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# Athletic Trainers' Perceptions of their Role in the Mental Health Care of Student-Athletes

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*There are unique aspects of the collegiate athletic culture that can increase the risk for mental health concerns among student-athletes. Athletic trainers, due to the amount of time spent with student-athletes, are considered a key member of student-athletes' holistic care team. Athletic trainers are many times the first point of mental health referrals for student-athletes, so this study sought to understand athletic trainers' own perceptions of their role in the mental health care of student-athletes. Eight participants from Southeastern Conference institutions participated in semi-structured interviews. Three themes were constructed from the data analysis: (a) first line of defense, (b) holistic care team, and (c) scope of practice. Athletic trainers understood their role as distinct from mental health professionals but called for more specific training in recognizing mental health concerns and appropriate referral practices within interprofessional teams, so that they could stay within their scope of practice. Understanding the athletic trainers' perception of their role on interprofessional care teams in addressing student-athlete mental health offers insights how to best structure mental health services in collegiate athletic departments.*

*Keywords: interprofessional teams, collaborative practice, holistic care, NCAA*

It is estimated that more than 20% of adults will experience a period of diminished mental health each year, with the highest rates among college students (Kroshus, 2016). A high percentage of college students experience some form of mental health diagnosis during their time as students, with estimates suggesting 22.3% have some type of anxiety disorder (National Institute of Mental Health [NIMH], 2019) and 17.0% have had at least one episode of major depression (NIMH, 2020). Student-athletes have a college experience that is vastly different from those who are non-athlete students, which places them more at risk for potential mental health diagnoses (Bird et al., 2020; Rubin & Moses, 2017; Ryan et al., 2018), as their experience "presents challenges and stressors related to athletic status that can lead to a compromised well-being" due to the demands of competing at an elite level (Beauchemin, 2014, p. 286). Several aspects of the collegiate athletic culture can increase the risk for mental health concerns among student-athletes. These include over-identification with the athletic identity (Taylor, 2014), time demands (Kroshus, 2014), injury (Putukian, 2016), body image (McLester et al., 2014), the transition into collegiate athletics (Hardin & Pate, 2013; Pate et al., 2011), the transition out of athletics (Miller & Buttell, 2018; Smith & Hardin, 2018), over-training syndrome (Matos et al., 2011), and traumatic brain injuries (Kontos et al., 2012).

In addition to the aforementioned factors, there can also be a conflict between the culture of an institution's athletic department and the culture of the campus (Rubin et al., 2017). The student-athlete can often be focused on athletic performance and not personal development or academic performance (Whitehead & Senecal, 2020). Student-athletes can often be at a higher risk of experiencing some form of mental health diagnosis due to the conflict between athletic commitment and academic commitment (Cosh & Tully, 2014). Student-athletes also experience the rigors of a schedule that brings pressure to succeed academically and perform at a high-level during competition as well as high expectations from coaches and family members (Brown et al., 2014). The exact number of how many student-athletes suffer from some sort of mental health diagnosis is unclear, but the student-athlete population may be more susceptible to mental health disorders due to the demands of their experience (Ryan et al., 2018). It is estimated that upwards to 15% of National Collegiate Athletic Association (NCAA) student-athletes experience psychological issues that warrant some form of counseling (Born, 2017). Student-athletes are susceptible to depression and anxiety but view the symptoms as a result of having a busy schedule and not necessarily a sign of a mental health issue and do not seek professional help (Bird et al., 2020; Brown et al., 2014; Gayles, 2009; Gomez et al., 2018; Hilliard et al., 2019; Ryan et al., 2018).

These same student-athletes are also provided a plethora of resources for athletic and academic success particularly at the NCAA Division I (DI) Autonomous member level. College athlete departments in these conferences operate at budgets at $100 million or more with some topping the $200 million mark (NCAA, 2021b). Many professionals outside of the coaching staff are part of the student-athlete experience. They include academic counselors, tutors, dieticians, mental-performance coaches, medical doctors, strength coaches, chaplains, mental health professionals (e.g., social workers, professional counselors, psychologists) and athletic trainers (McHenry et al., 2021; Waller et al., 2016). Athletic trainers though are in a unique position as they spend a vast amount of time with direct contact with student-athletes (Lacy et al., 2020). There is a stigma in athletics of seeking the services of mental health professionals (Bird et al., 2020; Bisset & Timmenen, 2021; Gulliver et al., 2012; LeBrun et al., 2018), so athletic trainers are often the people student-athletes are willing to bring their issues (Bird et al., 2020). Thus, the

purpose of this study is to understand athletic trainers' perception of their role in the mental health care of student-athletes.

## Literature Review

Low levels of mental health literacy can make it challenging for student-athletes to pursue professional help for their mental health issues (Beasley et al., 2020; Corrigan, 2004; Gulliver et al., 2012). There are also inconsistencies in training specific to student-athlete mental health (McHenry et al., 2021) so there may also be a potential lack of clinical professionals who understand the nature of the student-athlete experience, which can diminish clinical care (NCAA Sports Institute, 2017). The time demands of student-athlete can also make it difficult to schedule appointments with counselors (Lopez & Levy, 2013; Ryan et al., 2018). Furthermore, the availability and awareness of mental health care resources vary among institutions which often places athletic trainers at the forefront of any potential mental health issue (Born, 2017; Gayles, 2009; Mazerolle et al., 2016). The surge in athletic training staff sizes during the past 10 years makes athletic trainers more accessible and available to student-athletes. The number of athletic trainers (head, associate, or assistant) increased by 50.8% across NCAA Division I overall and increased by 62.9% at Division I – Autonomous institutions from 2012 to 2021 (NCAA, 2021a).

