WORKSHOP: IMPLEMENTING BEST PRACTICES TO SUPPORT KEY STUDENT-ATHLETE HEALTH AND SAFETY INITIATIVES

NCAA Sport Science Institute

#NCAACONV
SSI Mission

To promote and develop safety, excellence and wellness in college student-athletes, and to foster life-long physical and mental development.

SSI Vision

To be the pre-eminent sport science voice for all student-athletes and NCAA member institutions, and to be the steward of best practices for youth and intercollegiate sports.
Strategic Priorities

Cardiac health
Concussion
Doping and substance abuse
Mental health
Nutrition, sleep and performance
Overuse injuries and periodization
Sexual assault and interpersonal violence
Athletics healthcare administration
Data-driven decisions

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PRESENTATION 1:
THE CONCUSSION PROTOCOL REVIEW PROCESS:
A STATUS UPDATE AND FUTURE DIRECTIONS

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NEW YORK UNIVERSITY SCHOOL OF MEDICINE
History of Concussion Legislation

• “Diagnosis and Management of Sport-Related Concussion Guidelines”
  – Resulted from the January 2014 Safety in College Football Summit.
  – Endorsed by 11 prominent medical organizations.
  – A template for inter-association consensus.

Guidelines Endorsements

• American Academy of Neurology
• American College of Sports Medicine
• American Association of Neurological Surgeons
• American Medical Society for Sports Medicine
• American Orthopaedic Society for Sports Medicine
• American Osteopathic Academy for Sports Medicine
• College Athletic Trainers’ Society
• Congress of Neurological Surgeons
• National Athletic Trainers’ Association
• NCAA Concussion Task Force
• Sports Neuropsychological Society
• American Football Coaches Association
• Football Championship Subdivision Executive Committee
• National Association of Collegiate Directors of Athletics
• National Football Foundation
Concussion Diagnosis and Management

• Education.
• Pre-participation assessment: one-time:
  – Brain injury/concussion history.
  – Symptom evaluation.
  – Cognitive assessment.
  – Balance evaluation.
  – Team physician determines pre-participation clearance.
• Recognition and diagnosis.
• Post-concussion management.
• Return to activity:
  – Return-to-play.
  – Return-to-learn.

2010 Legislation

An active member institution shall have a concussion management plan for its student-athletes. The plan shall include, but is not limited to, the following: (Adopted: 8/12/10)

(a) An annual process that ensures student-athletes are educated about the signs and symptoms of concussions. Student-athletes must acknowledge that they have received information about the signs and symptoms of concussions and that they have a responsibility to report concussion-related injuries and illnesses to a medical staff member;

(b) A process that ensures a student-athlete who exhibits signs, symptoms or behaviors consistent with a concussion shall be removed from athletics activities (e.g., competition, practice, conditioning sessions) and evaluated by a medical staff member (e.g., sports medicine staff, team physician) with experience in the evaluation and management of concussions;

(c) A policy that precludes a student-athlete diagnosed with a concussion from returning to athletics activity (e.g., competition, practice, conditioning sessions) for at least the remainder of that calendar day; and

(d) A policy that requires medical clearance for a student-athlete diagnosed with a concussion to return to the athletics activity (e.g., competition, practice, conditioning sessions) as determined by a physician (e.g., team physician) or the physician’s designee.
FBS-Autonomy Legislation

• Submit Concussion Safety Protocol to Committee by May 1.
  – Protocol shall be c/w: “Inter-Association Consensus: Diagnosis and Management of Sport-Related Concussion Guidelines.”
• Policies/procedures c/w Constitution (2010).
• Procedures for preparticipation baseline testing of each s-a.
• Procedures for reducing exposure to head injuries.
• Procedures for education, including return-to-learn.
• Procedures for appropriate management, c/w Guidelines.
• Procedures for ID/removal from game or practice are reviewed annually.
• Written certificate of compliance from AD.
• Provide information to Committee upon request.

Concussion Safety Protocol Committee

• Primary role is to serve as advocate.
• Timeline for submission and resolution by July 31.
• Development of “Checklist.”
• No review of individual concussion cases, but of protocols only.
**Pre-Season Education:**

Education management plan that specifies:

- Institutions have provided NCAA concussion fact sheets (NCAA will make material available) or other applicable material annually to the following parties:
  - Student-athletes.
  - Coaches.
  - Team physicians.
  - ATCs.
  - Directors of athletics.
- Each party provides a signed acknowledgement of having read and understood the concussion material.

