

## Summary

There is considerable evidence that we are not doing enough to support our elite performers in the Australian Sport System. Organisations must show genuine concern for each individual's wellbeing by *providing support throughout a performer's career*.

Current trends by organisations to address duty of care issues by training staff to identify adjustment and coping issues, and subsequently offering and possibly providing counselling after times of personal crisis do not reach the necessary standards required. Contemporary organisations provide ongoing monitoring and support by embedding professional psychologists in their coaching and welfare programs.

A contemporary approach is evidenced by organisations who:

- Show a genuine intention to support and 'protect their long term investment' in performers.
- Embrace a top-down operational culture that indicates a true concern for the individual's well-being.
- Allocate professional resources for daily monitoring and service potentials for the provision of specific interventions.
- Ensure ready access to the necessary professional skills and utilise service providers with a contemporary understanding of the support industry.
- Make ongoing monitoring of each individual's adjustment to and their coping with the demands of their performance environment a high priority.
- Provide personalised programs that predict periods of high stress and also that provide professional support potentials prior to the key associated career landmarks.
- Proactively build their coaches, athletes and support staff's understanding of how to be an elite performer.



#### About the author

**John Crampton** is a CoSEP member and runs Performance Enhancement Systems.

**CoSEP** is the peak body for the sport psychology profession in Australia. CoSEP members are registered psychologists with recognised skills in sport and exercise psychology.

**Performance Enhancement Systems** is a business that provides "management, training and support services to athletes, coaches and organisations".



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and expectations placed upon players as well as the highs and lows of training, injuries, selection, travel, performance, media and lifestyle.

They are also aware of the unusual situation that new and often young players find themselves in regarding a number of factors; their new heightened financial situation, relationships and partners, family systems, the strain of relocation and travel and so on.

This combination of factors can be overwhelming, confusing, exciting, stressful, invigorating and empowering all at once. Often, at a young age of 18, players are suddenly in a position where they are juggling these pressures and stresses without necessarily having the coping mechanisms or life skills to do so in a way that is healthy and sustainable. In the induction camps for young players, South Pacific Private have worked with RUPA to provide education and awareness to these young players around the signs to recognise in both themselves and in their team mates.

**“Early identification can be an important factor in someone’s treatment and in their recovery.”**

## Recognising the signs

*Even if no-one is talking about it – it’s happening.*

As part of the education agenda with RUPA South Pacific Private raised awareness around the following:

- Recognising, assessing and intervening in addictions and mental illness.
- Understanding addictions and mental illness in elite athletes.
- Defence mechanisms and core issues.
- Engaging and assessing players.
- Communication challenges within engagement and barriers to communication.

South Pacific Private’s Program Director Steve Stokes and Program Manager, Chris Mordue were able to personally address Player Development Managers and players around the importance of recognising the signs as well as the importance of communication and engagement with players when signs are present.

Steve recently commented, “It can be difficult for people with depression or anxiety to take that first step in getting help – no matter who they are. If left untreated, depression can lead to deep feelings of isolation and helplessness, and these feelings need to be taken seriously, just like physical pain on the field would be. In our relationship with RUPA we have

worked together to enhance knowledge about the nature of depression and anxiety but also about the pathways available if a team mate, family member, friend or player is suffering.”

He also affirmed, “The journey to recovery starts by talking to another person about the problem and to seek professional help. It’s vital that elite athletes and their support networks know what options are available to them and where to ask for that help.”

Education is critical and recognising the signs that may indicate a problem exists is very important. It’s especially critical in terms of the provision of support options for a person who may be experiencing the problem. Early identification can be an important factor in someone’s treatment and in their recovery.

The behaviours associated with mental health disorders such as depression, anxiety, alcohol or substance abuse vary across individuals. Behaviours may be exhibited as follows:

- More frequent, prolonged and increasing in intensity.
- Unusual or out of the ‘normal’ scope of behaviour exhibited by this individual, that is ongoing, irrational or disproportionately extreme.



Recognition of and education around these signs requires a commitment from sporting organisations to train and engage the management team and the broader workforce in the importance of supporting mental health issues. Given that many people experiencing mental illness do not seek treatment, it's important to recognise the role that early recognition can play.

### Looking out for your mates – The role of awareness within a team context

South Pacific Private educated players around the signs that are specific to their field to watch for in team mates. In addition, Steve Stokes and Chris Mordue spent time explaining the importance of recognising the signs in their team mates.

Asking for help is hard. As such, it might be the team mate, as opposed to the individual, who becomes aware of the visible signs of an addiction or of depression. The person suffering is likely to be in denial, unable to ask for help or may simply not be aware of how their behaviour is impacting the team and the game. The team surrounding someone who is suffering from depression and/or addiction are a vital support network as are the coaches, Player Development Managers and the rest of the staff. It's important to try to get the individual the support they need and to recognise that they may need help.

Typical visible behavioural signs to watch for could include (but are not limited to):



**“As such, it might be the team mate, as opposed to the individual, who becomes aware of the visible signs of an addiction or of depression.”**

### What does a typical day in treatment look like at South Pacific Private?

By the time clients, or their families, reach out to South Pacific Private for help with their problems there is often a significant crisis. Inpatient treatment gives both the individual and their family the respite needed to manage the crisis, begin treatment and to take those first steps in creating the necessary change.

