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Original Research

Collaborative Mental Health Care in Collegiate Athletics: Behavioral Health Providers' Perceived Role of the Athletic Trainer

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Context: Developing effective interprofessional teams is vital to achieving quality care for those dealing with behavioral health concerns. Athletic trainers (ATs) play a vital role, as they are often the first health care providers to interact with student-athletes participating in intercollegiate athletics. However, research regarding how behavioral health providers view the AT's role on interprofessional behavioral health teams is limited.

Objective: To explore behavioral health providers' perceived role of ATs in collaborative behavioral health care.

Design: Qualitative study.

Setting: Individual interviews.

Patients or Other Participants: Nine behavioral health care providers (women = 6, men = 3; age range = 30–59 years, years in clinical practice = 6–25) from National Collegiate Athletic Association Power 5 schools were interviewed.

Data Collection and Analysis: Participants were contacted via publicly available information on their university websites. Participants engaged in individual, audio-only interviews using a commercially available teleconferencing platform. All interviews were recorded, transcribed, and returned to participants for member checking. A phenomenological approach with inductive coding and multianalyst triangulation was performed to analyze the transcripts for common themes and subthemes.

Results: Three themes emerged: (1) provider experience, (2) the AT's role in behavioral health, and (3) collaboration. Provider experience included subthemes of formal education and interaction with ATs. Subthemes of the AT's role included care coordination, information gathering, and positive proximity. Subthemes for collaboration included structural collaboration, cultural collaboration, collaboration concerns, and suggestions for ideal collaboration.

Conclusions: Collaborative care models can enhance providers' abilities and maximize support of student-athlete wellness. In this study, we demonstrated that behavioral health providers working within a collaborative care model with ATs had overall positive experiences with such collaboration and that clear role delineation and responsibilities helped to foster high-quality patient care.

Key Words: interprofessional care, collaboration

Key Points

- Collaborative care in behavioral health can enhance providers' ability to support student-athlete wellness.
- Athletic trainers should integrate behavioral health professionals into athletic medicine to improve interprofessional collaborative practice.
- Interprofessional education on roles and responsibilities can help to bridge the gap between athletic trainers and behavioral health providers in terms of mental health services.

Collaboration occurs when 2 or more entities work together to produce a desired outcome,[1] which in health care is believed to yield better health services and outcomes for those being served.[2] Researchers[3] stated that interprofessional collaboration improved efficiency, skill mix, levels of responsiveness, holistic services, innovation, and creativity and fostered patient-centered practice. In health care, interprofessional collaborative practice occurs when multiple clinicians from different professional backgrounds provide comprehensive services by working with patients, their families, and communities to deliver the highest quality of care across settings.[4] Interprofessional collaborative care is achieved when clinicians have mutual respect for one another and their professions and willingly participate in a cooperative atmosphere.[5] Ideally, interprofessional collaborative practice extends into athletic settings, creating cohesion between physical and behavioral health care.

An athlete's psychosocial response to injury can unveil or incite behavioral health challenges, including anxiety, depression, suicidal ideation, disordered eating, and substance use.[6] Anxiety and depression are the most frequent behavioral health challenges among athletes,[7] with up to 20% of college student-athletes being diagnosed with depression.[8] Previous authors[9] identified that National Collegiate Athletic Association (NCAA) Division I student-athletes faced many of the same behavioral health concerns as other students but had higher levels of other behavioral health concerns, including substance abuse, than nonathlete students. Although student-athletes are exposed to an increase in external stressors such

as classes, practices, and relationships, they are often less likely to seek help for behavioral health than nonathletes.[10,11] Barriers to help-seeking typically stem from fear of the reactions of teammates or coaches, worry about the effect on playing status, a lack of time or ability to engage with a behavioral health provider, a perceived stigma surrounding behavioral health conditions, or all of these.[12]

In 2013, an NCAA task force created a behavioral health best-practices document stating that student-athlete mental well-being was best served through a collaborative process of engaging the full complement of available campus and community resources.[12] It also noted that identifying available resources and developing strong interprofessional relationships were critical to ensuring quick, informed, and effective responses from involved professionals. Professionals should be linked in a collaborative model of care that enhances providers' ability and maximizes support of student-athlete wellness.[12] Developing effective interprofessional teams is vital to achieving patient-centered, safer, timelier, more effective, efficient, and equitable care.[13] Interprofessional collaborative teams promote more efficient care coordination, reduce medical errors, and improve patient advocacy.[14]

Regarding the collaboration between athletic trainers (ATs) and behavioral health providers, previous researchers[15] observed that ATs were often the first line of care for athletes. Currently, wide variability is present in how behavioral health services are provided to student-athletes, the use of behavioral health screening tools is inconsistent, and no standard collaborative or integrated care delivery model for student-athletes, especially within NCAA Division I institutions, exists.[15] Investigators[15] described the need to explore how NCAA institutions can adopt collaborative health care models to deliver comprehensive care to student-athletes. The current literature is lacking in the perspectives of behavioral health providers on this form of collaborative patient care. Athletic trainers are in a prime position, seeing patients nearly daily, to effectively partner with behavioral health providers. Therefore, the purpose of our study was to explore behavioral health providers' perceptions of ATs in collaborative behavioral health care to determine the role ATs should have in monitoring the treatment, adherence, and progress of patients diagnosed with behavioral health conditions.