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**Pre-Participation Assessment:**

Pre-participation management plan that specifies:

- Documentation that each varsity student-athlete has received at least one pre-participation baseline concussion assessment, that addresses:
  - Brain injury and concussion history.
  - Symptom evaluation.
  - Cognitive assessment.
  - Balance evaluation.
- Team Physician determines pre-participation clearance and/or the need for additional consultation or testing.*

*Consider a new baseline concussion assessment six months or beyond for any varsity student-athlete with a documented concussion, especially those with complicated or multiple concussion history.*
Recognition and Diagnosis of Concussion:

Recognition and diagnosis of concussion management plan that specifies:

☐ Any student-athlete with signs/symptoms/behaviors consistent with concussion:
  ☐ Must be removed from practice or competition.
  ☐ Must be evaluated by ATC or team physician with concussion experience.
  ☐ Must be removed from practice/play for that calendar day if concussion is confirmed.

Initial suspected concussion evaluation management plan that specifies:

☐ Symptom assessment.
☐ Physical and neurological exam.
☐ Cognitive assessment
☐ Balance exam.
☐ Clinical assessment for cervical spine trauma, skull fracture and intracranial bleed.
Post-Concussion Management:

Post-concussion management plan that specifies:

- Emergency action plan, including transportation for further medical care, for any of the following:
  - Glasgow Coma Scale < 13.
  - Prolonged loss of consciousness.
  - Focal neurological deficit suggesting intracranial trauma.
  - Repetitive emesis.
  - Persistently diminished/worsening mental status or other neurological signs/symptoms.
  - Spine injury.

- Mechanism for serial evaluation and monitoring following injury.
- Documentation of oral and/or written care to both student-athlete and another responsible adult.*

*May be parent or roommate.

Evaluation by a physician for student-athlete with prolonged recovery in order to consider additional diagnosis* and best management options.

*Additional diagnoses include, but are not limited to:

- Post-concussion syndrome.
- Sleep dysfunction.
- Migraine or other headache disorders.
- Mood disorders such as anxiety and depression.
- Ocular or vestibular dysfunction.
Return to Play:

Return-to-Play management plan that specifies:

☐ Final determination of return-to-play is from the team physician or medically qualified physician designee.

☐ Each student-athlete with concussion must undergo a supervised stepwise progression management plan by a health care provider with expertise in concussion that specifies:

☐ Student-athlete has limited physical and cognitive activity until he/she has returned to baseline, then progresses with each step below without worsening or new symptoms:

☐ Light aerobic exercise without resistance training.

☐ Sport-specific exercise and activity without head impact.

☐ Non-contact practice with progressive resistance training.

☐ Unrestricted training.

☐ Return-to-competition.

Return-to-Learn:

Return-to-learn management plan that specifies:

☐ Identification of a point person within athletics who will navigate return-to-learn with the student-athlete.

☐ Identification of a multi-disciplinary team* that will navigate more complex cases of prolonged return-to-learn:

*Multi-disciplinary team may include, but not be limited to:

- Team physician.
- Athletic trainer.
- Psychologist/counselor.
- Neuropsychologist consultant.
- Faculty athletic representative.
- Academic counselor.
- Course instructor(s).
- College administrators.
- Office of disability services representatives.
- Coaches.
Compliance with ADAAA.

No classroom activity on same day as concussion.

Individualized initial plan that includes:

- Remaining at home/dorm if student-athlete cannot tolerate light cognitive activity.
- Gradual return to classroom/studying as tolerated.

Re-evaluation by team physician if concussion symptoms worsen with academic challenges.

Modification of schedule/academic accommodations for up to two weeks, as indicated, with help from the identified point-person.

Re-evaluation by team physician and members of the multi-disciplinary team, as appropriate, for student-athlete with symptoms > two weeks.

Engaging campus resources for cases that cannot be managed through schedule modification/academic accommodations.

Such campus resources must be consistent with ADAAA, and include at least one of the following:

- Learning specialists.
- Office of disability services.
- ADAAA office.
Reducing Exposure to Head Trauma:

☐ Reducing head trauma exposure management plan.*

*While the Committee acknowledges that ‘reducing’ may be difficult to quantify, it is important to emphasize ways to minimize head trauma exposure. Examples of minimizing head trauma exposure include, but are not limited to:

Adherence to Inter-Association Consensus: Year-Round Football Practice Contact Guidelines.