Choosing to enter inpatient treatment for mental health or addiction issues is a life changing experience. It can be daunting to admit for residential treatment but by the time individuals are ready to leave South Pacific Private and to re-enter their home and work environments people will have experienced the most amazing journey into recovery which many treasure for the rest of their lives.

**“One of the most challenging aspects of the disease of... mental illness... is the powerlessness that... team mates may feel as they watch the problems unfold.”**

The days in treatment are full and structured and each individual's treatment program is tailored to their specific needs. Through the differing phases of their treatment pathway they will attend various components and specialised segments of the program, as recommended by their multidisciplinary treatment team.

South Pacific Private's Inpatient Program immerses individuals in a full and intensive therapeutic program designed to address problematic behaviours, attitudes and feelings. The structured program offers psychiatric care, 24hr nursing care, daily group therapy, and comprehensive psycho-education.

**“Inpatient treatment gives both the individual and their family the respite needed to manage the crisis, begin treatment and to take those first steps in creating the necessary change.”**



So let's look at what a typical day in treatment at South Pacific Private may look like:

**A Typical Day in Treatment**

SOUTH PACIFIC PRIVATE  
Australia's leading treatment centre

6.45am	The day begins with a beach walk along beautiful Curl Curl Beach, or with a yoga class.
7.30am	Breakfast
8.15am	Community Meeting - Discussions and interactions between clients outside of structured program activities are an integral part of therapy.
9.00am	Lecture - interactive workshops delivered by experienced therapists covering an extensive range of topics.
10.00am	Morning Tea
10.15 - 12 noon	Group Therapy - A core component of treatment at SPP is group therapy.
12 noon	Lunch
1.00pm	Lecture
2.15 - 4.00pm	Group Therapy
4.15pm	Beach Walk
5.15pm	Dinner
6.00pm	Peer Group Meeting
6.30pm	News
7.00pm	External meetings, workshops or other activities
8.30pm	Supper
9.00pm	Mindfulness

### Where to get help

One of the most challenging aspects of the disease of addiction, mental illness and trauma related conditions, is the powerlessness that friends, family members and in this context, team mates may feel as they watch the problems unfold.

For RUPA there is a clear structure to follow as players are educated about talking to their Player Development Managers as a first step, prior to communication with South Pacific Private about what may follow.

However, for other sporting organisations or for individuals who want to ask for help (for themselves or for someone they care about) South Pacific Private are accessible 24/7. It's as simple as calling 1800 063 332 confidentially or visiting our website for more information at [www.southpacificprivate.com.au](http://www.southpacificprivate.com.au)

If you are interested in exploring educational opportunities for Player Development Managers, coaches or others within

your team management and player support structure you can connect with South Pacific Private's Relationship Manager, Jacque Grant on 1800 063 332.

**“I was drinking quite heavily to numb everything, but I didn't know back then alcohol was a depressant, and I was already depressed about my injury... I hid it from everyone. I called my parents when I was in treatment, they were shocked.” – Kelly Smith, England and Arsenal Ladies Football Player, MBE in an interview with The Independent UK on her depression.**

### About the author

South Pacific Private is a treatment centre on Sydney's northern beaches specialising in the integrated medical, psychiatric and psychotherapeutic treatment of addictions and mood disorders. In addition to being a registered Acute Care Psychiatric Hospital fully licensed by the NSW Department of Health, South Pacific Private is accredited by the Australian Council on Health Care Standards.

[www.southpacificprivate.com.au](http://www.southpacificprivate.com.au)

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## A multidisciplinary approach to aerobic exercise prescription for mental illness



Robert Stanton, Dr Simon Rosenbaum, Associate Professor Peter Reaburn and Professor Brenda Happell provide insight into how exercise can be used as an intervention to combat mental illness; however it is not without its barriers.

### Background

More than 1 in 5 Australians will experience a mental illness at some time in their life. Mental illness is a leading cause of non-fatal disease burden, with depression by far the most common mental illness presentation to General Practice<sup>1</sup>. In addition to the burden of disease, there are significant economic implications. Mental illness costs the health care system approximately \$7 billion<sup>2</sup> and results in around \$6 billion in lost productivity annually<sup>3</sup>. Furthermore, compared to the general population, people with mental illness often face additional inequalities and physical health challenges. They are more likely to be overweight or obese; to develop chronic illnesses such as cardiovascular disease and diabetes; and to experience disparities in the provision of health care services<sup>4-8</sup>.

The causative factors for poor physical health are complex and multifactorial. However, poor physical health behaviours such as nutritional inadequacy, low levels of exercise, smoking, and excess alcohol consumption are known contributors<sup>9,10</sup>. In addition, some medications, particularly second generation antipsychotics such as clozapine and olanzapine, are associated with significant weight gain and adverse cardiometabolic effects early after commencement<sup>11,12</sup>. In combination, these factors contribute to an early mortality of up to 20 years in persons with mental illness<sup>13,14</sup>.

