



Beyond the False Choice: Integrating Mental Health and Mental Performance Services in Sport

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Abstract

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Athletes do not divide their psychological lives into clinical and performance compartments; yet, many organizations still deliver support as if they do. This editorial examines three broad approaches: a same-person model in which one professional addresses both domains, a separate-provider model based on specialization and referral, and a hybrid model in which distinct providers work through a coordinated system. No large sport-specific randomized trial has directly compared these approaches, and the available evidence does not justify declaring any one model universally superior. A dual-trained provider may reduce stigma, fragmentation, and disruptive handoffs, but blurred roles can create concerns about competence, scope of practice, confidentiality, and accountability. Separate providers preserve specialization and regulatory clarity, but separation without active coordination can produce referral dropout, duplicated work, and uncertain follow-up. Evidence from collaborative care outside athletics, together with emerging sport-specific literature, supports a middle position: integration at the system level without erasing professional boundaries. I argue for integrated differentiation: coordinated pathways built on explicit roles, informed consent, clear referral thresholds, consent-based communication, measurement-based follow-up, and athlete-centered confidentiality. The goal is not to collapse disciplines or build walls between them. It is to create bridges with guardrails while comparative effectiveness research determines which arrangements work best, for whom, and under what conditions.

Keywords: Comprehensive integration, multidisciplinary governance, triage protocols, ethical safeguards, integrated differentiation

Athletes do not experience mental health and mental performance as separate lives. The anxious athlete is not anxious only off the field. The depressed athlete does not lose energy, concentration, sleep, motivation, or confidence only outside sport. The injured athlete does not bring one mind to rehabilitation and another to competition. Yet, sport organizations often build service systems as if mental health and mental performance can be divided neatly into separate lanes: therapy over here, performance enhancement over there, and referral as the bridge between them.

That distinction is useful, but it is incomplete. The better question is not whether mental health and mental performance services should be integrated or separate. The better question is how sport organizations can integrate care without erasing professional boundaries.

For purposes of this editorial, the current literature can be organized into three broad models.^{1,2} In a same-person model, one professional provides both mental health and mental performance services.^{1,3} In a separate-provider model, a licensed mental health clinician addresses clinical concerns and a mental performance consultant addresses performance enhancement, with referral between them as needed.^{1,2} In a hybrid or interdisciplinary model, distinct providers maintain their scopes of practice but work within a coordinated system of communication, triage, referral, and follow-up.²

No large sport-specific randomized trial has directly compared these three models. Accordingly, the available evidence does not establish that any one model is universally superior. Still, the available literature gives enough direction to reject two extremes: the idea that one highly trained person should always do everything, and the idea that role separation alone is enough.^{1,2,4} The most defensible position is this: mental health and mental performance services should be integrated at the system level, while professional roles, scopes of practice, confidentiality rules, and referral thresholds remain explicit.^{1,2,4}

Clinical sport psychology has long challenged the artificial divide between performance and well-being. Moore and Bonagura described clinical sport psychology as a model built from both clinical and sport sciences, capable of addressing performance improvement, performance dysfunction, psychological disorders, personal development, and well-being when the practitioner is appropriately trained and when referral is used when needed³. This continuum view is compelling because athlete concerns rarely arrive pre-sorted. Performance slumps may conceal depression, disordered eating, trauma, sleep disturbance, substance misuse, or injury-related distress. Conversely, clinical treatment often must attend to performance restoration because sport is not incidental to an athlete's functioning; it is central to identity, routine, relationships, and occupational life.

The same-person model has real advantages. A dual-trained clinician-consultant may reduce fragmentation, avoid disruptive handoffs, and preserve trust when an athlete's concern shifts from performance anxiety to clinical anxiety, or from injury frustration to depressive symptoms. This may be especially valuable in small programs, rural settings, or resource-limited sport environments where multiple specialists are unavailable. The Swedish sport psychology continuing professional development model reflects this logic, aiming to strengthen the connection between performance enhancement and clinical support and reduce the need for referral to other professionals.⁵

The same-person model may also reduce stigma. Athletes seek formal mental health support at low rates; a recent systematic review and meta-analysis found a pooled formal help-seeking proportion of 22.4%, with barriers including stigma, athlete identity, fear of deselection, confidentiality concerns, low mental health literacy, and negative attitudes toward services.⁶ If an athlete is already seeing a provider under the acceptable language of "performance," the threshold for disclosing distress may be lower.