Student-athletes often have daily interactions with athletic trainers which leads to a personal bond between the parties (Mazerolle et al., 2013). The athletic trainer is usually the first interaction a student-athlete has after suffering an injury or returning from an injury. They may also be the among the first staff members in which a student-athlete interacts each day as they prepare for practice or a training session. A general workday for an athletic trainer can be upwards to 16 hours with many of those hours in direct contact with student-athletes (i.e., preparing for practice, injury rehabilitation, post practice recovery) or in the presence of student-athletes (i.e., attending practice, competitions; Mazerolle et al., 2016). This leads to building a strong connection between the athletic trainer and student-athlete which in turn often leads the student-athlete to confide in the athletic trainer or seek support for mental, emotional, or social issues (Mazerolle et al., 2016).

## Holistic Care and Interprofessional Teams

Athletic trainers are seen as health care providers on the surface, but they clearly have a more substantial role in the care of the student athletes. Athletic trainers hold several roles and can provide what is called integrative care for student-athletes (American Psychiatric Association, n.d.). The integrated care model focuses on a balance between behavioral health services with other general or specialty health services (American Psychiatric Association, n.d.). However, until the 2010s, the model for caring for student-athletes had been a traditional medical model (Whitehead & Senecal, 2020). The traditional medical model focuses on the the physical aspects of student-athlete care, but it does not take account complete health which also includes the mental, emotional, and social well-being of a person (World Health Organization, 2003). A medical model for athletic training has the athletic trainer typically reporting directly to a primary care physician or a coach (Eason et al., 2015). Eason et al. (2015) reported the medical model can create role congruency and a higher chance for a positive work-life balance but also found that it can often create role conflict and intersender conflict. The medical model of care in athletics is an outdated practice that does not consider the varying psycho-social-emotional needs of student-athletes.

There has been a shift to the holistic model of care that addresses the physical as well as the mental, emotional, and social well-being of student athletes (McHenry et al., 2021; Waller et al., 2016). This type of care requires an interprofessional team in which many professionals collaborate to provide care to student-athletes (e.g., Bader & Martin, 2019; Barkley et al., 2020; McHenry et al., 2021; Waller et al., 2016). Interprofessional care teams are comprised of members with different professional training, and they work together to provide holistic care to student athletes (Steffen et al., 2014). The best results for interprofessional teams derive from effective communication (Nancarrow et al., 2013), understanding individual team member's scope of practice (Pecukonis et al., 2008), and having clearly defined roles, responsibilities, and referral procedures (Packard et al., 2012).

Some scholars, especially in the injury context, have suggested that athletic trainers play a key role on care teams in athletic department, due to their proximity and daily contact with student-athletes (Clement & Arvinen-Barrow, 2013; Wiese-Bjornstal & Smith, 1999). Therefore, it is important to gain insight into how athletic trainers perceive their role in the mental health care of student-athletes. Although research has discussed the ways in which athletic trainers provide psycho-social-emotional support to student-athletes (e.g., Clement & Arvinen-Barrow, 2018) and how collaborative practice enhances athletic trainers' satisfaction in their role (e.g., Zakrajsek et al., 2015), less work has examined athletic trainers' own views of their perceived role in the interprofessional team when specifically addressing the mental health of student-athletes. Thus, the purpose of this study is to examine athletic trainers' perceptions of their role in the mental health care of student-athletes.

## Method

An interpretative qualitative design was use for this study (Denzin & Lincoln, 2011), and purposeful criterion sampling was used to recruit participants (Patton, 2015). The criterion were athletic trainers working at Southeastern Conference (SEC) institutions. This specific conference was chosen because of the resources available in these institutions and the likelihood that each sport would have a specific athletic trainer to provide care for the student-athletes (NCAA, 2021a). One institution of the 14 members of the conference was excluded due to the research team's familiarity with the athletic training staff.

Participants (head, associate, or assistant athletic trainers) were identified through public, online university staff directories, and contacted via their publicly available email address. One hundred and eighty-four athletic trainers were contacted with a recruitment email, and a follow-up invitation was sent two weeks later. Eight athletic trainers from six different universities agreed to be interviewed for this study. Demographic information is reported as a group to maintain confidentiality due to the small population of participants (Antle et al., 2021; Streubert & Carpenter, 2011; Taylor et al., 2018). The sample was comprised of four men and four women with primary sport responsibilities ranging from football to track to tennis. Six of the participants identified as White, and two participants identified at Black. The average age of the participants was 34-years old. At the time of the interviews, the participants had worked in a collegiate athletic training setting for an average of nine years and had been at their current institution for an average of just less than six years. Institutional Review Board approval was obtained prior to participant recruitment, and participants signed informed consent forms prior to their interview.

### *Data Collection*

Qualitative interviews were used for data collection, as the focus of this study was understanding the participants' experiences (Agee, 2009; Denzin & Lincoln, 2011; Josselon, 2014). Semi-structured interviews were conducted by a member of the research team with an interview guide (see Table 1), but allowing participants to lead the conversation, which facilitates an in-depth discussion of the participants' experience (Merriam & Tisdell, 2016). The interview guide was comprised of 13 open-ended questions to explore the athletic trainers' perceptions of their role in the mental health care of athletes. The interview guide was based on the work of Taylor and Hardin (2016) on their interviews with female collegiate athletics directors; Beasley and colleagues' (2019) interviews with social workers working in collegiate athletic departments, and Antle and colleagues' (2021) study on dieticians working in college athletic departments. The interview guide was pre-tested with an experienced qualitative researcher as well as athletic trainer who did not participate in the study. Questions were modified based on feedback from them (Fraenkel et al., 2012). There were also discussions among the research team members in finalizing the interview guide. Demographic data were collected during the interview with opened-ended questions. Only members of the research team had access to the demographic information and the interview transcripts.