**“... the exact exercise dose likely to result in positive outcomes for people with mental illness remains unclear.”**

### Exercise and mental illness

One strategy which has the potential to address many, if not all, of the mental and physical health concerns of Australians, is exercise<sup>15,16</sup>. While psychotherapy and pharmacological interventions will continue to be the first line treatments for mental illness, there is a growing body of evidence supporting the ‘Exercise is Medicine<sup>®</sup>’ statement. Almost all recent reviews<sup>17-20</sup> highlight that exercise and physical activity are valuable in the prevention and treatment of a number of mental illnesses including depression, schizophrenia, eating disorders, substance use disorders, and post-traumatic stress disorder. In fact, for depression, some studies show exercise to be as effective as medication<sup>21,22</sup> or psychological interventions<sup>23</sup>. The safety of exercise for people with mental illness is also confirmed with few, if any, adverse events reported<sup>24-26</sup>.

Despite evidence for the beneficial effects of exercise in the treatment of mental illness, the exact mechanism of action remains open for debate. It is possible that a variety of psychological means such as a shift towards more internal locus of control, distraction from ruminating thoughts, developing a sense of mastery, and social reinforcement may contribute to improved mental health outcomes<sup>27-29</sup>. Exercise is also known to increase brain-derived neurotrophic factor (BDNF) which acts to protect nerve structures and may play a role in neurogenesis<sup>30</sup>.

Exercise may also serve to decrease sympathetic nervous system and hypothalamic-pituitary-adrenal (HPA) axis activity<sup>31</sup>, with recent reviews suggesting these pathways are similar to those of medications<sup>32,33</sup>. It is unlikely that either of these mechanisms works in isolation. Rather, both psychological and neurobiological mechanisms, the exact combination of which may be unique to each individual, combine to exert the positive benefits of exercise on mental health.

**“Embedding AEPs in hospital and community care services... might overcome many of the barriers to exercise delivery experienced by mental health consumers in Australia.”**

As with the mechanisms responsible for the benefits of exercise on mental health, the exact exercise dose likely to result in positive outcomes for people with mental illness remains unclear. A problem with exercise studies generally, and particularly for those conducted in mental health settings, is the poor reporting of exercise intervention parameters such as the frequency, intensity, time and type (FITT) of exercise utilised<sup>18</sup>. This makes comparisons between studies difficult, and translation of the findings to the ‘real world’, almost impossible.

Despite this research limitation, there have been a number of attempts to summarise the FITT exercise program variables based on studies which result in positive outcomes. For depression, a program of at least nine weeks duration, comprising low to moderate, or participant-preferred intensity, supervised aerobic exercise such as walking, cycling or cross trainer exercise, in either group, individual or combined formats, performed three to four times weekly, with sessions lasting 30 to 40 minutes, is likely to improve symptoms<sup>26</sup>. For people with schizophrenia and related disorders, a group-based program of at least 12 weeks of aerobic exercise such as treadmill walking or cycling, performed for 30 to 40 minutes per session and undertaken three times weekly appears to be effective<sup>25</sup>.

**“... there are significant barriers to the prescription and uptake of exercise as a treatment for individuals with mental illness.”**

The appropriate exercise intensity, the effect of supervision, and the impact of group versus individual exercise programs remain unclear. However, based on the exercise guidelines for healthy individuals, ‘moderate’ intensity exercise might be a useful recommendation and is supported by the exercise and mental health literature<sup>34</sup>. Programs similar to those advocated for depression are likely to be effective for post-natal depression<sup>35</sup>, while more frequent exercise may be more effective in people with bipolar disorder<sup>36</sup>. However, clinicians should be cautious when prescribing exercise for people with bipolar disorder since exercise during periods of mania may result in overexertion or injury<sup>37,38</sup>. The table below outlines the current exercise recommendations based on the FITT principles for people with mental illness. It is important to remember that, unlike exercise recommendations for the general population, these guidelines are based on a small number of studies, often with a small numbers of participants. People with mental illness are often highly sedentary, and recent reviews suggest that mental and physical health benefits may be derived from substantially less activity<sup>39</sup>. Moreover, given the association between aerobic capacity and global functioning in people with schizophrenia<sup>40</sup>, even a modest increase in exercise may lead to improved functioning in this population.

As shown in Table 1, the exercise recommendations for people with mental illness are not vastly different from those for the general population<sup>15</sup>. Thus, while the benefits of exercise for people with mental illness are becoming more well-accepted, and people with mental illness acknowledge the value of this underutilised treatment strategy<sup>41,42</sup>, there are significant barriers to the prescription and uptake of exercise as a treatment for individuals with mental illness.

**Table 1. Applying the FITT principles of aerobic exercise prescription to people with mental illness.**

Condition	Frequency (weekly)	Intensity	Time	Type
Depression	3–4 times	Low-moderate or patient preferred	30–40 min	Any aerobic activity
Schizophrenia	3 times	Moderate	30–40 min	Any aerobic activity
Post-natal depression	3 times	Moderate	40 min	Pram-walking
Bipolar disorder	5–7 times	Moderate	30 min	Not reported

## The need for a multidisciplinary approach

In a study of Australian psychologists<sup>43</sup>, a significant proportion of respondents were confident with providing exercise advice and physical activity counselling to patients, and reported doing so on a routine basis. However, they were less confident with monitoring exercise and tailoring advice to the individual patient. A more recent study of Australian health professionals including General Practitioners, Psychologists and Psychiatrists<sup>44</sup> confirmed the support of clinicians for physical activity and exercise in the treatment of mental illness, but did not consider the delivery of exercise to consumers. Australian General Practitioners, as in other parts of the world, are supportive of the role exercise may play in the treatment of mental illness, however a lack of familiarity with exercise prescription guidelines and the strong reliance on pharmacotherapy might impede the delivery of exercise in primary care settings<sup>45</sup>. Interestingly, the personal exercise habits of medical practitioners is an independent predictor of exercise prescription practices<sup>46,47</sup>. As such, targeted interventions aimed at increasing exercise adoption in mental health professionals might serve to subsequently improve exercise delivery to mental health consumers.