METHODS

Participants

Recruits were included if they were behavioral health providers (eg, sport psychologist, psychiatrist, social worker) employed by or contracted with an NCAA–affiliated Power 5 conference (Atlantic Coast, Southeastern, Big 10, Big 12, or Pac-12), which is composed of 65 universities.[5] Participants had to be currently working directly with their university's student-athletes and had to have worked directly with an AT at some point in their career. We selected the NCAA Power 5 conferences because they span all parts of the country and offered a broad sampling of schools that were more likely to have the resources to employ behavioral health providers.

After the study was deemed exempt by the Indiana State University Institutional Review Board, a member of the research team (G.M.) created a contact information database from publicly available information for the director of sports medicine, associate director of sports medicine, head AT, and behavioral health provider of all 65 NCAA Power 5 institutions; 89 behavioral health providers were identified, added to the contact information database, and sent a direct recruitment email inviting them to participate in the study. In addition, 20 other individuals (director or associate director of sports medicine or head AT) were sent an email with the recruitment opportunity and asked to forward it to the behavioral health provider when behavioral health provider contact information was publicly unavailable. Recruits were contacted via their publicly available contact information on their university websites as described earlier. An email was sent inviting them to participate in the study, which included a link to the informed consent and screening items, as well as a brief demographic survey, which asked about job setting and role, credentials, age, years in practice, and in what ways they had interacted with ATs in the past. Eligible, willing volunteers filled out this brief survey, and a member of the research team (G.M.) then reached out to schedule interviews. Participants were selected as the first available for interviews, with recruitment continuing until data saturation was achieved, when no new information was being gathered during data collection. Overall, 9 participants (women = 6, men = 3; age = 39 ± 9 years; years in clinical practice = 12 ± 6 years) from 4 of the NCAA Power 5 conferences (Atlantic Coast, Southeastern, Big 10, and Pac-12) were interviewed (Figure 1). Full demographics are provided in Table 1.

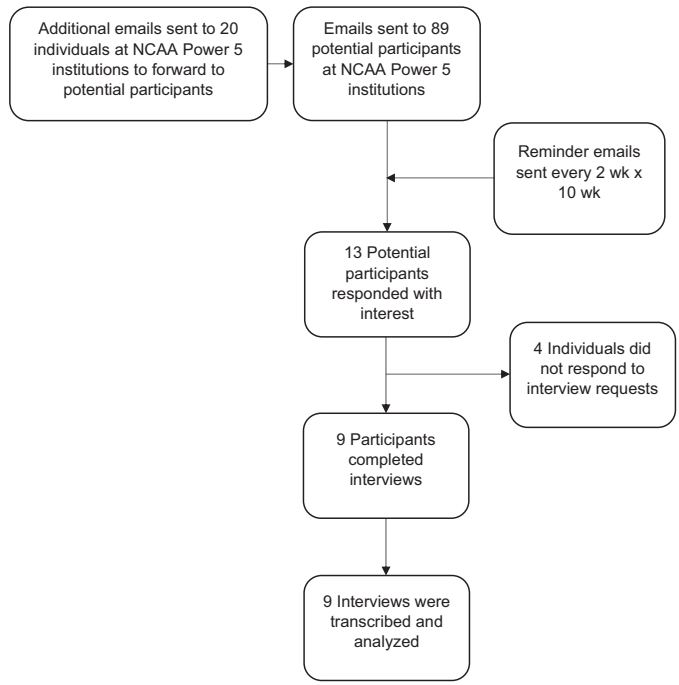

Figure 1. Recruitment flow chart.

Data Collection

Each participant scheduled and engaged in an audio-only, individual interview using a commercially available teleconferencing platform (Zoom). First, the research team member obtained oral consent and permission to record the interview and reiterated the purpose of the study. The interview began with participants sharing their paths to working as behavioral health providers, followed by the interview protocol as described in Table 2. The interview protocol was developed by members of the research team with

Table 1. Participant Demographics

Participant Pseudonym	Sex	Age	Years in Practice	NCAA Conference	Degree or Certification
Alejandro	Man	37	10	Big 10	PhD CMPC HSPP
Camille	Woman	30	7	Big 10	PsyD
Dalonté	Man	41	15	ACC	Licensed psychologist
Emily	Woman	30	6	Big 10	PsyD
Erin	Woman	32	8	SEC	MSW LCSW CAADC
Felipe	Man	39	9	Big 10	PhD ABPP
Latisha	Woman	41	14	Big 10	MSW LSW
Sandra	Woman	59	25	PAC-12	PhD Licensed psychologist
Valerie	Woman	45	16	SEC	PhD CMPC

