

Beyond the Field of Play: Creating a Seamless and Holistic Interdisciplinary System for Student-Athlete Mental Health

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Abstract: The collegiate student-athlete experience represents a demanding dual-career pathway within a unique micro-community, the athletic department, where deeply ingrained cultural norms of invincibility contribute to a pervasive mental health stigma and significant treatment gap. Despite organizational efforts by the NCAA to shift toward fostering healthy, supportive environments, a multi-level, systemic solution remains critical. This article proposes a robust interdisciplinary collaboration model, grounded in the principles of the Social-Ecological Model (SEM), leveraging three key professional groups to address mental health across multiple levels of influence.

The Athletic Trainer (AT) serves as the crucial frontline Community Gatekeeper, leveraging daily contact for early identification and triage at the individual level. The Licensed Professional Counselor (LPC) provides essential clinical expertise for targeted therapeutic intervention at the relational level (individual and group counseling). Critically, the Social Worker (SW) addresses the systemic and environmental determinants of health, offering resource navigation, policy advocacy, and community linkage at the organizational and macro levels. By combining the AT's immediate access, the LPC's clinical depth, and the SW's systemic advocacy, this triadic model facilitates institutional transformation, builds community-level resilience, and offers a replicable framework for integrating mental wellness support in similar high-pressure population groups, such as local schools and community sports organizations.

Keywords: Interdisciplinary Collaboration, Student-Athlete Mental Health, Social-Ecological Model, Community Resilience, Athletic Trainer (AT), Licensed Professional Counselor (LPC), Social Worker (SW), Holistic Care / Integrated Care, NCAA Best Practice, Institutional Transformation.

The life of a collegiate student-athlete is a demanding dual career, characterized by intense training, travel, academic rigor, and the persistent pressure to perform (Kegelaers *et al.*, 2024). This unique combination of stressors has led to a growing, yet often unrecognized, mental health epidemic, making the well-being of this population a critical component of overall health and athletic success. However, the culture of athletic environments often reinforces an expectation of physical and mental invincibility, which actively discourages athletes from disclosing symptoms of distress (Brown *et al.*, 2025). This deeply ingrained stigma is a major factor contributing to the significant gap in mental health help-seeking between student-athletes and their non-athlete peers (Edwards, Froehle, & Fagan, 2023).

Historically, mental health support for athletes has been inconsistent, frequently leading to poor outcomes for those struggling with anxiety, depression, and other clinical challenges (Bird, Chow, & Cooper, 2020). In response to rising awareness and, tragically, several high-profile athlete deaths, national governing bodies have intensified their efforts to standardize care. The NCAA's Mental Health Best Practices consensus,

evolving from a focus on practitioner license in 2016 to a broader strategy prioritizing the Creation of Health Environments in 2020, underscores the recognition that effective mental health care requires a multi-layered, preventative, and collaborative approach (NCAA 2016; NCAA 2020). The updated document broadened its scope, prioritizing the Creation of Healthy Environments and adding essential guidance on issues like trauma-informed care and the impact of Name, Image, and Likeness (NIL) on athlete well-being (NCAA, 2016; NCAA, 2020). More recently, the addition of mental health first aid as a resource underscores the modern recognition that effective mental health care requires a multi-layered, preventative, and collaborative approach.

This article aims to explore the distinct and complementary roles of three key professional groups: Athletic Trainers (ATs), Licensed Professional Counselors (LPCs), and Social Workers (SWs) in supporting student-athlete mental health. Specifically, we will highlight the unique qualifications, ethical boundaries, and scope of practice for each profession. Ultimately, this paper advocates for a robust, interdisciplinary collaboration model that leverages the specialized expertise of each group to provide comprehensive and culturally competent care. The following sections will first detail the conceptual

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grounding of this model, followed by a focused analysis of the critical, complementary functions of the three professions, and finally a proposal for optimal interdisciplinary mental health care in collegiate athletics.