The open-ended questions also gave participants the ability to express their experiences fully and to allow for follow-up questions, which leads to rich data (Turner, 2010). The questions inquired about the participants' interactions with student-athletes, their role in the mental health care of student-athletes, and their training in providing support in the mental health care of student-athletes. All participants were interviewed via Zoom video teleconferencing due to geographic considerations (Cachia & Millward, 2011; Fenig et al., 1993). The interviewer controlled who could enter the session by creating the session with a waiting room so only the interviewer and interviewee could be admitted into the session. Pseudonyms were assigned based on the gender identity of the participants with commonly used names. The interviews ranged in length from 23 minutes to 59 minutes with an average interview time of 42 minutes. Saturation was determined by the research team to have been met after the eighth interview due to the redundancy of initial themes (Merriam & Tisdell, 2016). Therefore, no additional recruitment took place.

The data were stored on a secure server at the researchers' university that required a password and two-factor authentication to access the files. Only members of the research team had access to the data. The file names of the interviews were the pseudonyms of the participants. Only the research team had access to information to match the pseudonym with the actual participant's identity. The Zoom session was recorded but only the audio file was saved on the secure drive at the university. Other files associated with the Zoom recording were deleted. The audio file was then transcribed by a member of the research team and saved using the participant's pseudonym as a file name.

### *Positionality*

Grounded in social constructivism and interpretivism, it is important to acknowledge the research team's positionality (Denzin & Lincoln, 2011). The research team was comprised of three members, and each provided a specific role in the research project. One member of the research teams works in college athletics and has intimate knowledge of the inner workings of the day-to-day life of athletic trainers and student-athletes. This member was responsible for participant recruitment, data collection, and initial data analysis. This could have possibly

Table 1
*Interview Guide*

| **Questions** |
|---|
| How many hours do you interact with your primary sports athletes during the season and during the off-season? |
| How do your interactions begin with athletes? |
| What is your immediate response when an athlete brings up a potential mental health issue? Does this response differ based on the athlete or situation? |
| What do you believe your role is in the mental health care of athletes? What about the roles of athletic trainers in general? |
| Who do you refer an athlete when a referral is needed? |
| Does your institution have a care team or a chain-of-care process when an athlete is struggling with a mental health issue? How does it work? |
| Does your institution have any training programs to help you know what to do in a situation like this? |
| When an athlete comes to you, or shares that they are struggling, where do your own ethics lie? Do you feel compelled to act and help, or do you follow the prescribed protocol? Does it change based on the athlete? |
| How does your familiarization or relationship with the athlete influence how you would handle this type of situation? |
| There was the situation at Washington State with Tyler Helinski that story made major headlines. How did your department react to his death? Were any new processes put in place? Did you complete any sort of training? Did anything change? |
| Has your department taken any action since the passing of the NCAA legislation regarding mental health care for student-athletes? Were there any new policies implemented by your department? How were those policies implemented? How are they followed? |
| Did you take any coursework during your undergraduate or even graduate studies that could or would prepare you a situation dealing with a mental health issue with an athlete? |
| What policies or practices would you like to see implemented in your department for assisting athletes with mental health issues? |

influenced the development of the interview guide, the framing of questions, or data interpretation (Peshkin, 1988). However, this author was also able to build rapport with the participants due to similar career experiences. This also enabled a deeper understanding of the interviews and enhanced the data analysis because of the familiarity with college athletics (Gobo & Molle, 2017).

Another member of the research team is a sport management faculty member and well-versed in qualitative data analysis. This member is trained in mental health care and is a licensed to provided mental health care services. This member was instrumental in the interview guide development, the data analysis process and finalizing the themes that emerged. The third member of the research team is also a sport management faculty member. They have an exceptional knowledge of collegiate athletics, and the holistic care of student-athletes. This member was primarily involved in the conceptualization of the research and interpreting the findings. Additionally, collaborative work, such as the use of peer debriefing in the data analysis process, with a research team, was used to ensure data trustworthiness (Saldaña, 2015).

### *Data Analysis*

A thematic analysis was completed following Braun and Clark's (2006) six steps: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining the themes, and producing the report. The lead author began with a close-reading of the transcriptions, using in-vivo coding, where actual words and terms the participants used are identified as initial codes (Saldaña, 2015; Strauss & Corbin, 1998). The lead author then completed the second round of coding to group the in-vivo codes into overarching themes and created the codebook (Braun & Clarke, 2006). Then, the lead author and second author reviewed the codebook, made minor adjustments, and then agreed on its accuracy. They both independently re-coded each transcript for the themes using this codebook. All three authors then met after this individual coding was complete for peer debriefing to discuss any discrepancies in codes and come to a full agreement on all codes to finalize the themes (Saldaña, 2015). Specifically, in these peer debriefing discussions, the research team reviewed each segment of data that was coded as a different theme by each researcher, discussed reasons it may fit in each different theme, and then decided on which theme it best fit under. The lead researcher made the final decision on which theme the data was ultimately coded. During the peer-debriefing process, the research team also made the decision to assign an initially coded primary theme as a subtheme of another primary theme. Additionally, after the first round of peer-review, two sub-themes were suggested by the reviewers. The lead researcher and one other member of the research team reviewed the data, coded based on the recommendation, and identified two additional subthemes. These measures added creditability to the data analysis process by bringing in multiple perspectives (Lincoln & Guba, 1985).

### *Trustworthiness*

Several methods were used to ensure the trustworthiness of the qualitative data. First, member-checking was completed by sending participants a copy of the transcription which they edited for accuracy (Lincoln & Guba, 1985; Lindlof & Taylor, 2011). Four participants returned the transcript with edits, and the edits were incorporated. The edits from the participants were syntax related and did not impact the content of interviews. Second, members of the research team used analytical memos, which are reflexive notes on the connection of certain concepts and

the reasons codes were coded in certain ways (Saldaña, 2015), which adds credibility to researcher process by increasing transparency throughout the research process (Given, 2008).