Abbreviations: ABPP, Board Certified in Counseling Psychology by the American Board of Professional Psychology; ACC, Atlantic Coast Conference; CAADC, Certified Advanced Alcohol and Drug Counselor; CMPC, Certified Mental Performance Consultant; HSPP, Health Service Provider in Psychology; LCSW, Licensed Clinical Social Worker; LSW, Licensed Social Worker; MSW; Master of Social Work; NCAA, National Collegiate Athletic Association; PsyD, Doctor of Psychology; SEC, Southeastern Conference.

various levels of experience in qualitative interviewing (M.J.D., G.M., Z.K.W., K.E.G.). Due to the lack of a preexisting instrument, we developed the interview protocol in alignment with the research question. The protocol was designed as a semistructured script to allow the researcher flexibility as well as the ability to ask clarifying questions. The protocol was sent to 2 external content experts to determine face validity. These experts were ATs with experience in qualitative research and the treatment of behavioral health conditions in athletic training. Finally, the interview script was piloted with 2 recruits who were ineligible for this study. Pilot interviews were conducted to prepare the interviewer and confirm the comprehensiveness of the interview script. The protocol interview questions were modified as necessary based on the peer feedback and pilot interviews.

To ensure consistency with the delivery of the interview protocol, 1 member of the research team conducted all the interviews (G.M.), which lasted 25 to 35 minutes. Interviews were recorded and transcribed verbatim using the automated transcription service via Zoom (Otter.ai). The researcher (G.M.) deidentified the transcripts and listened to each recording to check transcript accuracy and edit as needed.

Data Analysis

The researchers formed a 3-person coding team consisting of 1 novice (G.M.) and 2 expert (Z.K.W., K.E.G.) qualitative researchers. The 2 experts had experience in qualitative research, behavioral health, and interprofessional and collaborative practice in athletic training. The team followed a general inductive coding approach in analyzing the transcripts for common themes and subthemes. The analysis consisted of multiple phases, beginning with an initial review and coding of 3 transcripts by each team member; the members used this initial review to curate their own individual codebooks of themes and subthemes as well as field notes. This process grounded our analysis to ensure that common information was being extracted from the transcript. The coding team then discussed the coded transcripts and developed a joint codebook that contained the final themes and subthemes represented in the transcripts. The researcher (G.M.) used this codebook to code all 9 transcripts. After this, the coding team met to internally review all 9 transcripts and discuss any discrepancies. Once the coding team confirmed the codes for all 9 transcripts, an external reviewer (M.J.D.) confirmed the consensus code book, coding, and accuracy of the analyzed information. The research team used the Standards for Reporting

Table 2. Interview Questions[a]

1. What experiences have you had collaborating with an athletic trainer?
2. In what ways, if any, do you currently partner with an athletic trainer during patient care? Describe.
   a. If currently partnered with an athletic trainer: What have you found to be successful? What have you found to be a challenge?
   b. If not currently partnered with an athletic trainer: Have you tried this type of collaboration before, and if so, was it unsuccessful and why? If you have not been engaged in this type of collaboration before, would you consider trying it?
3. What, if any, role do you believe an athletic trainer should play in monitoring treatment, compliance, and progress of patients diagnosed with a behavior health condition?
4. In what ways, if any, do you see benefits to an athletic trainer participating in a patient's ongoing care?
5. In what ways, if any, do you see concerns to an athletic trainer participating in a patient's ongoing care?
6. In what ways, if any, could your care be supplemented by another provider who sees patients near daily?
7. Is there anything else related to this topic that you think I should know or would like to discuss?

[a] Questions are presented in their original format.

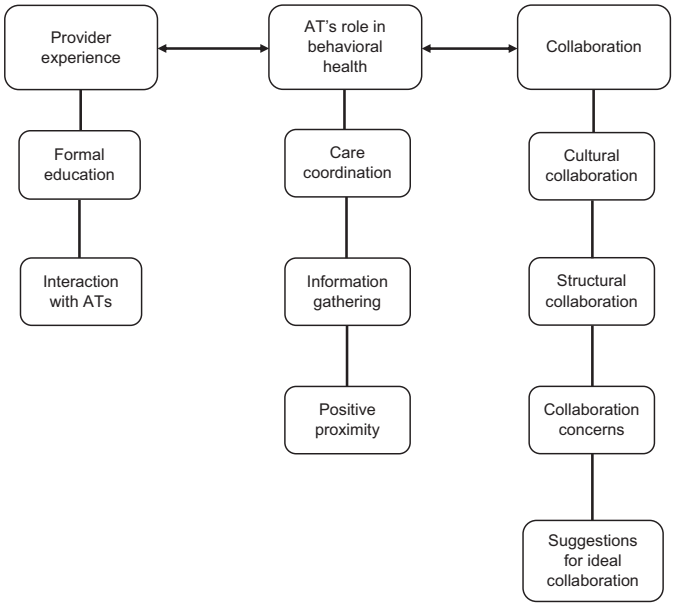

Figure 2. Themes and subthemes. Abbreviation: AT, athletic trainer.