**“... our failure to provide affordable, accessible and sustainable exercise programs to mental health consumers only serves to widen the health service disparity experienced by those with mental illness.”**

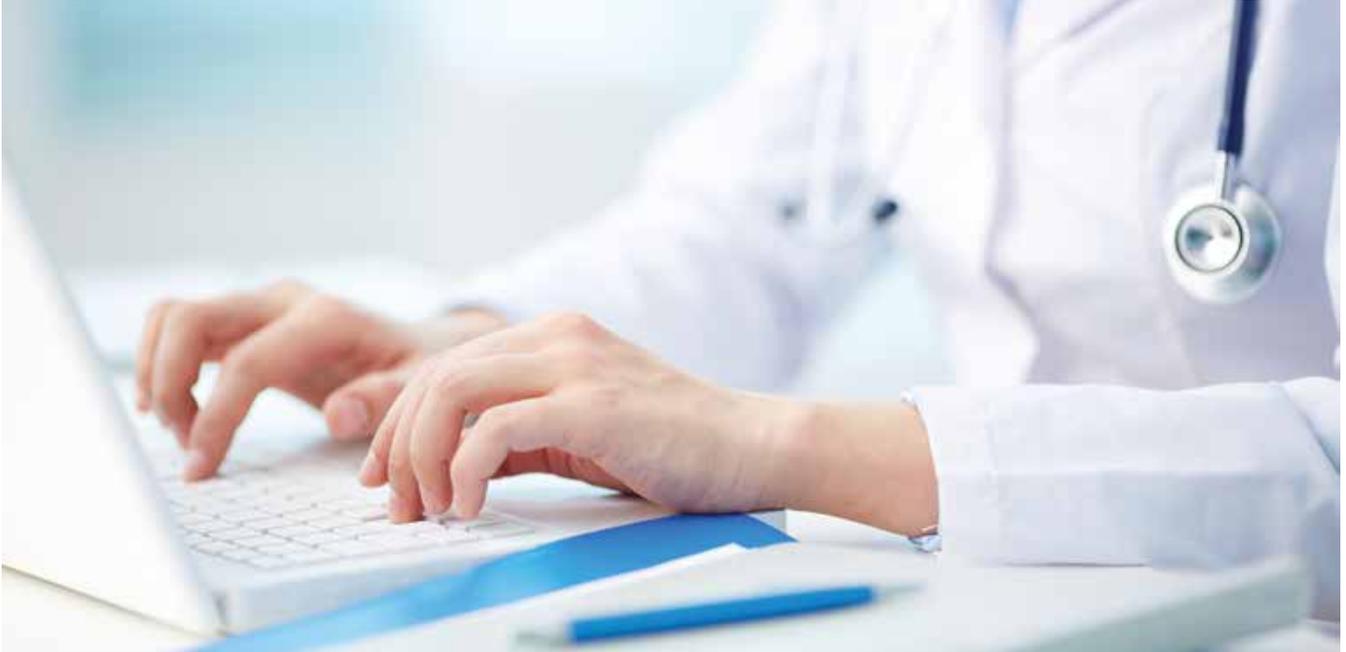


**“... some studies show exercise to be as effective as medication or psychological interventions.”**

There are also significant barriers to physical activity and exercise prescription experienced by mental health consumers. For example, psychiatric symptoms, medication side effects, fatigue, low motivation and a lack of enjoyment are all issues to be addressed when developing programs<sup>48-50</sup>. At a practical level, mental health consumers also experience barriers to exercise participation such as cost, lack of transport, limited access to exercise resources, low perceived exercise capacity, stigma, poor physical health, injury, no clothing or equipment with which to undertake, and low priority for physical health care.

**“... the personal exercise habits of medical practitioners is an independent predictor of exercise prescription practices.”**

Given the above barriers to delivery and uptake of exercise by mental health consumers, there is a need to develop an integrated, multidisciplinary service model which facilitates easy and affordable access to exercise. In inpatient mental health settings, nurses are arguably best placed to deliver exercise programs to this population as a result of the level of contact and therapeutic relationships with consumers. However in practice, personal barriers such as lack of training in exercise prescription and counselling, and organisational barriers such as competing interests and lack of resources make the delivery of exercise interventions difficult<sup>51</sup>. Accredited Exercise Physiologists (AEPs) play an important role in the Australian healthcare system by providing individualised exercise interventions to individuals with chronic and complex health problems. This extends to people with mental illness and is supported with evidence from multiple studies<sup>52,53</sup>. Exercise & Sports Science Australia (ESSA) hosts a mental health Special Interest Group, focused on the promotion of AEP-delivered exercise in the prevention and treatment of mental illness. Referrals to AEPs under Medicare or Department of Veterans' Affairs schemes in Australia offer an opportunity for those with mental illness to access low- or no cost services. Unfortunately, the utilisation of this group of health professionals, has, to date, been poor<sup>54,55</sup>. Internationally, physiotherapists are more widely recognised as the peak provider of physical activity and exercise programs for mental health consumers, particularly in the hospital setting<sup>56</sup>. Although the placement of physiotherapists in mental health settings in Australia is not as widespread as in other parts of the world, their potential role in the delivery of exercise intervention must be considered. Embedding AEPs in hospital and community



care services such as *Headspace* (national youth mental health service) and community mental health settings might overcome many of the barriers to exercise delivery experienced by mental health consumers in Australia. There has also been a call for the continued utilisation of *Medicare* and other government-funded schemes in Australia to improve access to exercise services for mental health consumers<sup>57</sup>.