## Findings

Three themes were constructed from the data analysis: (a) first line of defense, (b) holistic care team, and (c) scope of practice. The theme of first line of defense includes the subthemes of direct contact and safe space, and the theme of holistic care team includes the subthemes of model of care, recognize, react, refer and normalization of care. The theme of scope of practice includes the subtheme of need for education and training. Athletic trainers understood their role as a constant presence for the student athletes, and realize their role is distinct from mental health professionals. They also wanted more specific training in recognizing mental health concerns and appropriate referral practices within interprofessional teams, so that they could stay within their scope of practice.

### *First Line of Defense*

First line of defense refers to how participants were often the first person who may recognize a mental health concern in a student-athlete, because of the shear amount of time they spend with them each day. As Edward explained, "We're the first person that's going to see it. We're the first person that's going to hear it and probably 10 times out of 10, we're going to be the first person that's there to do something about it." Daniel described what first line of defense meant to him, and provided the initial steps he would take if a situation does arise:

> The athletic trainers are the first line of any kind of mental illness, because of the amount of hours we spend with these athletes. That's why we would be the first contact in the event of something happening, or them having something they want to share. Usually, if there is ever a time where a student-athlete has something going on, and we're just not equipped to handle it, or we just don't want to take on the full burden of what's going on, we luckily have a director of mental health (for referrals).

The subthemes of direct contact and safe space comprised this theme. Multiple considerations went in to being this first line of defense, however all participants discussed the importance of athletic trainers having direct contact with the student-athletes and the importance of creating, what they termed, a safe space through building of relationships.

*Direct Contact*. Direct contact refers to the pure number of hours the athletic trainers spend with student-athletes. Each participant described a full day in their job as lasting anywhere from 10-14 hours whether their sports were in-season or not. Of this time, roughly half, and often more, were spent in direct contact with student-athletes. As Christine explained, "In a 12-hour day, I don't think I would be exaggerating to say that at a minimum, about eight of them are spent with student-athletes." Edward discussed that this time with student-athletes does not change, even if they are in the off-season. He described the portion of his workday spent with athletes as, "It's pretty much all day." Gertrude relayed a similar schedule of team meetings, rehabilitation sessions, practices, and staff meetings: "We get here at about 5 or 5:30 in the morning, the guys are rolling in for taping and treatment around 6 a.m.… (then we would leave) by 5 or 5:30." Interestingly, Abner pointed to the impact of NCAA policy on athletic trainers' time spent with student-athletes: "The NCAA dictates to the coaching staff certain periods of

time where they can't have interaction with student-athletes. (I don't have that.) I'm a medical provider for the team, so I can reach out to them in any capacity." Thus, there (are) less institutional barriers to spending time with the student-athletes.

Each participant described the process of their days, highlighting just how much time they spent at work in direct contact with student-athletes. Frank insightfully explained, "You're just bound to get to know people when you spend as much time with them as we do." Thus, it would not come as a surprise, that the ATs may be the first to notice behavioral changes in the athletes they interact with every day.

*Safe space*. Safe space refers to the way the participants viewed the athletic training facility as a place for student-athletes to discuss any topics without the fear of a coach or anyone else overhearing them. The participants believed the safe space of the athletic training facility was a necessity, because of how much time athletic trainers spent with the student-athletes. Abner said, "I would say the athletic training room is sort of an athlete's escape from whatever else they've got going on in their day." Christine similarly discussed not only having the athletic training facility be a safe space, but the importance of creating that environment:

> Personally, I look at the athletic training room as a safe space where they can talk about anything and a lot of times we do talk about difficult things, because they're important and it affects how they're feeling. I feel like I try to promote an environment where my athletes feel they can come and talk to me about anything. I think all of us try to do that here and that's a goal of mine. I want them to know that I care about them as a person. I've said to athletes who are recovering from a serious injury, "I don't really care if you ever get back on the field again. I care that you can walk around and hold your kids one day if that's what you want."

In this way, creating a safe environment created a sense of trust between the athletic trainers and the student-athletes. As Hailey reflected on her relationships with the student-athletes, "If we do face an emergency the conversation is easier, because they've already established that they are cared for. They know that I care for them and that our department cares for them." This sense of trust allowed the athletic trainers to be better equipped to care for their athletes, while allowing for the relationship between the athletic trainer and the athlete to organically grow. Tellingly, Becca discussing how the environment she created provided student-athletes with the opportunity to open up in ways they may not with other athletic staff, friends, or even family. She explained:

> I never had a conversation I didn't like. While some of them made me sad or uncomfortable, I never backed away. Mental health, drugs, sex, these are all things they wanted to talk about at this age, but maybe couldn't talk to their moms about. I was sort of ground zero for them.

This ability to provide a space for athletes to feel comfortable talking about their lives beyond the field helped to foster and build the relationships and rapport with the athletes. Specifically, several participants spoke about how creating a safe space through the building of relationships with the athletes relied on getting to know the athlete outside of sport. Becca commented that many of the conversations she had with student-athletes in the athletic training facility had nothing to do with sport, which lead to her being "engaged with them in a way that maybe made them feel like more than just an athlete." Christine similarly reflects that she created this safe space by "talking about anything." She continued, "I'll talk about movies, the news, different

shows. I really feel like I try to promote an environment where my athletes feel like they can come and talk to me about anything." These types of conversations, which had nothing to do with sport, helped create a trust between athletes and their athletic trainers.

Athletic trainers were many times the first to notice diminished mental health of the student-athletes due to the direct contact with student-athletes and the emphasis of creating a safe space for student-athletes to discuss issues related to mental health. Therefore, the participants in many ways were the first line of defense in their athletic department for student-athlete mental health. However, to foster discussions with student-athletes about mental health, the athletic trainers placed an importance on building effective relationships with the athletes.