Qualitative Research checklist to ensure accurate data reporting throughout the manuscript.[16,17]

Credibility and Trustworthiness

Credibility and trustworthiness were established and maintained using multianalyst triangulation, a peer external reviewer, and member checks. Participants were sent their transcribed interviews to review for accuracy. Each person was instructed to return the document with any necessary edits to the research team within 10 days. If the individual did not return the document, it was assumed that the transcript was accurate and data analysis could begin. None of the participants responded to member checking, and thus, no edits were made. Multianalyst triangulation was conducted by the 3-person coding team that independently reviewed and coding the data following the same procedures. Finally, the peer external review was completed by a member of the research team but not the coding team who reviewed the coding documents, transcripts, and themes to ensure agreement with the presented results.

RESULTS

Themes and subthemes are shown in Figure 2. Three themes emerged from the interviews: (1) provider experience, (2) the AT's role in behavioral health, and (3) collaboration. Provider experience included subthemes of formal education and interactions with ATs. Table 1 presents context to the providers' formal education. Subthemes of the AT's role in behavioral health included care coordination, information gathering, and positive proximity. Collaboration included subthemes related to structural collaboration (eg, office space, shared schedules), cultural collaboration (eg, staff meetings, shared team presentations), collaboration concerns (eg, confidentiality, medical independence, role confusion), and suggestions for ideal collaboration.

Provider Experience

Formal Education. Participants' descriptions of their formal educational paths varied, but all spent a significant amount of time gaining the necessary education, and all had experience with a broad range of populations. Alejandro said:

> I did a practicum in all kinds of settings: a counseling center, community mental health clinic, domestic violence agency. Many people do not have any idea how much training goes into becoming a sports psychologist.

Most participants seemed to follow a similar formal educational path of an undergraduate degree in psychology, a graduate degree in a more specific area (ie, athletic counseling, social work), and then a doctorate followed by postdoctoral fellowship and residency. They described their formal education and experiences as being guided by a unique interest in working with athletes. Camille stated:

> I have clinical training, but throughout graduate school, I knew I wanted to do sports psychology or sport emphasis, which doesn't really exist in like a formal sense. It's more of created as you go along and getting experience, so on a couple of my rotations, I was able to work with some athletes, and then I created and did an elective one on top of that. . .

Erin also mentioned that her past experiences influenced her decision to pursue education focused on athletes:

> I realized I do have a passion for working with college athletes. I see this need [for behavioral health services] from my experiences [as a former college athlete] that is really not being met, so I really devoted all of my graduate work and postgraduate work on research and advocacy for social workers working in collegiate mental health.

Most respondents conveyed an experience that created interest in sport psychology or a related field and played an integral part in their educational path toward providing behavioral health services to collegiate athletes.

Interactions with ATs. Participants spoke well of their interactions with ATs at their respective institutions, citing collaboration on topics such as eating disorders, major depression and suicidality, attention-deficit virgule and close up hyperactivity disorder, and anxiety. All individuals believed that ATs had played a vital role in the recognition and referral processes, expressing that ATs had a willingness to refer and aid the athlete in obtaining help whenever they noticed that something was wrong. Dalonté attributed part of the referral success to the trust built between ATs and athletes:

> I do find that [ATs] are usually the people that the athletes are trusting most because I think they generally see most of the time that their [ATs] do seem to have their best interests at heart.

However, Dalonté expressed concern that

> Sometimes, I feel like what happens is it's difficult for [ATs] to know sort of where the boundaries are, like

where their job as the AT should cut off and then becomes somebody else's responsibility to do with the behavioral health side of things. At times, I feel like they feel compelled to take on more than they need to.

In addition to participants sharing experiences with collaboration on recognition and referral, they spoke about interpersonal experiences with ATs and the mutual understanding and respect that helps to foster good interprofessional collaborative care. Emily shared that she "values the expertise that the AT is coming into a scenario from a kinesiology standpoint—fitness and health and wellness standpoint":

I can tell that [the ATs] value what I am bringing to the table. They recognize that my background and area of study is on emotions and behavior and thought processes, and there is no expectation for me to understand what the rehab[ilitation] process is going to be for my athlete's torn ACL [anterior cruciate ligament], and there's no expectation on my part for them to understand what might be happening cognitively for my athlete who is going through a breakup or a loss or anxiety or depression. So, there is a mutual understanding of our competencies, and we operate from that understanding.

Most respondents reflected these sentiments, describing positive experiences and relationships with ATs in their institutions, supporting the idea of effective interprofessional collaboration.

The AT's Role in Behavioral Health

Care Coordination. Every participant spoke on the AT's role of referral and coordinating care, with some even expressing that their institution's ATs had direct access to their calendars and did not need to contact a third party to schedule a patient with a behavioral health provider. Felipe expressed that the value of the AT in these processes is so vital that their "model is that the [AT] is the hub of the wheel, in the middle of all care. All care goes through the [AT]," He went on to say:

[W]e really need to include the [AT] in things that are happening because they're monitoring [the patient] every day. They have a better sense than I do, who sees them once a week, of what is the context of the concern that [the patients] are experiencing.