## Summary and closing comments

As so eloquently stated by Booth and colleagues<sup>58</sup>, “... we know of no single intervention with greater promise than physical exercise to reduce the risk of virtually all chronic diseases simultaneously” (p.778). Exercise has been shown to have considerable benefits for many mental illnesses with few adverse events or negative side-effects. It is well tolerated and well accepted by consumers. Arguably, our failure to provide affordable, accessible and sustainable exercise programs to mental health consumers only serves to widen the health service disparity experienced by those with mental illness. There is an urgent need for researchers in the exercise and mental illness field to heed the guidelines for reporting details of exercise interventions<sup>59</sup> and to extend the findings of these studies to the ‘real world’ within both clinical and community settings. A consumer-centered, multidisciplinary approach that includes both clinical and community partners is needed to effectively develop and deliver exercise programs which meet the individual preferences and needs of the mental health consumer.

**“Mental illness costs the health care system approximately \$7 billion and results in around \$6 billion in lost productivity annually.”**

### About the authors

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References, as indicated within the article, are available at [sma.org.au/publications/sport-health](http://sma.org.au/publications/sport-health)

## Glasgow 2014 Commonwealth Games Medical Program



Aussie Physios in Glasgow: L-R Andrew McGough, Mark Brown and Keren Faulkner.

### SMA Queensland Branch Executive Officer and Sports Physiotherapist, Mark Brown reports on the Glasgow 2014 Commonwealth Games Medical Program.

I was fortunate enough to attend the Glasgow 2014 Commonwealth Games to observe the host nation medical program as part of a small delegation organised by Griffith University, with a view to the forward planning of the 2018 Gold Coast Commonwealth Games. Whilst there I also worked as a physiotherapist for a few days in the Commonwealth Games Village with Team Papua New Guinea, who both Sports Medicine Australia and Griffith University have been assisting in recent times with training their medical team and coaching staff.

In total the Glasgow medical program included 84 medical service facilities consisting of the main Polyclinic in the Commonwealth Games Village, two smaller satellite polyclinics for two competition venues outside Glasgow, and 35 athlete medical rooms and 46 first aid rooms located in the actual competition and training venues.

**“With the unusually warm and sunny weather experienced by Glasgow for the early part of the Games many spectators visited the first aid services though generally only to seek shade, water and sunscreen.”**

Medical services were provided by 1,400 volunteers including 309 Doctors, 308 Physiotherapists, 129 Sports Massage Practitioners, 86 Nurses, 20 Dentists, 12 Dental Nurses and Hygienists, 18 Pharmacists, 12 Optometrists, 12 Podiatrists, and 320 First Aiders. All medical volunteers were recruited from the UK which circumvented the need for any special arrangements to be made regarding health professional registration of overseas volunteers. (Thanks to Liz Mendl, the Glasgow 2014 General Manager of Medical Services and Anti-Doping for providing this information and to whom great credit must go to for the excellent organisation of the medical program which was abundantly apparent while visiting some of the venues).

The main Polyclinic in the Commonwealth Games Village was housed in a temporary facility; essentially a high tech air conditioned tent with solid walls and flooring that was divided into several separate waiting areas and consultation rooms. The Polyclinic layout was broadly divided into two sections – Emergency/General Medicine and Sport and Exercise Medicine. As well as the Doctors and Nurses who were the first point of contact in both of these two sections also located in the Polyclinic was a pharmacy, physiotherapy/massage therapy, a small recovery centre with inflatable and stand up hot and cold immersion baths, a dental consultation room, optometry and podiatry. Imaging services were comprehensive with X-Ray, Ultrasound, CT and MRI also available on site.

Venue medical services at the competition venues included both athlete care medical services provided by doctors, physiotherapists and massage therapists, as well as spectator care services provided by nurses and other first aid personnel and ambulance services. The equipment levels for these spectator care services was substantial with all featuring one or more dedicated treatment areas, each with comprehensive first aid equipment including an Automated External Defibrillator. With the unusually warm and sunny weather



Physiotherapist Shaun Clark with Team PNG.



Bright sunny conditions had many spectators looking for shade, water and sunscreen.



The Polyclinic and gym in the Commonwealth Games Village.



Mobile MRI, CT and US imaging services at the Polyclinic.

experienced by Glasgow for the early part of the Games many spectators visited the first aid services though generally only to seek shade, water and sunscreen.

In keeping with everything else associated with the Glasgow Games, the medical program appeared well organised with efficient and friendly staff. Great attention to detail was evident in not only the medical program, as transport and security arrangements ran smoothly at all of the venues and through the city generally. Combined with the good weather and an interesting and attractive city with both a great history and a positive sense of purpose all of the elements added up to a first class Commonwealth Games and a great experience for all involved.