Adherence to Inter-Association Consensus: Independent Medical Care Guidelines.

Reducing gratuitous contact during practice.

Taking a ‘safety first’ approach to sport.

Taking the head out of contact.

Coaching and student-athlete education regarding safe play and proper technique.

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Administrative:


*Please submit plan directly to Brian Hainline, NCAA Chief Medical Officer

☐ Written certificate of compliance signed by director of athletics that accompanies submitted plan.
FBS-Autonomy Status

- All 65 schools approved by July 31 deadline.
- All protocols posted on webpage:

DI Opt-in Status

- Submission through October 1.
- Review and report within 8 weeks of receipt.
- 138 schools opted-in.
  - 22 have met ‘Checklist’ requirements.
The Future

• Second Safety in College Football Summit:
  – Feb 10-11, 2016, Orlando.

• Developing a mechanism/process to standardize and assure quality in athletic healthcare delivery across the association.

Presentation 2:
Mental Health Best Practices

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DAWN BUTH, M.P.A
NCAA SPORT SCIENCE INSTITUTE
ASSOCIATE DIRECTOR FOR STRATEGIC COMMUNICATION AND EDUCATION
NCAA believes . . .

- That Mental Health is not apart from, but rather a part of athlete health.

- To promote health is to enhance performance.

- That sport specific issues must be addressed, engaging a wide range of experts.

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**Student-Athlete Fatalities 2004-2009**

- Accidents 51%
- Cardiac 16%
- Cancer 7%
- Suicide 9%
- Other Medical 3%
- Drug Overdose 2%
- Sickle Cell Trait 2%
- Homicide 6%
- Heat Stroke 1%
- Meningitis 1%
- Unknown 2%

*(Circulation. 2011;123:1594-1600.)*
### Mental Health - NCHA

<table>
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<tr>
<th></th>
<th>STUDENT-ATHLETES</th>
<th>NON-ATHLETES</th>
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<tr>
<td>Felt so depressed that is was difficult to function (Yes, in last 12 months)</td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>21% (1,680)</td>
<td>27%</td>
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<tr>
<td>Female</td>
<td>27% (3,459)</td>
<td>34%</td>
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<tr>
<td>Felt overwhelming anxiety (Yes, in last 12 months)</td>
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<tr>
<td>Male</td>
<td>32% (2,588)</td>
<td>41%</td>
</tr>
<tr>
<td>Female</td>
<td>49% (6,152)</td>
<td>57%</td>
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The opinions, findings, and conclusions presented/reported in this article/presentation are those of the author(s), and are in no way meant to represent the corporate opinions, views, or policies of the American College Health Association (ACHA). ACHA does not warrant nor assume any liability or responsibility for the accuracy, completeness, or usefulness of any information presented in this article/presentation.

### Aggressive Behavior in the last 12 months – NCHA

<table>
<thead>
<tr>
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<th>Males</th>
<th>Females</th>
<th>Overall</th>
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<tbody>
<tr>
<td></td>
<td>SA</td>
<td>Non-Ath</td>
<td>SA</td>
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<tr>
<td>Been in a physical fight</td>
<td>19%</td>
<td>12%</td>
<td>5%</td>
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<tr>
<td>Been physically assaulted (excluding sexual assault)</td>
<td>7%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Been verbally threatened</td>
<td>33%</td>
<td>28%</td>
<td>17%</td>
</tr>
<tr>
<td>In an emotionally abusive relationship</td>
<td>7%</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>In a physically abusive relationship</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

*highlighted items indicate a statistically significant difference, chi-square, \( p < .01 \)
### 2013 NCAA Substance Use Study

#### Prescription Medication

<table>
<thead>
<tr>
<th>Year</th>
<th>ADHD Medication: Adderall OR Ritalin</th>
<th>Pain Medication: Vicodin, Oxycontin OR Percocet</th>
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<tbody>
<tr>
<td>2009</td>
<td>4.3%</td>
<td>13.2%</td>
</tr>
<tr>
<td>2013</td>
<td>5.8%</td>
<td>18.0%</td>
</tr>
</tbody>
</table>

#### Alcohol

When you drink alcohol, typically how many drinks do you have in one sitting? (Substance Use 2013)