Although ATs play a vital role in this process, it is still paramount that they remain within their scope of practice and engage in healthy professional boundaries. Dalonté cautioned that the AT's role is more in coordination of care than in monitoring the care, saying that

. . . whenever the [AT] is the one doing the referring, I think it is appropriate to say, "Did [the patient] make their appointments?" but do I think that they need to have ongoing progress reports from the behavioral health [provider]? Probably not.

That was not the only caution in care coordination. Camille expressed that ATs have "a lot on their plate" and "wear various hats," so she is cautious not to add more. She found it vital to "make sure that they are equipped to handle situations that come up but not try to become a quasitherapist." She recommended that ATs learn "appropriate skills that they could use quickly in the moment" and then refer to the behavioral health providers. Athletic trainers must strike a balance between knowing what care may be needed and assisting the patient in connecting with that care while not taking on personal responsibility for the patient's mental and behavioral health care. When ATs were reported to be performing this role well, participants expressed satisfaction and gratitude for the assistance in coordination.

Information Gathering. In addition to care coordination, participants commented that one of the most valuable parts of their collaboration with ATs was the unique information that ATs can gather through interactions with patients in varied settings. Alejandro noted:

We get that 1 snapshot of [the patient] for an hour a week. Our [ATs] are seeing them in competition, at practice, so they are seeing them in a more naturalistic setting more often than we do. . . They are able to give us valuable information about how this person is really actually doing or how they are interacting with their teammates or coaches.

Behavioral health providers are limited in their capacity to observe and obtain a holistic view of the patients they serve, so information gathering is a vital service that ATs can provide. By being present at team events such as weight lifting, practice, games, travel, and meals, ATs can organically see all facets of a patient.

The time that ATs spend around the patients they serve helps them build rapport and trust and provides many opportunities for patients to open up about potential behavioral health concerns. Camille reinforced this point: ". . . there is a really good relationship that [ATs] build with the student-athletes, too, so sometimes they are a little bit more willing to share information or disclose things."

The AT has the responsibility to foster an environment in which patients feel safe disclosing sensitive information. Further, this responsibility does not stop with creating a safe space but extends to conscious awareness in the interactions that ATs have with patients and intentional collaboration with behavioral health providers in sharing important information. Valerie drove the point home:

I've had [ATs] provide me with additional information and had it be very insightful. . . if we can collaborate or have the opportunity to collaborate, then we can kind of meet this athlete where they are and provide them with what they need.

Relying on all members of the care team in their most optimal environments and job responsibilities allows the patient to receive more comprehensive and effective services.

Positive Proximity. Given their physical proximity to and the amount of time spent with student-athletes, ATs can not only create a safe space where patients can open up but also leverage the trust they have built to influence patients. Participants described an AT's positive proximity as active and empathic listening, compassion, and depending on the influence of relationships. In Emily's experience,

> If the [AT] talks down about mental health or sports psych[ology], then that athlete might do so as well, might not feel comfortable asking for resources, or might continue to feel the stigma of mental health, but if that [AT] is warm and open and inviting around those topics, then that will empower the student to seek out the support that they need.

Many respondents described this phenomenon regarding how an AT speaks of mental and behavioral health, with several referring to it as a "crucial moment" or "moment of impact" because it can affect patients' care-seeking decisions. That first crucial moment of impact is not the only time when ATs can use their proximity for positive influence. Even without specific training, providers can leverage their relationships with athletes to good effect. Latisha described the positive use of proximity and a built relationship:

> I just think of the power in the relationships that [ATs] have. You have a relationship with your student-athletes, use that. . . We are not looking for brilliance here. We are looking for connection, and we are looking for safety for our student-athletes. So, use your relationship that you already have.

It is important to note that most participants mentioned this connection and encouraged ATs to use and leverage the influence they have in these relationships, but several also cautioned ATs not to overextend themselves and take on the weight or responsibility of patients' mental health care. Compassion and empathic listening must be balanced with strong boundaries, and ATs ought to rely on behavioral health providers as a resource to support those boundaries through collaboration.

Collaboration

Structural. Sandra made a bold statement, saying that "the single greatest pulse on our student-athlete body is athletic medicine. It is the athletic training staff more than anybody." Most participants discussed having integrated facilities and systems, which they believed increased care-seeking tendencies and use of resources by patients, facilitated better cultural collaboration among providers and assisted with the scheduling and referral processes. Each participant who described a highly integrated structure reported the higher degree of integration to be correlated with a decrease in the stigma surrounding mental health conditions overall as well as related care-seeking. Alejandro shared:

> [W]e have actually found that the closer you are, the more integrated it is. I think it helps to destigmatize mental health [conditions] and makes it easier for them to come in and see us because it isn't far away.

Integrated systems and facilities not only assist in decreasing stigma, but they also help to foster rapport among providers and with patients, allow for ease of access, and remove barriers for providers.