COLLEGIATE ATHLETICS AS A MICRO-COMMUNITY

Collegiate athletics is a unique, high-pressure micro-community with deeply ingrained cultural norms that profoundly affect mental health. This environment features a high degree of social cohesion among teammates (Cranmer *et al.*, 2025), but is also characterized by a rigid hierarchy and a pervasive culture of physical and psychological invincibility that frames seeking help as a weakness (Brown *et al.*, 2025). This cultural narrative contributes to self-stigma and fear of negative professional consequences, such as losing playing time or scholarships (Bird *et al.*, 2020; Edwards *et al.*, 2023). Therefore, effective mental health support must engage with and work to transform the cultural norms of this micro-community, rather than simply treating individual distress.

CONCEPTUAL GROUNDING AND CONTEXTUAL DYNAMICS

The Social Ecological Model (SEM) as a Framework

The foundational model for this study is drawn from Castillo, Ijadi-Maghsoodi, Shadravan, Moore, Mensah III, Docherty, Aguilera Nunez, Barcelo, Goodsmith, Halpin, Morton, Mango, Montero, Rahmanian Koushkaki, Bromley, Chung, Jones, Gabrielian, Gelberg, Greenberg, Kalofonos, Kataoka, Miranda, Pincus, Zima, & Wells (2019) whose work integrated complex service systems—including K-12 education, mental health, criminal justice, homeless services, and early psychosis intervention—under a unified framework. We adapted this framework to view collegiate athletics as a micro-community, specifically examining the collaborative roles of Athletic Trainers (ATs), Licensed Professional Counselors (LPCs), and Social Workers (SWs) within that setting.

Crucially, this adaptation aims to move beyond fragmented, individual-level care by grounding the intervention strategy in the Social-Ecological Model (SEM). The SEM provides a conceptual bridge, positing that mental health outcomes are determined by the complex interplay between individual factors and the surrounding environmental and societal systems. Applied to the context of student-athlete mental health,

the SEM dictates that successful intervention and support must occur across multiple, nested levels: Individual, Interpersonal, Institutional, Community, and Policy (Castillo *et al.* 2019). The application of the Social-Ecological Model (SEM) to collegiate athletics requires intervention at five nested levels:

Individual Level

The Individual Level focuses on enhancing the student-athlete's knowledge, coping skills, and self-advocacy. The Athletic Trainer (AT) often serves as the initial gatekeeper, helping to address hesitancy by facilitating the crucial link between physical issues (like injury or performance) and emotional well-being. By normalizing mental health discussions and assisting in navigating referrals to a clinical provider, ATs directly increase the access and acceptability of mental health services (Castillo *et al.* 2019). An intervention example would be developing a Mental Health Check-In Protocol, where ATs systematically ask brief well-being questions during rehab and provide warm handoffs to on-campus counseling or social work services when necessary.

Interpersonal Level

The Interpersonal Level aims to strengthen relationships, trust, and communication within the immediate social environment, primarily the athletic team. Intervention here centers on psychoeducation and skill training delivered by Licensed Professional Counselors (LPCs) and Social Workers (SWs) to mitigate mental health consequences (Castillo *et al.* 2019). Educational topics include time management, healthy collegiate living, and connecting athletes with resources for food security and academic support. An intervention example would be creating a Team Wellness Program, featuring monthly workshops led by clinicians on resilience, inclusion, and healthy coping, with ATs ensuring the integration of these lessons into daily training routines.

Institutional Level

The Institutional Level is focused on embedding mental health care and equity practices directly into the operations of the athletic department. This requires advocates to influence institutional processes—such as referral systems, screenings, and treatments—to prioritize emotional and social well-being. ATs and SWs are essential at this level for designing and implementing effective screening and referral mechanisms. The triadic team (AT, LPC, SW) collaborates to assess and refine program policies and

procedures to ensure equitable access and appropriate care navigation. An intervention example would be forming an Integrated Behavioral Health Team, which meets weekly to review cases, share observations, and develop coordinated treatment and prevention strategies.

Community Level

The Community Level emphasizes building partnerships between the athletic department and broader community resources. The goal is to leverage external settings (e.g., local non-profits, healthcare providers) where social relationships occur. Institutional leaders, guided by the expertise of the LPCs and SWs, foster these external relationships to implement shared mental health services, reduce stigma, and enhance overall mental health literacy. An intervention example would be developing a Community Athlete Support Network, where local agencies provide workshops and resources focused on mental health, nutrition, and post-sport transition planning.