But the same-person model also carries risks. McHenry and colleagues argue that expecting one professional to cover both mental performance and mental health may hinder interprofessional collaboration and ignore important distinctions among Certified Mental Performance Consultants, licensed psychologists, licensed social workers, and licensed professional counselors.¹ These are not interchangeable credentials. They reflect different histories, theories, training pathways,

competencies, and regulatory obligations. A professional may be excellent in one domain and underprepared in another. Depth matters. So does accountability.

The ethical concerns are not theoretical. The overlap between coaching, consulting, and therapy has been described as a potential quagmire involving roles, skill sets, education, licensing, credentialing, confidentiality, and reimbursement.⁷ Life coaching literature similarly warns that blurred helping roles may confuse vulnerable clients about what is and is not treatment.⁸ Psychotherapy ethics emphasize boundaries, informed consent, confidentiality, and the structure needed to protect the therapeutic relationship.⁹ In sport, where providers may be hired by institutions, interact with coaches, attend practices, and support selection or return-to-play contexts, these boundaries require even more explicit protection.

The separate-provider model responds to these concerns by preserving specialization. A mental performance consultant can focus on goal setting, attentional control, imagery, confidence, arousal regulation, routines, communication, and performance behaviors. A licensed mental health clinician can assess, diagnose, and treat mental disorders, manage risk, coordinate higher levels of care, and protect clinical confidentiality. Consensus guidance supports this distinction: sport performance consultation may be provided by licensed or nonlicensed individuals, but licensed mental health practitioners are the only providers licensed to treat problematic emotional responses.⁴

This model has clear advantages. It protects scope of practice. It clarifies regulatory responsibility. It reduces the risk that diagnosable disorders are mislabeled as “mental toughness” problems or treated only with performance skills. It can also help athletes separate clinical work from performance work, which may be useful when shame, fear, or role confusion is present.

Yet, separation alone is not a care model. It is a staffing arrangement. Without active coordination, separate services can become fragmented services. Referral introduces a point of possible dropout, and athletes already face many barriers to seeking care.^{6,10} Communication failures can produce duplicated assessments, inconsistent recommendations, or confusion about who owns follow-up. A separate-provider model is strongest when referral is warm, consent-based, timely, and closed-loop: identify the need, route the athlete, confirm contact, deliver care, document appropriately, and review whether the plan is working.

An extensive evidence base from outside sport may inform this discussion. Collaborative care in primary care has been tested extensively. Kroenke and Unützer summarized evidence from more than 80 randomized trials and identified core components of effective collaborative care: population-based identification, measurement-based care, treatment-to-target strategies, care management, psychiatric supervision, and brief psychological therapies.¹¹ The Department of Veterans Affairs and Department of Defense guideline for major depressive disorder strongly recommends collaborative or integrated care models in primary care, citing high confidence in the quality of evidence.¹² The Collabri Flex randomized trials in Denmark found collaborative care superior to consultation liaison for depression and anxiety at six months,¹³ with sustained advantages for depression at 18 months.¹⁴ In the SPIRIT trial, teleintegrated care and telereferral care both improved outcomes for complex psychiatric disorders in primary care, but the integrated approach used less scarce specialist time, leading the authors to recommend incentivizing integrated approaches when feasible.¹⁵

Sport is not primary care, and findings should not be imported uncritically. But the mechanism is relevant. Collaborative care is not simply “everyone talks.” It is a structured system. It defines roles. It uses measurement. It tracks outcomes. It escalates care when needed. It creates specialist supervision and consultation without requiring every athlete to begin in specialty care. These principles translate well to sport, where the challenge is often not absence of caring professionals, but absence of an operating system.

The emerging sport-specific literature supports this direction. McHenry and colleagues call for interprofessional competence and collaboration among mental performance and mental health professionals, applying the World Health Organization framework for interprofessional education and collaborative practice to sport psychological support teams.¹ Van Slingerland and colleagues’ interdisciplinary case study of the Canadian Centre for Mental Health and Sport showed how collaborative care unfolded over 11 months for a high-performance athlete with chronic pain, low mood, and anxiety.² Collaboration was driven by the athlete’s symptoms and needs, facilitated by secure communication tools, openness, flexibility, mutual respect, and complementary expertise, and hindered by logistics, overlapping scopes, and client factors.² Importantly, the case suggested that collaborative care allowed the athlete to access different services depending on comfort, need, and psychological risk while allowing practitioners to remain within their competencies.²