Latisha commented that, in her setting, all the services are provided in 1 central location. She conveyed, "[F]rom a social work lens, that removes barriers for me, because if there is someone that is having a crisis in the athletic training room, they can walk over to our offices," and complete a warm handoff, and that she "can pop into the athletic training room and just hang out and talk to [ATs] and see students and say hello and just be a familiar face for them as well." The participants' responses showed that structural integration benefits ATs, behavioral health providers, and patients alike. Communication integration from the start helps to facilitate cultural collaboration as well.

Cultural. Participants described cultural collaboration by the types of cases they often collaborate on, meetings that make collaboration more effective, collaboration in preparticipation physical examinations, and more. Descriptions of cases on which they often collaborated primarily led to the information presented in the section on the AT's role in behavioral health. Individuals talked about having regularly scheduled care team or treatment team meetings. Felipe expounded on the structure:

> [A]thletic performance team meetings are set up that have athletic training, coach, nutrition, and especially if there's a mental health thing going on, we'll be in that meeting, and that's a regularly scheduled meeting for every single team.

Respondents believed that these meetings helped foster a better sense of collaboration and bolstered communication among providers, which in turn promoted more comprehensive care of the patients. Latisha explained:

> [T]he benefit is holistic care. I talk to my students about holistic health—so it is mind, body, spirit, emotion, all those things. When I think of the [AT's] participation in it, I think of it as just as one more spoke on the bicycle tire. It is 1 more way of support and 1 more thing that we can have. It is just like, sort of, that seamless care or that seamless collaboration.

Participants who described these regularly scheduled meetings reported them to be more effective than speaking or collaborating on an as-needed basis alone (eg, when a patient was in crisis). Dalonté agreed:

> [W]e have really been trying to make a big point that we do not want to end up kind of crumbling, and then after the fact, we are having to try to pick up the pieces. We want to be initiative taking when somebody has an injury and go ahead and try to get those things set up.

These are some of the details that are addressed in care team meetings.

Another person spoke of the AT–behavioral health collaboration wheel of cultural collaboration during preparticipation physical examinations. Latisha said, at her institution, this collaboration starts in the preseason, coordinating with ATs to meet with new student-athletes, whether incoming first-year students or transfers, and to be part of the preparticipation examination process:

> [The sports psychology staff] coordinates with [ATs] at the beginning of each season to meet with the new student-athletes, whether incoming freshmen or transfers, and we are part of the PPE process, which is the preperformance

[sic] examination. We [meet] with [student-athletes], and they fill out a GAD [General Anxiety Disorder]-7 [instrument] and a PHQ [Patient Health Questionnaire]-9 [instrument], so they're screeners for anxiety and depression, and we meet each of them individually. We introduce ourselves, tell them about our services, look over their screeners, give them our business cards, and say, "Hey, if you ever need anything from us, let us know."

Latisha felt that behavioral health providers being a part of the preparticipation process normalized mental health as part of the process at her institution. It is evident that collaboration is necessary, possible, and beneficial; however, potential concerns of collaboration must be addressed.

Concerns. Participants' primary concerns in collaborations with ATs centered on confidentiality: how it affects the patient, engagement in a care plan, and reasons ATs may break confidentiality; stigma surrounding mental health conditions; moment of impact; and ATs overstepping into the role of a behavioral health provider. Individuals cited pressure from coaches being 1 reason for an AT to break patient confidentiality regarding behavioral health concerns. Beyond pressure from coaches, Latisha recognized that well-meaning yet potentially detrimental sharing with coaches could occur based on built relationships:

Because [ATs] are with the team so much, that means they are also with the coaches. They build those relationships with coaches, and sometimes those boundaries get a little bit blurry. Then what happens is, when so-and-so has a rough day at practice, the [AT] has information about that, and sometimes that information gets shared with coaches that should not be shared.

This can obviously affect a patient's comfort level in speaking with the AT or the behavioral health provider, which in turn can pose a barrier to engagement in the plan of care.

In the moment of impact, as cited in the "Positive Proximity" section, how an AT speaks of behavioral health and care as well as how an AT responds to a patient in the moment it comes up has a remarkable effect on the patient's likelihood of seeking care and remaining open. Valerie stated:

The reason things can go wrong in that moment of impact, meaning the first time an athlete comes to the [AT] and expresses a concern, what the [AT] says next can effectively make or break my opportunity to serve that student-athlete.

Finally, participants cited concerns over ATs already being overextended and not needing to take on the responsibility of caring for patients with behavioral health concerns. Multiple respondents said they had experienced ATs naturally caring for the whole patient and unintentionally slipping across that boundary. Dalonté described:

Sometimes the [ATs] end up doing a little bit of side talk therapy with athletes, sort of unintentionally, or it kind of ends up happening where somebody is constantly pouring out, when the [AT] probably needs to say, "We really need to be referring you to somebody outside of this to talk about it, and it's not that I don't care. It just sounds like you need more than just me listening."