Policy Level

The Policy Level aims to advocate for structural and cultural changes that advance mental health equity across the sporting environment and the university

system. This involves encouraging leaders to create policies and incentives that formalize partnerships between the athletic department and other university stakeholders (faculty, staff, student health). An intervention example would be creating an Athletic Department Mental Health and Equity Policy, mandating guaranteed access to mental health services, diversity training for staff, and confidential mechanisms for reporting mental health concerns.

This multi-level approach is critical because a professional focusing only on the individual or one specific level (e.g., one-on-one therapy) will inevitably be undermined by systemic barriers (e.g., prohibitive policies or unaddressed social determinants of health). The triadic collaboration (AT, LPC, SW) is thus designed to ensure a dedicated professional is explicitly addressing and intervening at each of the five levels of the SEM, as summarized in Table 1.

Community Resilience and Institutional Transformation

Transforming the Athletic Department Micro-Community

The triadic model contributes directly to community-level resilience and institutional transformation by

Table 1: Integration of Professions & SEM

Level	Goal	Role Examples
Individual	Build knowledge, coping skills, and self-advocacy in athletes	Counselor: Provides individual therapy and psychoeducation. AT: Screens for mental health concerns during injury evaluation. Social Worker: Connects athletes to financial or housing supports affecting stress.
Interpersonal (Team)	Strengthen relationships, trust, and communication within the team environment	Counselor: Leads group sessions on stress, relationships, and identity in sport. AT: Models supportive communication during treatment. Social Worker: Facilitates family or roommate sessions to address outside stressors.
Institutional / Program	Integrate mental health care and equity practices into athletic department operations	Counselor: Embedded in sports medicine team to offer same-day appointments. AT: Coordinates care and monitors return-to-play readiness with input from mental health professionals. Social Worker: Trains staff on trauma-informed and culturally competent care.
Community	Build partnerships between athletics and community resources	Social Worker: Links athletic program with local mental health nonprofits and community clinics. Counselor: Coordinates outreach workshops for youth athletes on performance anxiety and coping. AT: Hosts injury prevention and wellness fairs in collaboration with community partners.
Policy / Societal	Advocate for structural and cultural changes that advance mental health equity in sport	Social Worker: Advocates for equitable access to mental health resources for all teams and genders. AT: Participates in policy review to ensure safe workload and recovery standards. Counselor: Advises administrators on implementing NCAA mental health best-practice guidelines.

engaging the Athletics Department micro-community across all SEM levels. By combining the LPC's psychoeducation for staff and athletes (Individual/Relational) with the SW's advocacy for changes to organizational policies and resources (Organizational/Macro), the model creates a virtuous cycle of change. The goal is a cultural shift where help-seeking is normalized, and mental health is prioritized as much as physical performance (NCAA 2020). This requires coaches, ATs, and administrators to actively foster a culture that does not penalize athletes for prioritizing their well-being.

Extending the Model to Community Wellness Systems

The framework is replicable and can inform other high-pressure population groups. In local schools, for example, a similar collaboration between a School Nurse (Gatekeeper), School Counselor (Clinical Intervention), and School Social Worker (Systemic Advocacy/Resource Broker) can address mental health and environmental determinants like food insecurity or family stress, building resilience in that community system. This demonstrates how the principles of an interdisciplinary, SEM-driven model can be a blueprint for integrated care far beyond the collegiate setting.

Professional Roles and Contributions to Student-Athlete Mental Health

Student-Athlete Mental Health: Dual Demands and Barriers to Care

Student-athletes navigate a dual career (DC) path marked by the concurrent pursuit of high-level athletic and academic success. This introduces a unique set of stressors beyond those faced by non-athlete peers, including intense role strain (Kegelaers *et al.*, 2024), which contributes to stress, anxiety, and depression (Cranmer *et al.*, 2025). Additional stressors include frequent injuries, the intense tie between their identity and their sport (making the post-sport transition high-risk), and new pressures introduced by Name, Image, and Likeness (NIL) activities (Kegelaers *et al.*, 2024; NCAA 2020).