### *Holistic Care Team*

The holistic care team is the group of professionals that athletic departments have in place for their student-athletes should any of those non-sport related conversations turn into a mental health related issue. These resources differed from institution to institution, with each participant describing how their athletic department handles the mental health care of its student-athletes. The overarching theme is comprised of the three subthemes of model of care, recognize, react, refer and normalization of care. These subthemes refer to the how different athletic department structured their care teams (i.e., which professionals are involved), athletic trainers' ability to notice when there is a possible mental health issue and refer the student-athlete to the appropriate health care professional. The athletic trainers also recognized the need to ensure student-athletes that seeking mental health care services is acceptable.

*Model of Care*. The mental health care process begins when a student-athlete discloses a mental health concern. An important aspect of this process for the participants was knowing all the different professionals that are available to student-athletes. Daniel indicated the professionals in the mental health department in his athletic department had backgrounds that included counseling, social work, and performance psychology, and this variety in commonly seen in athletic departments (Beasley et al., 2019; McHenry et al., 2021). Hailey described the multitude of people and resources they have at her institution and explained the different competencies each bring to the holistic care of the student-athlete. She said:

> For eating disorders specifically, we have an eating disorder team, and we have an off-campus therapist that works on that team who we refer out to for services. We do the same for substance abuse. We have a facility we use here in town for testing, hospitalizations, and intensive outpatient services. The other thing we separate is sport performance. We do that, because we want them to know the difference between a clinical mental health counselor and a sport psychologist and to keep the performance side separate, so they can keep their identity separate as well. We have a licensed professional counselor and a licensed clinical social worker that are in-house and only work with our athletes. So, they see the full gamut of our mental health disorders and they are also substance abuse certified. That means when they are done seeing off-campus resources, off-campus resources may refer them back to our clinicians for what we call after care to help them through the recovery process. Then, our psychiatrist oversees every bit of that wheelhouse.

She described how keeping everything in-house allows for the processes to be streamlined, explaining:

> We mirrored it like athletic training. We did it in that, if I am an athletic trainer, if I am doing rehab on your Achilles (tendon), there's still a physician that is signing off on that rehab and guiding it. So, we wanted to mimic the same thing with our behavioral medicine side.

Christine brought up the unique situation at her university, as they were in the process of hiring a mental health coordinator. They refer outside of the athletic department for mental health care. She said:

> We have a good relationship with our university counseling center. We have some contacts there, where if I had an athlete that was struggling, I would give them that info and they would talk to someone over there. We (also) have a bunch of contacts at the medical center, which is great. So, I can just get a kid's medical records, send a note to a physician and ask if they have time to see one of our athletes. We also have a clinical psychiatrist that we keep in contact with, and he does a lot of work and helps with medication management and stuff like that.

These are two different institutions that are both in the same conference, yet the type and scope of the resources they have at their disposal is vastly different. Gertrude explained how their university has a hybrid model of a holistic care team, wherein there is a mental health professional on staff who facilitates community referrals if needed:

> We have hired a full-time person in the athletic department who is a licensed social worker, and she serves as our gateway. She's full-time. She creates programs for the teams. She does actual counseling, and she is the gatekeeper for our other providers.

These different models of care teams—in-house, refer out, or a hybrid—are common among NCAA athletic departments (Chew & Thompson, 2014). However, participants seemed to agree that having at least one mental health professional on staff in the athletic department has its advantages. Becca, in encapsulating the sentiment of many participants, said, "There are times where you are going to have to bring professionals in from the outside that may be different from who they are used to working with, but the more you can incorporate the mental health professionals into your program, the better off you are" as then the mental health professional is already a known part of the holistic care team. However, no matter the model of holistic care currently present in the athletic department, the athletic trainers played a key role in connecting the student-athlete to resources.

*Recognize, React, Refer*. Recognize, react, refer is the process athletic trainers practice in order to recognize diminished mental health of student-athlete, react to the situation, and then refer the student-athletes to the most suitable for the next level of care. As Hailey described the mental health chain of care at her institution, "it always goes back to recognize, react, refer…ask the same questions: 'What are you recognizing?' 'How are you reacting?' and 'Who are you referring to?'" For a number of the participants the process of recognizing and reacting to situations occur in everyday conversations. Daniel explained that recognition comes from knowing the student-athlete. As he explained, "You know what's normal and what's not normal for them. Then, you are able to decipher if (a student-athlete) usually says 'Hey!' and comes in and does his thing, but today he walked in, didn't say anything to anyone and walked out. So,

what's wrong with (the student-athlete)?" From there, participants put an emphasis on reacting appropriately in the moment. Christine demonstrated the importance of being there for the student-athlete, stating, "I've had athletes come to my office crying and saying they want to jump off a parking garage and I just took their hands, stayed with them."

Although following similar structure, each institution had a different process for referring its student-athletes. Abner reflected on the process at his institution for different levels of mental health concerns:

> Anyone in athletics that comes in contact with a student-athlete has the capability to make a referral. It's a website that you can login to and either you can list your name, or do it anonymously and say "I would like behavioral medicine to check-in with Susie, because I noticed these things going on." Anyone in athletics can log on to the website and then all that does is trigger someone in behavioral medicine to reach out, "Hey, Susie, how's it going?" That sort of thing, it's very low level.

There were urgent processes in place if a student-athlete appears in crisis. Abner added:

> Let's say a student-athlete walked in that was in crisis, our policy is that we keep them in vision, especially if they have voiced any self-harm issues or things like that. We keep them in our vision line, and then we have a specific athletic trainer that works specifically in behavioral medicine that we can reach out to. Then, that person helps us work through our options. Does that need to be a 9-1-1 call? Does that need to be a "Hey, I will come to your office, keep that person there." "Hey, bring that person to behavioral medicine." Does that person need to do a telemedicine conference with a specific provider? They are the gateway to get that person to the right person for treatment or whatever is going on.