Suggestions for Ideal Collaboration. In their responses on ideal collaboration with ATs, participants touched on psychoeducation for ATs in recognizing potential concerns; equipping ATs to assist with certain techniques; better education among professionals on their roles, face time, and proximity; and education from ATs on the return-to-play process for major injuries.

Camille highlighted the first 2 points:

[T]here's instances where just providing some consultation or psychoeducation can be helpful, like things to look out for, some basic skills that could be helpful if you're running into someone and they are having a panic attack or just really heightened anxiety. . . it's awesome when ATs can be part of that support system as we're working on making some of these changes or developing some of those coping skills.

Erin and other participants expounded on the idea of incorporating ATs in assisting with patient coping skills:

I think of it like a mental health first aid type of intervention. For instance, if somebody is having a panic attack, most of our ATs know box breathing and things like that, so in that moment, they will start with the patient on box breathing, and then they will call us and say, "Okay, now what do we need to do?" They present the emergency or the urgent situation and then ask, "What [do] you want us to do next?"

Other individuals who discussed an AT's actions in this capacity spoke of accountability to patients by encouraging patients to share some of the coping skills they were learning from the behavioral health provider with their AT so that the AT can remind them to use these in moments of need or assist them in use (eg, box breathing, imagery). Multiple participants did not feel they received sufficient education on the roles of ATs before working in their professional capacities. In addition to the need for the behavioral health community to receive more education on AT roles, they proposed that ATs engage in professional development in behavioral health. Erin's suggested:

I know that athletic training has its own continuing education requirements. I think it would be great for the [athletic] training profession to have their own trainings about it, but also the [National Athletic Trainers' Association] as a whole saying can they offer credits towards [ATs'] certification if you go to one that is approved for psychologists, social workers, or counselors.

Recommendations also focused on behavioral health providers having face time around ATs, coaches, patients, and other stakeholders. Dalonté observed:

The best way to have a good mental health program at a university is going to be if those professionals can get in front of the team as early and often as possible, so the players see you around, the coaches see you around, you get a chance to have those side conversations with the [ATs], because it makes it a little bit more normalized and comfortable that you are going to see somebody because you have seen them before, and you have seen them

around and know they are invested and how everything is working.

Other respondents supported the idea of positive proximity for both ATs and behavioral health providers, which supports both the structural and cultural collaboration mentioned earlier. Beyond this, participants talked about the moments when they would want education from an AT on the injury, healing, and return-to-play process for season- or career-ending injuries. Emily explained:

> I find it really helpful for [ATs] to give me a walk-through when an athlete might be experiencing a career-ending injury or an injury that is just not as straightforward as one would like it to be regarding rehab[ilitation]. That's information that can help me so that I can translate that in my sessions with the athlete as [he or she is] processing a potential loss or processing anxiety that one would feel knowing that [he or she] can do this exercise or this rehab process for 6 months and see very minimal changes but helping [him or her] to understand that that's the reality of [his or her] injury and that [his or her AT] is doing everything that [he or she] can.

Touching on the value that participants place on information gathering to explain the recovery process of a major injury can help behavioral health providers contextualize the information they are receiving from the patient as well as properly prepare the patient for the journey.

DISCUSSION

Collaborative practice increases patient-centered care,[3] which has been identified as 1 of 6 key elements of high-quality health care.[18] General health care researchers[2] have shown that collaborative practice produced better health services and outcomes for those being served, but data on interprofessional collaborative care for athletic populations are limited. These investigators highlight the importance of a collaborative health care model, with behavioral health providers viewing ATs as the first point of contact for student-athletes and noting that how an AT speaks about mental health can dictate what decisions student-athletes make regarding their mental health.

Provider Experience

Participants in this study identified that formal educational experiences informed their knowledge and experience in their roles as behavioral health providers and this knowledge and experience should be integrated, rather than isolated, in an interprofessional care team. Interprofessional collaborative practice centers on promoting the active involvement of each discipline and cultivating respect among providers in different disciplines.[4,19] A mutual understanding of each discipline's competencies is a necessary basis for quality collaboration and to bridge gaps in health care practice.[20] However, some respondents noted that ATs overstepped interprofessional boundaries, reflecting the need for further education on quality interprofessional care. At its core, interprofessional education is about learning and working together as a team to improve health care delivery and increase patient-centered care.[4,20] Researchers[21] have suggested that interprofessional clinical education should include the creation of an interprofessional learning environment, increased awareness of interprofessional practice, role clarification, enhanced interprofessional communication, and reflection and evaluation.

Emphasizing role clarification and interprofessional communication, our participants noted positive experiences with ATs when both parties exhibited a mutual understanding of competencies for each profession. However, health care teams must also set strong interprofessional boundaries.[22] Participants noted that they were more comfortable working in systems with high levels of proximity and communication when they had clear role boundaries. All providers working interprofessionally with behavioral health clinicians, including ATs, must respect the "minimum necessary" rule, a provision of the Health Insurance Portability and Accountability Act (HIPPA). This rule requires providers to consider that the minimum necessary information to perform a job may go beyond the HIPAA laws they are familiar with and be intentional in protecting behavioral health information.[23] Further, team members must respect when a behavioral health provider chooses not to share that information with them. They should also respect the training and clinical decision-making of behavioral health providers sufficiently to not feel obligated to receive all details on a patient's behavioral health status.