## ‘Being there’: Sports Trainers and depression in athletes



**Matthew Pearce, Head Trainer/Myotherapist at the AFL Richmond Football Club and the AFL Trainers Association President provides sports trainers with advice on how to tackle depression in athletes.**

In the eyes of many, our athletes are superheroes who don't seem to be susceptible to the issues that you or I face in day to day life. In my experience this could not be further from the truth.

The pressures of elite sport affect many of our athletes in various ways – some thrive in this type of environment and others will track down a different path resulting in them suffering (sometimes silently) from the effects of depression.

This is no different to the weekend warrior, you can almost guarantee that at least one of your player/players is, or has suffered from depression or mental illness.

Thankfully, in the current climate there is a lot more awareness and education around mental health issues and how to deal with these.

So the question is, how as a sports trainer can we effectively help identify these issues and also ‘be there’ to support our athletes during these times.

At an elite level we're incredibly lucky to have an enormous amount of support for our athletes in all areas, including player welfare. At a local level this level of professional support is generally less but that doesn't mean that the players don't face the same problems. As a sports trainer at local level we all know that you are the ‘jack of all trades’, often playing a larger role than just that of a sports trainer. And as a result

there is a large amount of trust between the player and trainer. Your players will generally talk to you before anyone else about what's going on in their lives, and at times this is where you can help to recognise that what may be going on with them is more than ‘just a bad day’.

**“... how as a sports trainer can we effectively help identify these issues and also ‘be there’ to support our athletes during these times.”**

The signs and symptoms of depression can vary from one person to another, and some of these symptoms may be part of a normal ‘low’ within our lives. But if someone is displaying several of these and they do not seem to be going away or getting stronger then this is when that little red flag should be going off in your brain.

- **Lack/loss of energy** – Even doing the smallest task may seem exhausting or they may feel mentally and physically fatigued a lot of the time.
- **Irritability or anger** – Sometimes a person who is completely rational will start displaying a short temper or acting like everything ‘gets on their nerves’.
- **Strong feelings of worthlessness or strongly criticising your faults/mistakes** – being angry or disappointed with a mistake can be extremely normal in sport, but if the athlete is doing this more or an athlete who doesn't normally do this starts doing it regularly this can be another indicator.

- **Weight changes** – Unexplained significant weight loss or gain.
- **Withdrawing or loss of interest** – A loss of interest in favorite hobbies/pastimes or social activities or not wanting to be involved in social activities.
- **Aches and pains** – Aches and pains are completely normal in sports, however if an athlete starts presenting with headaches, back pain, muscular aches and pains, stomach pains that cannot be attributed to any other cause then again this may be an indicator of something going on. This has been a sign that I have personally noticed in previous dealings with athletes who were suffering from undiagnosed clinical depression.
- **Lack of concentration**
- **Reckless behaviour** – Athletes engaging in ‘reckless’ behaviour or behaviours that are not normal for that person is also a sign that something may be going on.

**“As a sports trainer at local level we all know that you are the ‘jack of all trades’, often playing a larger role than just that of a sports trainer.”**



Experience tells us that if you notice some of these signs and symptoms and ask an athlete “How are you?” the standard answer will generally be ‘good’ or ‘I’m alright’ even when this may not be the case.

If you are concerned about one of your athletes try starting a conversation with them in a one-on-one situation using some of the following statements.

- I’ve noticed some differences in you/your behaviour lately and was wondering how you are going/doing?
- You have seemed a bit flat/down lately, is everything ok?
- Hey I’ve been a bit concerned about you lately because...

If you get a response from the athlete in that they start to open up, then you can follow up with the following questions.

- When did you start feeling like this?
- What happened to make you start feeling this way?
- How can I, or the club, help you?
- Have you thought about or tried getting help for this? (The Life Line help line [13 11 14, available 24 hours/7 days a week] or the Beyond Blue website [www.beyondblue.org.au](http://www.beyondblue.org.au) or phone line 1300 224 636 are a good starting point).

It’s extremely important that you continue to provide a compassionate and supportive environment for your athlete throughout these times, and at all costs avoid telling them things like ‘It’s all in your head’ or ‘We all go through times like these’.

Once this dialogue is started then in my experience you’re well on your way to helping this person head down the right track in terms of dealing with their problems.

In conclusion, just by being aware of your players and understanding the signs and symptoms of depression then you’ll have some of the tools necessary to deal with any situations that may arise in your club.

And please remember two very important points

1. You alone cannot fix someone’s depression.
2. Please look after yourself – dealing with these issues can be draining for you as well.

#### **About the author**

##### **Matthew Pearce**

Head Trainer/Myotherapist, Richmond Football Club  
AFL Trainers Association President

## Discipline group news and events

### Australasian Academy of Podiatric Sports Medicine (AAPSM)

#### News:

AAPSM are calling for grant applications for the AAPSM Research Grant. The AAPSM research grant is an initiative to promote and assist sports podiatry research in Australia. The purpose of the research grant is to provide financial support for sports podiatry research, as well as to encourage the dissemination and promotion of research findings within the sports medicine community. Funds can only be allocated to an approved Australian research or public institution.

To obtain a copy of the guidelines and application form, visit [www.aapasm.org.au](http://www.aapasm.org.au), visit the AAPSM Facebook page or email [admin@aapasm.org.au](mailto:admin@aapasm.org.au). The deadline is May 1, 2015.