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Division I</td>
<td>Division II</td>
<td>Division III</td>
<td>Division I</td>
</tr>
<tr>
<td>More than 4 drinks</td>
<td>31.9%</td>
<td>32.6%</td>
<td>37.8%</td>
<td>39.6%</td>
</tr>
<tr>
<td>10+ drinks</td>
<td>2.4%</td>
<td>3.2%</td>
<td>3.3%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>
Marijuana Use by Division
(Within the Last 12 Months)

Intersection of Mental Health Concerns and Drug Use

From Maryland College Life Study
### Average Sum of Hours Spent Per Week In-Season on Academic and Athletic Activities in 2010 (GOALS- SA Self-Report)

<table>
<thead>
<tr>
<th></th>
<th>Division I</th>
<th>Division II</th>
<th>Division III</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseball</td>
<td>Men's Basketball</td>
<td>Football (FBS/FCS)</td>
</tr>
<tr>
<td>Ave. Sum</td>
<td>73.7</td>
<td>76.5</td>
<td>81.3</td>
</tr>
<tr>
<td>Ave. Sum</td>
<td>71.8</td>
<td>73.5</td>
<td>74.2</td>
</tr>
<tr>
<td>Ave. Sum</td>
<td>70.4</td>
<td>65.6</td>
<td>71.0</td>
</tr>
</tbody>
</table>

**Note:** Green = 2+ hours less on academics/athletic sum vs. 2006; Red = 2+ hours more on academics/athletic sum vs. 2006.

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### NCAA Mental Health Task Force November 2013

- Clinicians, researchers, advocates, educators, athletics administrators, coaches and student-athletes
- to address emotional health in our student-athletes;
- to advance recommendations and recommend research that support members institutions in meeting their membership obligations to provide a healthy and safe environment for student-athletes
• Personal narratives

• Experts on student-athlete depression, anxiety, eating disorders, substance abuse, gambling

• Stressors on student-athlete mental health: transitions, performance, injury, academic stress, coach relations

• Sexual assault, hazing bullying

• Cultural pressures: African-American student-athletes; Lesbian, Gay, Bisexual and Transgender student-athletes

• Roles & responsibilities of sports medicine staff

• Coaches’ needs and roles

• Models of service

Purpose of Inter-Association Best Practices

• To assure availability and accessibility of appropriate mental health care for all student-athletes, independent of institutional resources

• To create and maintain an environment within the athletics department that de-stigmatizes and promotes help seeking
Mental Health Best Practices
Inter-Association Consensus Document

What are Mental Health Best Practices?

- Four best practice recommendations for athletics departments to implement in partnership with campus stakeholders
- Roadmap to support student-athlete mental health and well-being
Why are Mental Health Best Practices important?

• Student-athlete driven
• Address critical need
• Developed and endorsed by medical and sports medicine organizations across the country

Endorsing Organizations
Best Practice #1
Clinical Licensure of Practitioners Providing Mental Health Care

- Coordination and management through primary athletics health care providers
- Evaluation and treatment by licensed practitioner
- Importance of cultural competencies

Best Practice #2
Procedures for Identification and Referral of Student-Athletes to Qualified Practitioners

- Clearly communicated procedures for referring athletes
- Mental Health Emergency Action Management Plan
- Routine Mental Health Referrals
Best Practice #3
Pre-Participation Mental Health Screening

• Mental health screening as part of annual pre-participation exams
• Consultation with licensed mental health professionals
• Alignment with campus-wide referral procedures

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

• Annual meeting between athletics health care providers and licensed practitioners
• Education for student-athletes and SAAC representatives
• Self-care, stress management, signs and symptoms of mental health disorders, peer intervention, sleep
Best Practice #4
Health-Promoting Environments That Support Mental Health Well-Being and Resilience

Coaches play a central role and should be:
• Educated on signs and symptoms of mental health disorders
• Trained in empathic response
• Encouraged to create a positive team culture
• Advised of department referral protocols

Additional Considerations

• Medication Management Plan
• Transitional Care
• Financial Support
• Communication Strategies
• Disability Services and Reasonable Accommodation
In Summary

• Mental Health is not apart from, but rather a part of athlete health

• Athletic environments can support help seeking and facilitate early identification through appropriate referral and care

• Establishing protocols for care means more equitable care across sports and within institutions

• Implementation of Best Practice is an important step towards ensuring a model of care for student-athlete mental health

Discussion Points

• What challenges do you foresee with your athletics department in implementing the best practices guidelines:
  1. Ensure mental health services are provided by licensed practitioner
  2. Identify and disseminate referral protocol
  3. Include mental health screening in PPEs
  4. Create and maintain a health-promoting environment that supports mental well-being and resilience

• How can the Sport Science Institute best support your athletics department in the implementation of best practices?
STRETCH BREAK
:10

Presentation 3:
Drug-Use Deterrence-
A Shared Responsibility!