Daniel described a similar process:

> (In a mental health situation), we would find the athletic trainer for their sport, evaluate them and decide whether this is something that needs to be evaluated more by professionals who deal with this kind of thing. If it is, then we refer them to our director of mental health. She does an evaluation and quick interview with them and then she refers on depending on her findings from that evaluation.

Gertrude pointed the importance of having some type of emergency plan in place for mental health crisis situations so that "people know directly who to call and who not to call." Aside from having a written plan, relationships with the mental health staff are also important. Frank discussed how having relationships with the mental health staff within the athletic department was important for his own referral process:

> We have a really good and close working relationship with our mental health department. The three (providers) each have specific sports they are assigned to, so we have our primary contact should one of our athletes want to talk to someone. But we also communicate with all three of them, just depending on who would be a better counselor for the student-athletes' needs.

However, some institutions may not have a mental health professional on staff. As Christine explained that until a provider was hired in house "we have emergency personnel" outside the

department that can be consulted. Yet, no matter the structure appropriate referral allowed for the chain of care to begin.

*Normalization of Care*. Each participant described the different ways in which their respective institution normalized mental health care for student-athletes. Gertrude explained that the presence of the social worker in the athletic department may have led to an increased number of student-athletes seeking their services as "she is more visible than anyone we have ever had before." Christine agreed that one of the best ways to normalize care was to demonstrate to student-athletes that the mental health professional "work alongside the AT" and they are "a part of the team." Abner also discussed the importance of the mental health professionals' presence in the athletic department with the creation of a behavioral health department located in the athletic training facility, "What it has done is take the stigma out of mental health that other people talk about it. Our athletes are used to talking about behavioral medicine and mental health." Daniel reiterated the increased visibility of mental health, "We are now at the point where we are placing such an emphasis on it that we have a massive section in our football athletic training room that is solely responsible for mental health care."

Edward discussed how he normalized mental health care in his own conversations with student-athletes by likening it to physical health. He explained:

> I always try to put it into terms of, "You're running to second base, and you rolled your ankle. It hurts you and you can't do what you want to do. If you're not coming to rehab and the training room, then, it's not going to get better." It's the same thing with anxiety. "Okay, you know you're anxious. You know you're having trouble focusing on whatever it is. What are you doing for it? Nothing? Ok, then you're not really helping yourself."

Abner described a similar perspective at his institution, suggesting, "we want to treat behavioral medicine in the same way as if you have an ankle sprain, or a concussion, or an ACL tear. It's just something you need to rehab."

Ultimately, having a holistic care team on staff that can address the mental and physical health needs of student-athletes was important. Yet, to make this care effective, the athletic trainers needed to have knowledge of recognizing diminished mental health and then specific knowledge of how and where to refer. This required knowing how the holistic care team was structured (i.e., in-house versus contracted), building strong relationships with the mental health professionals on staff, as well as working to normalize the mental health professional as part of the student-athlete care team.

## *Scope of Practice*

Scope of practice encompasses the bounds of an athletic trainer's role in the mental care of the student-athletes and includes the subtheme of need for education and training to adequately address mental health issues. Multiple participants stated that they are not mental health professionals, or even mental health care providers. They described this role as not knowing how to treat mental health but knowing the full extent of the resources that are available to the student-athletes. Gertrude, in speaking about the education of athletic trainers, said, "At the end of the day, I'm not diagnosing someone with bi-polar disorder. I just need to know when I need to call somebody else." In reflection on the education of athletic trainers generally, she suggested:

> We need to spend less time on the signs and symptoms of these mental health issues, because I'm not going to school to be a mental health professional. I am going to school to be an athletic trainer. It's more about knowing where we function in mental health care. When is referral needed? How do we refer? Where do we refer? In our education, we need to train people of how to get those answers, not what those answers are.

Frank agreed, and cautioned, "I also think it's important to not overstep what our training is. I think some people try to take on too much and more than what they're capable of." For him, staying within his scope of practice meant, "making those referrals." Abner viewed his scope of practice similarly:

> I am absolutely not a mental health expert. I am comfortable helping my student-athlete get to the next care level. I certainly would never counsel a student-athlete or tell them any recommendations. I literally just want to get them to the next level of care and the appropriate level of care wherever that needs to be. Then, on the back end, once they've received care, I want to help them re-enter the sport.

*Need for Education and Training*. All participants agreed that support, recognition, and referral were the main responsibilities of athletic trainers in the mental health care of student-athletes. However, many participants lamented the lack of education they had in even being able to recognize diminished mental health. Frank described his education in athletic training, "I mean, beyond the basic psychology class that was required for my athletic training undergrad degree, there wasn't anything that was specific to mental health." He suggested, "I think every athletic trainer should have some sort of mental health first-aid, or some sort of credential to go along with it to have something a bit more practical." Christine, in reflecting on her own education, identified a gap in her education related to be able to have effective and supportive conversations with student-athletes around mental health. She said, "I would love it if we had some sort of general counseling course at my school. I have taken some continuing education courses and stuff like that but looking back I wish I had just had a general counseling class." Edward had received some education on how to handle crisis situations, such as suicidal ideation, but his education lacked in learning how to handle non-crisis mental health of student-athletes. In reflecting on the information in his athletic training seminar on mental health, he said it was "based off the severe cases of how you're going to handle someone who is trying to end their own life or are self-injuring themselves or claiming they want to injure other people. Those things are important to know, but they're not necessarily something you see every day." Yet, even this limited education is still not widespread in athletic training programs, as Hailey suggested most athletic training undergraduate programs across the country "(teach) you nothing in regard to the mental health side of the ball."

The participants also pointed to the lack of continued education and trainings at their institutions. Daniel lamented:

> We didn't have much training in terms of mental health, but we did meet to discuss the avenue for how to carry out your evaluation to decide if it's something you can handle as an athletic trainer, or if it requires a referral. So, we went through the chain of command in terms of where to go, where to send and who to refer to, but there wasn't any formal training in terms of telling us what to do in various situations.