**For more information visit [www.aapasm.org.au](http://www.aapasm.org.au)**

### Sports Dietitians Australia (SDA)

#### News:

Once again, SDA was delighted to be part of the be active 2014 conference in Canberra. Congratulations to SMA on a fantastic event! At our stand, we took the opportunity to canvas delegates on their perceptions of sports dietitians and how they work (or don't work) with them. It's always insightful to get other people's impressions of our industry and what we do.

SDA continues to collaborate with SMA and ESSA in the development of a flow chart to help educate community sporting clubs on the complexities of supplements and their appropriate administration by suitably qualified health professionals. Our aim is a creative poster which guides a club's thinking and decision making on the 'what, how and who' of supplements in their club. Our work was presented at the Play by the Rules Supplements Forum in November.

The new year will also bring with it a new website and we're getting excited! Happy holidays from us all at SDA.

**For more information visit [www.sportsdietitians.com.au](http://www.sportsdietitians.com.au)**

### Sports Doctors Australia (SDrA)

#### News:

This year has consisted of looking at and deciding on the future direction of SDrA. The committee has been provided with wonderful feedback from members via a questionnaire sent earlier in the year. SDrA was also involved in a joint meeting of BJSM society groups from around the world, all of whom are trying to provide the best for their members and the sports medicine community in general. SDrA will look to implement some of the changes that have arisen from the questionnaire. Watch this space for further information.

SDrA was once again actively involved in education at the be active 2014 conference, as well as the GP14 conference. Areas covered included a clinical update and workshop on shoulders (that is put together as an active learning module for GP sports doctors). We are also organising a symposium on supplements in sport.

Following the AGM in Canberra (held alongside the SMA conference) SDrA is looking forward to making changes to how we provide information and service to our members.

**For more information visit [www.sportsdoctors.com.au](http://www.sportsdoctors.com.au)**

### Sports Physiotherapy Australia (SPA)

#### News:

SPA has just finished a successful national tour with American orthopaedic surgeon Ben W Kibler. Dr Kibler presented in six locations around the country in September.

SPA would also like to thank SMA for once again organising a content-packed conference in Canberra in October. The sports component was well received by the physiotherapists that attended from SPA.

#### Upcoming events:

APA Conference, early October 2015, Gold Coast.

**For more information and to access the extensive SPA PD calendar visit [www.physiotherapy.asn.au](http://www.physiotherapy.asn.au)**

## The *Journal of Science and Medicine in Sport* podcasts

Did you know that the *Journal of Science and Medicine in Sport* (JSAMS) offers podcasts highlighting particular issues and papers available through a series of interviews with authors, researchers, and practitioners?



### The SMA CEO podcast series

In the first *Journal of Science and Medicine in Sport* podcast led by Sports Medicine Australia CEO Nello Marino, Professor Ian Rogers from St John of God Murdoch Hospital and the University of Notre Dame discusses a piece of research he co-authored examining whether oral

or intravenous administration of hypertonic saline is more effective for treating runners with hyponatremia.

Exercise associated hyponatremia is one of the most serious medical consequences of endurance sport. If left untreated, severe exercise associated hyponatremia can result in serious medical complications and be potentially life-threatening.

To listen to this podcast and for more in the SMA CEO podcast series visit [www.jsams.org](http://www.jsams.org)

### JSAMS podcasts also available:

- Population estimates of Australian children's exposure to food and beverage sponsorship of sports clubs.
- The effect of ankle taping or bracing on proprioception in functional ankle instability: A systematic review and meta-analysis.
- Exercise prescription for patients with type 2 diabetes and pre-diabetes: A position statement from Exercise & Sport Science Australia.
- Re-examination of the post half-time reduction in soccer work-rate.
- Biological maturity influences running performance in junior Australian football.
- Association between post-game recovery protocols, physical and perceived recovery, and performance in elite Australian Football League players.
- Evaluating the influence of different modes of administration of a pre-exercise screening tool.



## Vale John Hart



John Hart completed his medical degree at the University of Melbourne graduating MB BS, but went on to specialise and became an eminent orthopaedic surgeon.

John entered academic life in the Anatomy Department at Monash University where he carried out early research using the electron microscope to investigate articular

cartilage in guinea pigs and became a Lecturer in the Anatomy Department.

He returned to the clinical field as a Registrar in General Surgery at The Alfred Hospital where he obtained his fellowship of the Royal Australasian College of Surgeons in 1969. He then worked in orthopaedics before winning a fellowship to the prestigious Nuffield Orthopaedic Centre in Oxford where he studied orthopaedics for three years. During that time he developed an interest in sports medicine and was the doctor for Oxford United who were in the 2nd division of the National Football League in England at that time.

John returned to Melbourne in 1972 and held positions in the Department of Surgery and as an Orthopaedic Surgeon at the Alfred and Prince Henry's Hospitals. In 1975 he was appointed as a Visiting Orthopaedic Surgeon at the Alfred and left Prince Henry's.

He was President of the Victorian branch of the Australian Sports Medicine Federation from 1981–1983, made an ASMF Fellow in 1984 and became National President in 1985. He was made a life member of the Australian Sports Medicine Federation in 1991 and an honorary fellow of the Australian College of Sports Physicians in 1993. During this period he was orthopaedic surgeon to a number of AFL teams in Melbourne and attended the Calgary Winter Olympics in 1988.