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Clinical Professor of Neurology
Indiana University School of Medicine
New York University School of Medicine
NCAA Committee on Competitive Safeguards and Medical Aspects of Sports

- Charged by Executive Committee to oversee NCAA drug testing.

- Working in conjunction with NCAA Sport Science Institute.

Elements of comprehensive deterrence

- Strong written policy with significant sanctions.

- Evidence-based education.

- Drug testing for early detection and intervention.
Emerging / Re-emerging Drug Issues

- Alcohol Abuse
- Marijuana
- Prescription drugs
  - Narcotics (opiates)
  - Stimulants

Two Primary Drug Classes

- Performance-enhancing drugs (PEDs):
  - These are drugs that can provide an athlete a competitive advantage.
  - PEDs pervert the essence of sport, and using PEDs is cheating.
- Alcohol and other recreational drugs:
  - These are drugs that do not enhance performance.
  - Recreational drugs can negatively impact health and society.
31.2.3.4 Banned PED Drug Classes

(a) Stimulants
(b) Anabolic agents
(c) Alcohol and Beta Blockers (banned for rifle only)
(d) Diuretics and other masking agents
(e) Street drugs
(f) Peptide hormones and analogues
(g) Anti-estrogens
(h) Beta 2 Agonists

Stated Testing Purpose

- To deter cheating.
- To protect health and safety.
- To maintain the integrity of the game.

Testing is part of a comprehensive approach to drug deterrence:
- Written policy.
- Education.
- Testing.
Current Testing Methods

• Urine continues to be THE testing medium.

• No-notice Testing: growing incrementally.

• No current blood draw.

NCAA Championship Drug Testing

• Since 1986.

• Purpose: To deter the use of banned drugs at NCAA championships and postseason football bowl games.

• Tests for steroids, stimulants, masking agents and street drugs.

• Subject to testing:
  – Any championship event.
  – All NCAA sports.
  – All Divisions.
### NCAA Postseason Test Results

(No action taken - monitoring)

| Year | 98 | 99 | 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 |
|------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Total No. of Tests | 1128 | 1488 | 1474 | 1657 | 1513 | 1561 | 1516 | 2565 | 2581 | 2512 | 2481 | 2572 | 2378 | 2263 | 2133 | 1005 |
| Stimulants | 5 | 10 | 5 | 7 | 10 | 14 | 22(23) | 30(27) | 37(33) | 52(42) | 49(39) | 66(54) | 89(55) | 83(55) | 41(27) |
| Steroids | 1 | 3 | 2 | 4 | 5 | - | 2 | 6 | 3 | 7 | 6 | 4 | 2 | 10 | 1 |
| Beta blockers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Diuretics or Manipulators | 1 | 3 | 4(2) | 2 | 7(2) | 1(1) | 2(2) | 0 | 1 | 4(1) |
| Street Drugs | 5 | 20 | 7 | 10 | 8 | 10 | 17 | 37 | 21 | 26 | 28 | 72 | 64 | 44 | 34 | 36 |
| Protocol issues | 1 | 2 | - | - | 1 | - | 2 | 0 | 1 | 0 | 1 | 1 | 2 | 1 | 1 | 3 |
| Peptide Hormones | 1(1) | 0 | 2(1) | [1] | 1(1) |
| Total Positives | 77(35) | 88(44) | [1] | 129(41) | [1] | 134(54) | 145(55) | 123(56) | 80(27) |

### NCAA Year-Round Drug Testing

- Testing on DI-DII campuses August through July
- Testing for steroids and masking agents
- Student-athletes chosen randomly
- Targeted and repeat testing of PED high risk sports:
  - Baseball
  - Football
  - Lacrosse

- Other Sports Tested Randomly
### Reported PED Use by Sport - 2013

<table>
<thead>
<tr>
<th></th>
<th>Andro</th>
<th>Norandro</th>
<th>Epi T</th>
<th>EPO</th>
<th>HCG</th>
<th>HGHInjected</th>
<th>HGHoral</th>
<th>Testosterone</th>
<th>Testosterone Boosters</th>
<th>Insulin</th>
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<td>1.7%</td>
<td>4.3%</td>
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### NCAA Drug Test Penalties

- **PEDs:**
  - Out 365 days from date of test for PEDs.
  - Loss of one year of eligibility.
  - Second positive = loss of remaining eligibility.