Christine described her institution's "training" as a meeting that happens twice a year. Although important information about the mental health referral process is shared, she conceded, "it would also be difficult for a new staff member who is anxious to come in and get with their team, because we don't really have a training course for them." Frank described a similar issue with mental health training at his institution: "It's not a formal training, it's really just for us to read the policy and ask any questions that may come up to our senior staff members."

Both Hailey and Becca described the strengths of the mental health trainings for athletic trainers at their respective institutions, which may act a guide for other athletic departments looking to expand this type of education for their staff members. Hailey said:

> I (do) an on-boarding session with our interns. I start it off by just asking them what they knew about the mental wellness side. I ask them about what they had seen and what they had been told. Then, after that we defined their level of understanding. We defined the need when it comes to statistically that one-in-five students in the collegiate realm suffer from some sort of mental illness and recognize that within our department of athletics, we're spot-on with that. We're actually right above that at 32%. Then, I went through our behavioral medicine guidance packet that defines key terms, talks about what the stressors look like, and how to have conversations once you identify the need.

Becca promoted her institution's training regime:

> I think we do a pretty good job here. In our curriculum, our mental health counselors do a few lectures related to identification of mental health struggles and illness. It takes more than just taking a sport psychology class. Psychology class isn't going to cover it. So, having people that are boots on the ground managing these types of chronic stressors that student-athletes experience and communicating and teaching basic skills to our student-athletic trainers as they're coming through is important.

This type of education and training is important, so that athletic trainers are better equipped to recognize diminished mental health, support student-athletes in disclosing a mental health concern, and then making an appropriate referral.

## Discussion

The purpose of this study was to examine athletic trainers' perception of their role in the mental health care of student-athletes. These findings can guide a greater depth of understanding of the role of an athletic trainer working at the collegiate level, and specifically expand the literature to understand how they perceive their role in the mental health care of student-athletes.

The participants in this study believed that they would be one of the first individuals to know of or find out about any mental health problem or potential diagnosis with a student-athletes because of the amount of time they spend with them. This time spent with the student-athletes is perhaps due to the lower ratio of athletic trainers to student-athlete, compared to other medical staff. Mazerolle (2010) reported most athletic departments have seven full-time staff members to cover anywhere from 20 to 28 sports. The time these athletic trainers spend with student-athletes does not just extend through the normal in-season and out-of-season periods during the school year. Most athletic programs will require their student-athletes to train through the summer months, leading to more time spent with athletic trainers (Mazerolle et al., 2016).

The time athletic trainers spend with student-athletes may give them an advantage in building foundational relationships with student-athletes, which may improve early detection of diminished mental health. Kroshus (2016) found that NCAA member institutions across divisions with lower athletic trainer to student-athlete ratios were more likely to engage in mental health screening practices. This may, of course, be due to increased organizational capacity to implement screening methods, but it may also speak to the established relationships between athletic trainers and the student-athletes. Participants also attributed decreasing mental health stigma to building these strong relationships with the student-athletes and creating a safe space of trust within the athletic training facility. Mental health stigma is common in sport (Chow et al., 2020; Gulliver et al., 2012; Whato et al., 2016), where the culture prioritizes winning over both mental and physical health (Putuikan. 2016). This stigma can lead to low help-seeking behaviors of student-athletes, who may be afraid of ridicule, appearing weak, and reduced playing time if they tell others about their mental health struggles (Bissett & Tamminen, 2020; Gulliver et al., 2012). Telling, both quantitative (e.g., Whato et al., 2016) and qualitative (e.g., DeLenardo & Terrion, 2014) research has found that high mental health stigma, both societal and self, is one of the largest factors in a student-athletes' decision to not seek needed help for a mental health issue.

Studies have explored ways to reduced stigma in the athlete population, such as mental health literacy programs (e.g., Breslin et al., 2017; Chow et al., 2020) and contact interventions where athletes speak to or hear from other athletes about mental health struggles (Kern et al., 2017). Recent literature has also found that when athletic department staff, such as coaches, are open about mental health, athletes are more likely to seek mental health help (Bissett & Tamminen, 2020). In fact, there is research that suggests individuals are more likely to seek professional help and follow-through on clinical therapy referrals if the initial conversation and referral comes from a trusted member of their support network, such as a coach (Bissett & Tamminen, 2020) or family member (Whato et al., 2016). Additionally, the NCAA, in their best practice guide on mental health, suggests that "the way we communicate about mental health" is one of the key considerations in creating an environment that prioritizes student-athlete well-being (NCAA Sport Sciences Institute, 2017, p. 14). Openly discussing mental health in a stigma-free way can create an environment that supports help-seeking in contrast to one that sees it as a weakness. Athletic trainers play a vital role in this due to the amount of time spent with student-athletes, and the trust many student-athletes have with athletic trainers. The findings of this study suggest a strong and trusting relationship between student-athletes and athletic trainers. Athletic trainers can play a significant role in decreasing mental health stigma by both creating a safe space in the athletic training facility to begin having conversations about mental health and being the trusting source that initiates mental health referrals for student-athletes.

Therefore, it may not be surprising the importance of relationships between medical and behavioral health staff and student-athletes in administrating the best care (e.g., Antle et al., 2021; Beasley et al. 2021) and specifically of the athletic trainer-athlete relationship, especially in injury rehabilitation (e.g., Bejar et al., 2019; Zakrajsek et al., 2018). Participants in this study agreed that building lasting relationships was important to provide the proper care to the athletes. Relationships were built by creating a safe space for the student-athletes prioritizing getting to know the person before the athlete. As multiple participants stated, knowing the athletes helped them identify diminished mental health when athletes were acting differently than their baseline.