This high-stress environment contributes to a "mental health epidemic" (Cranmer *et al.*, 2025), with specific concerns like anxiety, depression, eating disorders, and substance abuse being highly prevalent. Despite this, only about 10% of student-athletes experiencing anxiety or depression seek professional mental health services, underscoring a significant treatment gap (Edwards *et al.*, 2023). The persistent

stigma, compounded by logistical barriers like compromised time management and long waiting times for campus services, makes an integrated, accessible care model essential (Bird *et al.*, 2020; Edwards *et al.*, 2023).

The Unique Landscape of Student-Athlete Mental Health

The mental health of student-athletes is defined by a high-pressure environment resulting from competing demands and systemic cultural barriers to seeking support (NCAA, 2020). The provision of mental health services to this population must adhere to stringent professional standards. Clinical practitioners must follow the ethical and competence guidelines of the American Counseling Association (ACA) and the National Association of Social Workers (NASW), as well as the training guidelines set by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the Council on Social Work Education (CSWE). Furthermore, professional support from Certified Athletic Trainers (ATs) is governed by the Board of Certification (BOC) Code of Professional Responsibility and the National Athletic Trainers' Association (NATA) Code of Ethics. The educational programs for these professionals are accredited by the Commission on Accreditation of Athletic Training Education (CAATE), ensuring that AT practitioners prioritize the athlete's health and well-being and maintain appropriate standards of professional conduct, which includes mental health support (BOC 2023).

Dual Demands and Stressors

Student-athletes navigate a dual career (DC) path marked by the concurrent pursuit of high-level athletic and academic success. This situation creates a distinct set of stressors that exceed those faced by non-athlete peers. The DC environment, while offering benefits like positive identity development, introduces "multilevel demands at the psychological, social, and financial levels" (Kegelaers *et al.* 2024:849). The core challenge is the "role strain" stemming from the necessity of maintaining two careers at once (Kegelaers *et al.* 2024:862), which significantly contributes to stress, anxiety, and depression (Cranmer, Cox, Rey, Browning, Holbert 2025).

This workload, which includes extensive travel and competition schedules, compromises effective time management, a recognized barrier to seeking help (Bird *et al.* 2020). Sport-specific stressors further

compound these issues. Injuries are a frequent occurrence, and their adverse effects on academic performance are reportedly more severe for student-athletes than for non-athlete students, underscoring the compounding burden of DC demands (Kegelaers *et al.* 2024). The athlete's identity is intensely tied to their sport, making the post-sport transition into a high-risk period for mental distress (Kegelaers *et al.* 2024; NCAA 2020). Furthermore, while athletic scholarships offer financial support, they often impose an implicit contract of performance. The rise of Name, Image, and Likeness (NIL) activities introduces additional financial, legal, and reputational pressures that further complicate the student-athlete experience (NCAA 2020).

Stigma and Barriers to Help-Seeking

Despite the high-stress environment, help-seeking behavior is profoundly affected by the pervasive stigma inherent in athletic culture, often leading to lower utilization of mental health services compared to non-athletes (Brown *et al.* 2025). The culture of athletic environments usually reinforces an expectation of physical and psychological invincibility, which actively discourages athletes from disclosing mental health symptoms (Brown *et al.* 2025). This cultural narrative, which frames seeking help as a personal weakness, leads to self-stigma (Bird *et al.* 2020). This fear is often practical: athletes worry about stigma from coaches and fear negative professional consequences if they disclose their struggles, such as losing playing time or jeopardizing their scholarship status (Edwards *et al.* 2023). While coaches can act as a semi-formal source of support, athletes may still perceive seeking professional clinical help as a direct risk to their athletic standing (Bird *et al.* 2020). In response to tragic athlete deaths, national organizations have increased their attention, starting with the NCAA implementing Mental Health Best Practices and organizations like the Hilinski's Hope Foundation working to challenge the stigma by encouraging institutions to scale up mental wellness programs (NCAA 2020). Despite these efforts, the significant gap in treatment-seeking between athletes and non-athletes persists (Edwards *et al.* 2023).

Common Mental Health Challenges

The combined effect of dual demands and stigma contributes to a high prevalence of specific mental health concerns. Collegiate student-athletes face a "mental health epidemic," particularly concerning anxiety and depression (Cranmer *et al.* 2025:664).