- **Street Drugs:**
  - Withholding from competition for half season.
  - Second positive involving at least one street drug = additional year.

- **Appeal options:**
  - denied and the full penalty is upheld;
  - denied and the penalty is reduced by 50%;
  - granted and the positive test is overturned and no penalty is assessed.
Medical Exceptions for Banned Drug Use

• Not for street drugs

• Pre-approval required for anabolic agents (testosterone) and peptide hormones and analogues (EPO, hGH)

• Stimulants, diuretics, anti-estrogens, and beta blockers reviewed following a positive drug test
  – Documentation must be in place prior to test

Compliance Forms for Drug Testing

Drug-Testing Consent Form

• Must be signed to participate

• DI and DII:
  – Prior to practice or prior to the Monday of your institution’s 4th week of classes (whichever occurs first).

• DIII:
  – Prior to competition in Division III.

• Consequences of positive test.

• Copy of the list of banned drug classes attached.
10.2 Knowledge of Use

Staff who have knowledge of student-athlete use at any time of a substance on the list of banned drugs shall follow institutional procedures or shall be subject to Bylaw 19.5.2.2.

What if NCAA receives report of substance use by student-athlete?

• Must be in writing.
• NCAA Sport Science Institute sends letter:
  – To director of athletics.
  – As a courtesy.
  – To follow up according to institutional policy.
Institutional Drug Education

• Required under NCAA Bylaws
  – to disseminate list of banned drugs.
  – to educate student-athletes about products that may contain them.

• Published Minimum Guidelines
  – Review alcohol/tobacco/other drug use and drug-testing policies:
    • for NCAA, conference, institution and team.
    • each semester.

Should “Recreational Drugs” be included in NCAA testing or shifted to institutional testing

• What drugs should be classified as “recreational”?  
  – Alcohol
  – Marijuana
  – Other illicit drugs
  – Prescription drugs
Effective Recreational Drug Deterrence

- Shared responsibility
  - NCAA provides guidance and resources ($$?).
  - Campus delivers prevention and intervention.
- Goal of testing – detection for intervention?
  - NCAA assist in identifying standardized administration of testing protocol, labs, sanctions (different than NCAA PED), and best practice guidance for appeals—transparency.
  - Testing program is owned by institutions and/or conferences, who implement sanctions and intervention, and exceptions and appeal processes.

Recreational Drug Use

<table>
<thead>
<tr>
<th></th>
<th>Highest Users of Marijuana</th>
<th>Highest Users of Alcohol</th>
<th>Highest Percent of Excessive Drinking</th>
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<tbody>
<tr>
<td><strong>Men's Sports</strong></td>
<td>MLA</td>
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<td><strong>Women's Sports</strong></td>
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</table>
When you drink alcohol, typically how many drinks do you have in one sitting?

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<tr>
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<th>Female</th>
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<tbody>
<tr>
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<td>Division I</td>
<td>Division II</td>
<td>Division III</td>
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<td>More than 4 drinks</td>
<td>31.9%</td>
<td>32.6%</td>
<td>37.8%</td>
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<td>10+ drinks</td>
<td>2.4%</td>
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|                      | Males |                  |                  |                  |
|                      | Division I | Division II | Division III |                  |
| More than 5 drinks   | 39.6%  | 39.6%          | 50.4%           |                  |
| 10+ drinks           | 15.5%  | 16.8%          | 20.4%           |                  |

Alcohol

- Continues to be identified by the membership as the #1 issue.
- Impaired driving is a major cause of death of college-aged students, including NCAA student-athletes.
- Sexual assault is highly correlated with alcohol use.
Recreational Drug Use-Shared Solutions Model
Provide model/best practices to address substance abuse, mental/emotional stress, pain, anxiety as underlying factors.

– Continue implementation of existing NCAA best practice resources (APPLE, CHOICES, Step UP!).
– Bio-psycho-social medical model approach.

Evidence-based Educational Resources

– Provide myPlaybook to the membership/ NCAA-sponsored.
  • Consider implementation as part of PPE.