Another key in the relationship is among members of the student-athletes' care team (Beasley et al., 2021). Waller and colleagues (2016) have defined the holistic care team in athletic departments as the different types of professionals that can work together to meet the physical, mental, emotional, and spiritual needs of student-athletes. Resources differ among

institutions and are dependent upon financial restraints of schools resulting in NCAA Division I – Autonomous members more likely to provide some in-house mental health resources to their student-athletes (Kroshus et al., 2016). Most of the participants in this study discussed having at least one mental health professional in the athletic department to which they could refer student-athletes. Many participants termed the mental health staff "behavioral medicine." In these behavioral medicine offices, there tended to be a mix of social workers, psychologists, certified mental performance coaches, psychiatrists, and behavioral therapists.

The athletic trainers in this study observed that the stigma around using the services of mental health professionals was reduced when professionals had a consistent presence in the athletic department which supports previous research (Beasley et al., 2021). The visibility of mental health staff was beneficial for athletic trainers as well in knowing which professional was the best to serve the specific needs of a student-athlete when making a referral. Regardless of the resources available at a specific institution, it is imperative to note that student-athletes across the NCAA face the same mental health challenges. Student-athletes must deal with athletic identity challenges, competition pressures, academic challenges, transitioning issues, and the struggles of any other college student. It is important that all athletic trainers recognize their role in the mental health care of student-athletes regardless of competition level. The same principles apply in being the first line of defense, a member of the holistic care team, and making the appropriate referral when necessary.

For an institution's care team to function properly, however, understanding and practicing within one's scope of practice was also essential to an effective holistic care team in sport (McHenry et al., 2021). For the participants in this study, they defined their role in student-athlete mental health as: recognize, react, and refer. They were very clear that they were not mental health professionals. Although they may have built strong relationships with student-athletes, are around them for extended periods of time, and have mental health resources at their disposal, there are still limitations to what they are able to do and provide for their athletes.

Eason and colleagues (2018) examined the uniqueness of the athletic training profession compared to a mental health professional. They found that although athletic trainers and mental health professionals have similar paths in discovering their professional identities, the difference in education requirements, in-the-field hour differences, and supervisory requirements made the professions wildly different in terms of scope of care (Eason et al., 2018). Understanding who does what, or interprofessional cultural competence, is essential for effective practice in interdisciplinary settings, such as collegiate athletics (McHenry et al., 2021). Additionally, burnout and poor work-life balance are already prevalent in the athletic training profession (Eason et al., 2017; Eberman et al., 2019; Mazerolle et al., 2010). Thus, expecting athletic trainers to take on a role outside of the scope of their training, may only add to burnout. To meet the specific role of athletic trainers in student-athlete mental health, the participants in this study stated they needed more education how to recognize both crisis and non-crisis situations. They also reported needing more emphasis placed on teaching the referral process. The Commission on Accreditation of Athletic Training Education (CAATE) has recognized this need for mental health education. Standard 18 of the organizations' Standards and Procedures for Accreditation specifies students should gain experience with health conditions they may commonly encounter in practice. Those conditions not only include a variety of physical conditions but also specifies behavioral and mental health conditions (CAATE, 2022). Other standards also reference the ability to assess the mental health status of a patient who has sustained a concussion or brain injury as well as specific policies for behavioral health issues (CAATE, 2022). Athletic training programs must ensure that students are exposed to mental health education and the ability to recognize signs of diminished mental health. The findings from this study indicate that athletic

trainers are often among the first health care providers who have the opportunity to recognize diminished mental health and are able to refer the student-athlete to receive the care they need.

## Conclusion

There are some study limitations that must be noted. First, each participant worked at a similar sized university with similar athletic budgets, all of whom are in the same conference. While the study provided an in-depth look into the resources that are available at those institutions, future research should examine the experiences of athletic trainers at different institutions in different conferences, different divisions, and with different financial resources. A second limitation were the effects of the COVID-19 global pandemic which resulted in all interviews being conducted virtually. The pandemic also increased the workloads of many athletic trainers and may have resulted in potential respondents declining to participate in the study.

The results of this study can offer insights to various collegiate athletic stakeholders. For athletic trainers, the results of this study help further define their scope of practice. The day-to-day experience of an athletic trainer is one that is multidimensional (Mazerolle et al., 2016), which requires them to constantly be flexible in meeting the needs of student-athletes. It is clear from the study that athletic trainers many times develop important relationships with student-athletes. With this comes the potential to have to reach outside their professional limitations, resulting in compromised care for the student-athlete and a compromised life for the athletic trainer leading to burnout and/or poor work-life balance (Mazerolle et al., 2010). Thus, education and training on athletic trainers' scope of practice is needed for the athletic trainers, as well as for other stakeholders (i.e., coaches, administrators) to limit the institutional expectations that athletic trainers act as an "informal" counselor for student-athletes. Specific and formalized policies and procedures—i.e., who to refer to in specific situations—can further clarify for athletic trainers how to act in both crisis and noncrisis situations.

Additionally, administrators need to invest in hiring or contracting with licensed mental health professionals. Putting resources behind mental health care can allow athletic trainers to perform their job and support the student-athlete, while not having to step outside their scope of practice. Additionally, for the participants in this study, having mental health professionals on staff in the athletic department aided in both decreasing stigma around mental health care and for establishing relationships between the athletic trainers and the mental health professionals. Thus, for administrators considering how to structure mental health care for student-athletes, it seems some type of in-house model is most effective, both for the student-athletes themselves as well for other members of the student-athletes' holistic care teams.

Athletic trainers are a key support system and many times the first to recognize the diminished mental health of student-athletes due to the amount of time spent with them. However, there has been limited research on the perception athletic trainers have of their own role in student-athlete mental health care. The experiences of participants in this study demonstrated the benefit of in-house mental health professionals and highlighted the participants' desire to work within their scope of practice. Although not every institution may be able to afford in-house professionals, providing clear and concise referral policies can streamline mental health care, providing the student-athletes and athletic trainers the support they need.

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