Recent NCAA data from 2011–2019 show that 19.0% of varsity athletes reported being formally diagnosed with a mental health condition (Edwards *et al.* 2023). While a 2015 study suggested student-athletes were at a decreased risk compared to non-athlete students, they still experience distinct risk factors and barriers to treatment, including alcohol use, eating disorders, overtraining, injuries, and stigma around help-seeking (Kegelaers *et al.* 2023:850). Other key concerns include stress and burnout, with over a quarter of student-athletes reporting being mentally exhausted almost every day or constantly (Edwards *et al.* 2023). The lack of shared task approaches among teammates can also be "distressing and detracting from general well-being," contributing to this stress and burnout (Cranmer *et al.* 2025:664). Furthermore, athletes demonstrated higher rates for eating disorders and substance abuse compared to non-athletes, placing them in an at-risk population for these specific issues (Edwards *et al.* 2023; Kegelaers *et al.* 2024). Specific concerns, such as problem gambling behaviors, are also emerging areas of risk that require targeted screening and intervention (NCAA 2020). Despite the high prevalence of symptoms, only about 10% of student-athletes experiencing anxiety or depression seek professional mental health services, underscoring a significant treatment gap (Edwards *et al.* 2023).

Professional Roles and Contributions to Integrated Care

This model leverages the unique access and expertise of the Athletic Trainer (AT), Licensed Professional Counselor (LPC), and Social Worker (SW) to provide holistic care across the SEM. To maintain a focus on the collaborative dynamic, the following sections summarize the functional roles, condensing the detailed educational and ethical requirements

The Athletic Trainer (AT) serves as a frontline community gatekeeper, playing a vital role in the holistic care of student-athletes. As multifaceted healthcare professionals in daily contact with athletes, ATs are uniquely positioned to identify early signs of mental health distress and facilitate timely intervention. Their consistent presence and trusted relationships allow them to observe subtle behavioral or emotional changes that may indicate emerging concerns. Within collaborative care models, the AT's primary contribution occurs at the individual/relational and organizational levels, focusing on early identification, triage, and coordination of care. Guided by the National Athletic Trainers' Association (NATA, 2021) ethical

framework, ATs are committed to prioritizing the patient's welfare and safety above all else, while remaining within their defined scope of practice. When an athlete's needs extend beyond that scope, ATs ensure an appropriate referral to specialized clinicians such as licensed professional counselors (LPCs) or social workers (SWs). Through creating a safe space, engaging in critical conversations and managing initial crises, the AT plays an indispensable role in supporting both the physical and mental well-being of student-athletes.

Athletic Trainers Education, Role, and Ethics

Athletic Trainers (ATs) are vital, multifaceted healthcare professionals who operate under the direct supervision or direction of a physician across a multitude of settings, including secondary schools, colleges and universities, professional sports, orthopedic clinics, industrial settings, and the military. Their comprehensive role, as defined by NATA, includes injury prevention, wellness promotion, emergency care, examination and clinical diagnosis, and full therapeutic intervention and rehabilitation. This constant involvement with patients in all phases of their well-being positions ATs as essential frontline healthcare providers. By working closely with their patients and developing a strong rapport through daily interactions, ATs gain a unique perspective that allows them to observe and often detect early signs of mental health distress, making them crucial in the initial identification and appropriate referral for both physical and psychological health concerns.

Education and Qualifications

The rigorous qualifications and educational standards for ATs position them as qualified and prepared healthcare professionals ready to address both the physical and behavioral health needs of their patients. To become a certified AT, candidates must first earn a master's degree from a CAATE-accredited program and pass the Board of Certification (BOC) exam. Upon passing the BOC exam, the AT must apply for the required license or regulation for their state, which dictates the specific scope of practice and often relies on standing orders from a collaborating physician. Finally, ATs must maintain their ATC credential by submitting 50 continuing education credits (CEUs) on a two-year cycle and meeting any additional requirements for their state licensure or regulation.