The AT's Role in Behavioral Health

Many respondents commented that ATs are central to the care coordination for patients with behavioral health concerns. Athletic trainers are skilled in coordinating and managing patient care,[24] and coordinating AT services can increase efficiency and decrease injury rates in health systems.[25] The accrediting body for athletic training education programs, the Commission on Accreditation of Athletic Training Education (CAATE), places strong emphasis on interprofessional education in its standards.[26] The CAATE standard on interprofessional education dictates that interprofessional collaboration must be integrated into professional education programs.[26] Various methods can be used to incorporate interprofessional education, and to meet this standard, each student in the program must have multiple exposures to interprofessional education.[14] Our participants reiterated the need for further interprofessional education between these 2 disciplines. Opportunities exist for collaborative continuing education seminars and future interventional studies to test effective educational strategies.

Team members also recognized the importance of ATs' roles in leveraging the positive effects of proximity and information gathering. Typically, ATs spend a significant amount of time with student-athletes.[27] When ATs use positive interpersonal communication strategies, such as showing compassion and active listening, they can build strong trust that improves patient care overall,[28] and this trust transfers to behavioral health care.[27] Respondents acknowledged that ATs are useful as a source of positive influence and trust for patients but also stated that ATs can have negative influences on patients if they are not careful. This study emphasizes that ATs must be aware of their influence on patients and use their positive proximity to help build a healthy interprofessional health care team with patients and other providers.

Collaboration

Collaboration requires communication, and communication failures are a cause of preventable patient harm.[29] As reinforced by our findings, care teams that have strong structural integration experience effective cultural collaboration and enhanced communication among providers. Specifically, teams that have close physical proximity of behavioral health and athletic training facilities see benefits for patient care. We demonstrated that greater structural and cultural integration of ATs and behavioral health providers led to decreased stigma around behavioral health and was linked with increased care-seeking actions as well as resource use by student-athletes. However, not all sports medicine systems have strong structural and cultural collaboration among providers. Athletic trainers should evaluate their collaboration structures and promote a health care culture that supports effective collaboration among providers.

In this study, we also identified concerns that participants had with AT collaboration. Most notably, participants thought that ATs were at risk of breaching confidentiality due to their close connection with patients and stakeholders, namely coaches. Pressure from external stakeholders has been found to influence AT decision-making,[30–32] and this external pressure could result in a breach of confidentiality for patients, potentially breaking the trust that was formed by the AT's positive proximity. Athletic trainers can sometimes feel an obligation to share information with a coach or stakeholder due to a strong relationship with the individual, which can damage psychological safety for student-athletes.[33] Although this risk is not enough to exclude ATs from behavioral health care, ATs should consider setting strong boundaries with stakeholders regarding the behavioral health concerns of patients to mitigate the risk.

Respondents gave examples of ways they believed collaboration between ATs and behavioral health professionals could be improved. Timing was a major factor for some participants, who observed that meeting early and often in a sport season for collaboration was beneficial. Structural barriers, such as the schedules of many ATs, can make it difficult to find time to meet regularly with behavioral health providers.[34] Improving cultural and structural collaboration can help reduce the barriers to frequent meetings and may improve collaboration among providers.

Team members also mentioned education as a mechanism for improving collaboration, both for and from ATs. Researchers[35] have determined that in-service–type education for providers can improve provider knowledge and collaboration among groups. This knowledge and collaboration could also help to strengthen the culture of collaboration in a sports medicine environment, further improving patient care. As ATs and behavioral health providers continue to collaborate, they should consider their knowledge deficits and where they can collaborate to effectively teach and train each other.

LIMITATIONS AND FUTURE DIRECTIONS

Our investigation was limited by a criterion sample of behavioral health professionals in Power 5 institutions. We chose this sampling method due to the typically greater resources of these institutions, increasing the likelihood of having dedicated behavioral health services for student-athletes. As such, the findings might not represent the experiences of ATs in other settings, such as secondary schools or different collegiate institutions. Our goal was to examine behavioral health providers' views on interprofessional practice with ATs. Given the voluntary and self-reported nature of the study, participant sampling may have been biased toward providers who were already familiar with or who already had positive experiences with ATs, and this may have skewed our results.

Future researchers should explore how to better equip providers to build a collaborative structure and increase the spread of this collaboration to other athletic training settings. Additionally, future authors should examine the integration of behavioral health interprofessional collaboration within athletic training programs, specifically at the residency level, to develop behavioral health athletic training specialists on care teams.

CONCLUSIONS

Collaborative care models enhance the ability of providers to maximize support of patient wellness; however, effective interprofessional education is needed to support collaborative care models. We showed that behavioral health providers working within a collaborative care model with ATs had overall positive experiences with such collaboration and that clear role delineation and responsibilities helped to foster high-quality patient care.

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