John Hart became involved in the Australian Orthopaedic Association and was a member of the Victorian Board of Studies, became chairman of the Victorian Branch in 1991, a member of the National Executive in 1992 and chaired the national Continuing Orthopaedic Education Committee. He was elected President in 1998. He was a foundation member of the Australian Knee Society and its President in 1990.

He was also on the editorial board of *The Journal of Arthroplasty* and *The Knee* and has sat on a number of government committees related to musculoskeletal disease. He was a member of the National Arthritis and Musculoskeletal Conditions Advisory Group (NAMSCAG) and the founding chairman of the Victorian Orthopaedic Research Trust Board which supports orthopaedic research in Victoria. He has served on the Orthopaedic Board of the Royal Australasian College of Surgeons and is an examiner in orthopaedics for the College.

**We extend our deepest condolences to John Hart's family and loved ones.**

Source: Information from <http://www.mhsoba.org.au/news/john-arthur-lewis-hart> by Alan Gregory AM

## Sports Physiotherapy in New Zealand now has a code of conduct



**Dr Lynley Anderson, Senior Lecturer of the Bioethics Centre of the University of Otago highlights the newly launched Sports Physiotherapy NZ Code of Conduct.**

The Sports Physiotherapy New Zealand (SPNZ) special interest group of Physiotherapy NZ now has its own code of conduct (*SPNZ Code of Conduct 1*). This new code does not displace the overarching code for all physiotherapists in New Zealand (*Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct*), but seeks to apply the principles of that code to the sporting environment.

**“In creating a document such as this we feel we are providing useful guidance and support for sports physiotherapists in New Zealand, but also because, as far as we know, this may well be the first code of conduct for sports physiotherapists in the world.”**

In initiating the creation of a code, Sports Physiotherapy New Zealand recognised that sports physiotherapists face complex issues in the delivery of physiotherapy services in sport. As sports physiotherapists will be aware, coaches, athletes, fans and others may have priorities and objectives that strongly differ from those held by a physiotherapist. These differences may result in pressure being placed

on a physiotherapist that encourages them to deviate from standard clinical practice and traditional obligations to the welfare of the patient. These pressures may place the sports physiotherapist in difficult situations and one where there has traditionally been a lack of guidance.

Some might argue that sports physiotherapy do not need their own code, but should refer to the *Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct*. However the *Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct* is an overarching document and is designed to give general guidance on situations common to most areas of clinical practice. As such, it will not have the capacity for expanding into specific areas. Also, due to the complex nature of sport described earlier, SPNZ considered that further assistance is required specifically for this group. Having their own code also allows for the provision of material that is specific to the sporting arena and as such, is not relevant to physiotherapists working in other areas. This includes guidance on performance enhancing drugs and fair play in sport. The *Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct* remains the document for general guidance, but for specific guidance on sporting matters, a physiotherapist would be advised to access the SPNZ Code of Conduct.



Following a decision to develop a code of conduct specific for SPNZ, a small group of senior sports physiotherapists (Dr Angela Cadogan, Dr Tony Schneiders, and Michael Borich) met with myself (Dr Lynley Anderson) on a regular basis to progress the development of the code. Once the code was in draft form, legal advice was provided by Dr Jeanne Snelling (University of Otago). The first draft was sent out to stakeholders for consultation in the latter half of 2013; changes were made in response to that process.

The newly launched *Sports Physiotherapy NZ Code of Conduct* has some specific purposes. This code expresses the shared values of the group. It can be used as a shield to protect physiotherapists from demands from coaches and others who may expect the physiotherapist to act contrary to the values of the profession. Because the code spells out the standard of behaviour expected of physiotherapists working in the area, the code can be used to judge the actions of members who are considered to be acting outside the established parameters.

**“It can be used as a shield to protect physiotherapists from demands from coaches and others who may expect the physiotherapist to act contrary to the values of the profession.”**

This code of conduct, like other professional guidelines and codes, gains its status through endorsement by the profession but also through the *New Zealand Code of Health and Disability Services Consumers' Rights*. Right 4 of this document states that ‘Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards’. This means that if a complaint is made to the Health and Disability Commissioner about the actions of a sports physiotherapist, the Commissioner will refer to codes expressed by the profession to judge the professional's actions.

There are some particular highlights in the SPNZ Code of Conduct including:

- Good patient care: Including working with children; and people with mental health issues.
- Relationships with patients: including communication; and acting professionally in social situations with patients.
- Employment structure and relationships: including dealing with contractual demands; working in good faith with employers.
- Confidentiality and privacy: including guidance regarding sharing health information with others; and providing care in public spaces.
- Scope of practice: including working under standing orders when carrying and distributing medications in the absence of a doctor.
- Risk taking: including responsibilities and guidance for how to respond when athletes wish to take risks to their health.
- Fair play in sport: including banned performance enhancing substances; honesty and integrity.

The launch of the new SPNZ Code of Conduct document is cause for celebration for two reasons. In creating a document such as this we feel we are providing useful guidance and support for sports physiotherapists in New Zealand, but also because, as far as we know, this may well be the first code of conduct for sports physiotherapists in the world. The authors of this code consider that this code should undergo a regular cycle of review to ensure it is up-to-date and useful to practitioners and their patients.



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