The CAATE standards are crucial to student preparation, mandating that programs provide students

with experiences in a variety of health conditions, including behavioral health conditions (Standard 18). Athletic Training programs meet this standard by placing students in clinical education sites in various settings throughout their degree program to expose them to a variety of physical and behavioral health conditions. Furthermore, CAATE requires AT programs to explicitly instruct students on how to identify, refer, and give support to patients with behavioral health conditions (Standard 77), as well as teach the development and implementation of specific policies and procedures for identifying patients with behavioral health problems and referring those in a crisis to qualified providers (Standard 94) (CAATE n.d.).

Role of ATs

The role of the AT in supporting student-athlete mental health begins with initial recognition. Athletic trainers are known for creating safe spaces within their facilities and building strong relationships with their patients. This involves knowing the signs and symptoms of mental health issues and having the ability to conduct crucial conversations. Through their curriculum and clinical education experiences, ATs learn how to interact with patients and how to build and maintain trust. After graduation, individuals can enhance their education through continuing education courses such as Mental Health First Aid and QPR Suicide Prevention training, in addition to educational courses offered by NATA. Beyond recognition, ATs are versed in knowing how to manage crisis situations, handling their patient with care and respect, and understanding their role in the referral process. This includes knowledge of the various healthcare professionals better suited to care for their patient. The development and management of these relationships are very important not only for a smooth transition of care but also for ensuring patients receive the most appropriate care for their situation.

BOC Code of Professional Responsibility and NATA Code of Ethics

As discussed, the BOC's Code of Professional Responsibility mandates that all certified ATs act in a professional, responsible manner, prioritizing the patient's welfare and safety. For example, the AT must demonstrate sound clinical judgment supported by current research and knowledge (1.2). Furthermore, ATs must engage in lifelong professional learning activities (2.1), practice in collaboration and cooperation with others (3.3) and provide services in accordance with state and national laws. This code

outlines essential duties and obligations for ATs holding the ATC credential (BOC 2023).

Similarly, the NATA Code of Ethics specifically states the principles of ethical behavior for athletic training. The key principles relevant to mental health emphasize that the patient's well-being and long-term health are the primary duty of the AT, obligating them to place this concern above all other stakeholders (1.2). Members must provide competent care in all their decisions and actively advocate for the patient's best medical interest and safety. To ensure safe and effective practice, members are restricted to providing only services for which they are qualified through education or experience, and those services must be legally allowed by state athletic training practice acts and regulations. All services, referrals, and compensation sought must be necessary and in the best interest of the patient. Finally, to maintain a high standard of care and qualification, members must recognize the need for continuing education, participate in educational activities that enhance their skills and knowledge, and complete all requirements necessary to maintain their credential as ATs.

Both the BOC and NATA professional ethics and standards emphasize that patient care is the AT's foremost priority. Key principles reinforce the AT's responsibility for ethical decision-making, adhering to their scope of practice, acknowledging their practice limits, and ensuring collaboration and appropriate referrals to other healthcare professionals when a patient's need extends beyond that defined scope.

Licensed Professional Counselors (LPCs) / Clinical Mental Health Counselors Education, Role, and Ethics

The Licensed Professional Counselor (LPC): Clinical Depth and Therapeutic Intervention

Licensed Professional Counselors (LPCs, or equivalent titles like LMHC or LCPC) are clinical mental health experts specifically trained for therapeutic intervention. In a collaborative setting, the LPC provides the clinical diagnosis and targeted therapeutic intervention at the individual/relational level, applying evidence-based theories (e.g., cognitive-behavioral, psychodynamic) to treat mental, emotional, and behavioral disorders (NBCC, 2016). A key area of expertise involves helping student-athletes navigate their demanding dual career (DC) roles, a component often absent in other programs; they specialize in issues prevalent in this population, such as

performance pressure, managing athletic-identity loss (due to injury or performance issues), anxiety, depression, disordered eating, and substance use (NCAA, 2020). Finally, the core of LPC ethics centers on Informed Consent and strict Confidentiality (ACA, 2014); in the collaborative athletic setting, counselors must clearly explain confidentiality limits to both the athlete and the institution, especially in cases of imminent danger to self or others.