A recently proposed collegiate sport science hub model illustrates how this middle-ground approach can be operationalized without collapsing mental health and mental performance roles.¹⁶ The model links two distinct but connected lanes: a clinician-led mental health pathway for screening, triage, referral, and follow-up, and a non-clinical mental performance pathway for profiling and skills-based support. Its contribution is not that sport science replaces clinical care, but that governed infrastructure can connect identification to action through role-specific routing, privacy-secured systems, auditable handoffs, and clinician-led escalation when clinical concerns arise. Importantly, such a model should be treated as an implementation framework requiring prospective evaluation, not as proof that any one infrastructure is superior.

Sports psychiatry literature reinforces the same point. The first international consensus statement on sports psychiatry emphasizes the complementary knowledge of different disciplines and the importance of interdisciplinary collaboration.¹⁷ Claussen and colleagues argue that mental health and athletic performance cannot be considered separately, because mental disorders may reduce performance, impaired performance may signal mental disorder, and performance decline itself may increase risk for mental disorder.¹⁸ The American Medical Society for Sports Medicine likewise emphasizes detection, management, prevention, performance effects, and coordination across the athletic care network.¹⁹

Therefore, the practical recommendation is neither full merger nor rigid separation. It is integrated differentiation.

Integrated differentiation means that athletes experience a coordinated pathway, not a maze. It means that mental performance and mental health providers know each other’s roles, respect each other’s competencies, and communicate with consent. It means that athletes are told, in plain language, what information is private, what may be shared, with whom, for what purpose, and under what safety exceptions. It means that coaches receive performance-relevant and participation-relevant information only within appropriate boundaries, not clinical details. It means that mental performance providers have scripts and thresholds for referral when concerns move beyond performance skills. It means that clinicians understand sport culture well enough

not to pathologize ordinary competitive distress, while also being trained enough not to miss genuine disorder.

This approach is especially important in collegiate and high-performance sport, where athletes may be reluctant to disclose symptoms if they fear losing playing time, scholarships, selection, or trust. Confidentiality cannot be implied; it must be operationalized. Referral cannot be passive; it must be supported. Collaboration cannot depend on hallway conversations; it must be built into the workflow. Examples of collegiate-specific implementation guidance include the NCAA's *Mental Health Best Practices: Understanding and Supporting Student-Athlete Mental Health, Second Edition*²⁰ and, when performance technologies or athlete data are involved, *Performance Technologies Recommendations: Responsible Use in Collegiate Athletics*.²¹

A minimum system should include at least six guardrails. First, roles must be defined: who provides mental performance services, who provides mental health assessment and treatment, who manages crisis response, and who coordinates care. Second, informed consent must explain privacy, documentation, communication pathways, and limits of confidentiality. Third, screening and referral thresholds must be explicit, including suicidal ideation, eating disorder risk, substance misuse, trauma symptoms, severe depression or anxiety, psychosis, mania, abuse, or safety concerns. Fourth, communication must be closed-loop and consent-based. Fifth, services must be measured, not merely offered; symptom change, functioning, athlete satisfaction, referral completion, and service utilization should be monitored. Sixth, the system must support providers as well as athletes, because complex cases can overwhelm isolated practitioners.

There will still be contexts in which a dual-trained professional is the best available model. There will also be contexts in which strict separation is necessary because of licensing, institutional policy, risk level, or expertise. The point is not to ban either model. The point is to stop mistaking staffing structure for quality of care. A dual-trained provider without boundaries is risky. Separate providers without coordination are fragmented. A collaborative team without clear scope is confusing. The ethical target is not integration by title; it is integration by design.

The field now needs comparative effectiveness research in sport settings. Studies should test same-person, separate-provider, and hybrid pathways across outcomes that matter to athletes and organizations: mental health symptoms, service uptake, therapeutic alliance, confidentiality concerns, return-to-play outcomes, performance functioning, athlete retention, satisfaction, cost, equity, and safety. Until such evidence exists, sport organizations should make context-sensitive decisions while adopting the most defensible common principles: role clarity, interprofessional competence, measurement-based follow-up, and athlete-centered confidentiality.

Athletes deserve systems that match the complexity of their lives. Their mental health and mental performance are intertwined, but the professions that support them are not identical. The way forward is not to collapse boundaries or build walls. It is to build bridges with guardrails.

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