– Develop Best Practices comprehensive tool kit endorsed by the broader higher education/prevention community.
Tobacco

Target tobacco use interventions – high risk sports.

Reported Spit Tobacco Use – 2013 Substance Use Survey

- Baseball: 47.2%
- Men’s Lacrosse: 40.0%
- Wrestling: 36.9%
- Men’s Golf: 28.3%
- Football –23.8%

- Strategies—work with officials and coaches.

Prescription Drug Abuse

Proposed partnerships to develop:

- Strategies/model to work with NCAA Student Athlete Advisory Committees (SAAC).
- Student-athlete specific resources developed in conjunction with the GenRx movement.
- Longer range plan to include targeted outreach and resources for coaches.
Proposed Drug Deterrence Strategies

- Establish Universal PPE to include reporting all medications and supplements.
- Increase PED testing.
- Establish Conference Testing Programs
- Eliminate NCAA Street Drug Testing.
- Shift recreational drug intervention responsibility to member institutions and provide best practices both for education and testing models.

- Continue support of existing education resources.

NCAA Resources

- APPLE Prevention Conferences
- CHOICES Alcohol Education Grants
- Coaches Education- on Hazing Prevention, Mental Health
- myPlaybook online curriculum
- Step UP! Bystander Intervention
- SSI Newsletter
- Student-Athlete Drug Policy brochure
- Violence Prevention resources

Mind Body Sport – Understanding and Supporting Student-Athlete Mental Wellness

www.ncaa.org/ssi
PRESENTATION 4: INDEPENDENT, CONFLICT-FREE MEDICAL DECISION-MAKING IN ATHLETICS HEALTHCARE

John T. Parsons, PhD, ATC
Director, Sport Science Institute
Adjunct Associate Professor, Athletic Training
Indiana University
Boston University

SSI Strategic Priorities

Cardiac health
Concussion
Doping and substance abuse
Mental health
Nutrition, sleep and performance
Overuse injuries and periodization
Sexual assault and interpersonal violence
Athletics healthcare administration
Data-driven decisions
Objectives

1. Identify examples of conflicted, non-independent athletics healthcare.
2. Identify the medicolegal justification for independent and conflict-free medical decision-making
3. Define primary athletics healthcare provider
4. Identify the characteristics of an independent, conflict-free athletics healthcare department.

Examples

- 11% of ATs report to coach
- 32% said coaches influence hiring of AT position
- 52% pressured to return injured athletes early
- 42% pressured to return concussed athlete early

Examples

Problems

• Structural conflict of interest
• Degraded medical decision-making
• Threatened standard of care

“The potential for conflict of interest is omnipresent in sports medicine”

Conflict of Interest

TEAM PERFORMANCE → ATHLETE HEALTH → ATHLETE

Conflict of Interest

PERFORMANCE → HEALTH → ATHLETE
Problems (con’t)

• Conflict w/ federal / state regulation
• Disruptions and inefficiencies

References
References
Principles

1. Primacy of patient
2. Evidence-based decision making
3. Physician direction for AT services
4. Medical professionals make medical decisions


Principles

6. Documentation is key (discharge!)
7. Conflicting coach influence must be eliminated
8. Medicine evaluated by medical professionals
9. Administrative structures should facilitate adherence to these principles

Structural Components

1. Duties & responsibilities
2. Chain of command
3. Decision-making authority
4. Administrative authority
5. Performance appraisal

Chain of Command

Medicolegal

Physician

Other Medical Personnel

Coach

Class v. Towson University, Court of Appeals, 4th Circuit 2015
Duties & Responsibilities

• Team physician
• Athletic trainer
  – Other medical support staff

Primary Athletics Healthcare Providers

“The institution must affirm, in policy and protocol, that sports medicine providers are empowered to make best-interest decisions regarding the athlete at all times and in all settings, and these decisions are authoritative and not to be ignored” (p. 130)

Independent Medical Care

Goal: Association-wide provision

Personnel Appraisal

- Established performance tools
- Program evaluation
- Promotion & remediation plans
- Service metrics
Performance Appraisal

Team Physician  Patient Care  Administration  Athletics Director*

Coach

AT

Coach

Administrative Models

• Many models exist
• Student health model
  – Athletics as client
  – Personnel advantages
  – Medical hierarchy well-established

Conclusions

- Athlete-centered medicine
- Primary athletics healthcare providers
- Unchallengeable, autonomous medical authority
- Personnel management

THANK YOU.