Educational Requirements and Scope of Practice

To become an LPC, or its equivalent state title such as Licensed Mental Health Counselor (LMHC) or Licensed Clinical Professional Counselor (LCPC), an individual must graduate with a master's, educational specialist, or doctoral degree from a CACREP-accredited program (ACA 2017; SimplePractice 2025). This graduate training ensures a consistent, high standard of preparation, as the LPC's scope of practice is explicitly defined by state law. Unlike social work, which offers CSWE-accredited undergraduate Bachelor of Social Work (BSW) programs that can lead to advanced standing in the Master of Social Work (MSW) program, CACREP currently offers no undergraduate programs (CACREP 2024; CSWE 2022). Furthermore, CACREP standards influence faculty hiring by requiring that no more than 10% of full-time faculty lack a CACREP-accredited doctoral degree, encouraging programs to hire degree holders from accredited programs (CACREP 2024).

The curriculum in CACREP-accredited programs must address eight core competency areas: Professional Orientation and Ethical Practice, Social and Cultural Diversity, Human Growth and Development, Career Development, Helping Relationships, Group Work, Assessment, and Research and Program Evaluation (CACREP 2024). Notably, the requirement for a career development course ensures that LPCs are prepared to help student-athletes navigate their demanding dual career (DC) roles as both student and athlete, a curriculum component often absent in social work programs.

Licensure is then granted after meeting specific state standards, which commonly include earning at least a master's degree (often a 60-credit-hour program), completing a period of supervised post-master's clinical experience (typically 2,000 to 4,000 hours over two to three years), and passing one or both national examinations: the National Counselor Examination (NCE) and the National Clinical Mental

Health Counseling Examination (NCMHCE) (ACA 2017; SimplePractice 2025). To maintain the license, renewal is typically required biennially, often requiring 40 hours of Continuing Education Units (CEUs), including a mandated number of hours dedicated to professional ethics.

Clinical Training and Practice

Clinical training is a cornerstone of the LPC's preparation. For master's level students, CACREP mandates a minimum of 100 clock hours of supervised practicum, with at least 40 hours in direct service, and a minimum of 600 clock hours of supervised internship, with at least 240 hours in direct service, for a total of 700 minimum clinical hours (CACREP 2024). Direct service involves providing counseling, consultation, or professional services to clients, while indirect hours are spent on activities like record-keeping and supervision (CACREP 2024). Doctoral-level students in Counselor Education and Supervision must complete a minimum of 600 clock hours of doctoral internship, including experiences in counseling, supervision, teaching, research, and leadership/advocacy.

The core function of the LPC is to provide direct mental health services, including comprehensive assessments and diagnoses using current classifications, such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, to formulate appropriate treatment plans (ACA 2014; NBCC 2016). The central role is treatment and psychotherapy, which involves applying evidence-based theories to provide individual, group, and family counseling to address mental, emotional, and behavioral disorders (ACA 2014; NBCC 2016). The expertise of the LPC lies in their specialized training in therapeutic interventions, where they select and implement various approaches, including cognitive-behavioral, psychodynamic, humanistic, and systemic therapies, tailored to individual needs (CACREP 2024; NBCC 2016). When working with student-athletes, LPCs offer services that support mental well-being when navigating feelings of loss, anguish due to injury, or vulnerability from losing playing time. Notably, the profession emphasizes a preventive and wellness model of care, helping clients not only manage symptoms but also achieve optimal growth throughout their lifespan (ACA 2014).

Ethical Framework (ACA Code of Ethics)

Ethical practice for LPCs is governed by the ACA Code of Ethics, which rests on six foundational moral principles: autonomy, nonmaleficence, beneficence,

justice, fidelity, and veracity (ACA 2014). These principles translate into practical ethical considerations: Informed consent (A.2.a) is an ongoing process where counselors must review all aspects of the therapeutic relationship with clients to protect their autonomy, ensuring clients are informed of and consent to the treatment provided. Confidentiality (B.1.a) is a fundamental duty, though it has specific limits (B.2.a) that must be disclosed, such as when a client is an imminent danger to self or others. When working with minors or student athletes, counselors must clearly explain these limits to both the client and their legal guardians, balancing the client's autonomy with institutional and legal requirements (B.5.a, B.5.c). Counselors must also maintain appropriate professional boundaries (A.6.a), strictly prohibiting harmful nonprofessional relationships, including sexual interactions (A.5.c). Finally, counselors must demonstrate multicultural/diversity competence (C.2.a, A.4.b) by understanding their own biases and respecting the cultural context of their clients to uphold the principle of justice.

LPCs and Student-Athlete Support

LPCs provide crucial support to student-athletes by addressing the unique stressors in the collegiate athletic environment (ACA 2014). Through direct counseling, they offer individual, and group therapy focused on general mental health concerns like anxiety and depression. They help athletes develop coping strategies for stress and performance pressure using therapeutic techniques to regulate emotions and maintain focus, aligning with the need to mitigate the psychological toll of high-stakes competition (NBCC 2016; NCAA 2020). LPCs also assist with critical developmental and situational challenges, including managing athletic-identity issues (e.g., when an athlete is injured or unable to perform, leading to a loss of identity), navigating transitions, and addressing relationship conflicts. Furthermore, they are essential in providing or coordinating specialized interventions for complex problems prevalent in the athletic population, such as disordered eating (which can manifest as overeating or decreasing food intake to achieve a certain build), substance use, and trauma (NCAA 2020). Beyond direct care, LPCs contribute to a supportive environment by providing psychoeducation through workshops for athletes, coaches, and staff on topics like recognizing mental distress, stress reduction, and responsible substance use, which supports the NCAA's comprehensive educational recommendations (ACA 2014; NCAA 2020).

Licensed Clinical Social Workers (LCSWS) / Social Workers

The Social Worker (SW): Systemic Advocacy and Resource Connection

Social Workers (SWs), particularly those with clinical licensure as a Licensed Clinical Social Worker/Licensed Independent Social Worker-Clinical Practice (LCSW/LISW-CP), are mental health professionals whose identity is rooted in the Person-in-Environment (PIE) perspective (CSWE, 2022). The Social Worker's unique function is addressing the Organizational and Policy levels of the Socio-Ecological Model (SEM), as they view distress not just as an individual issue but as a manifestation of the struggle between the individual's needs and the resources of their environment (NASW, 2021). Social Workers excel as brokers and case managers, linking athletes to essential external resources like financial aid, housing, food security, and specialized medical care outside the university system. Furthermore, SWs are professionally mandated to engage in policy advocacy to reduce systemic demands and ensure equitable mental health support within the athletic department (CSWE, 2022). Finally, Social Work ethics are built on core values like Social Justice and the Dignity and Worth of the Person (NASW, 2021); they are ethically required to uphold the athlete's right to Self-Determination while also recognizing the importance of cultural competence to ensure services are relevant and respectful to diverse student-athletes.

Social Work Education, Role, and Ethics, Educational Requirements and Scope of Practice

Social work programs offer both undergraduate (BSW) and graduate (MSW) degrees, all of which are accredited by the Council on Social Work Education (CSWE). CSWE accreditation requires programs to address nine core competency areas in their curricula, spanning ethical behavior, advancing human rights and social justice, engaging Anti-Racism, Diversity, Equity, and Inclusion (ADEI) in practice, policy practice, engagement with various client systems (individuals, groups, communities), assessment, intervention, and evaluation (CSWE 2022).

Students in both BSW and MSW programs must complete a minimum number of supervised field experience hours, a cornerstone of social work education. BSW students must complete a minimum of 400 hours of supervised field experience, while MSW students are required to complete a minimum of 900

supervised field hours (CSWE 2022). A key distinction in social work is the advanced standing option for MSW students who hold a BSW from a CSWE-accredited program; they are often granted credit for the foundation year (including the 400 foundation field hours) and are required to complete only the advanced specialized field hours, usually totaling around 500 hours. This differs from counseling, as CACREP-accredited counseling programs currently do not offer an undergraduate degree or an advanced standing graduate program. While BSW students may not always work with student-athletes in a university counseling center, both counseling and social work graduate students may complete their supervised hours at a campus counseling center that serves a wide range of student populations.

For social workers who wish to work in the clinical field, such as a Licensed Clinical Social Worker (LCSW), or those with varying clinical titles like Licensed Independent Social Workers-Clinical Practice (LISW-CP), they are held to specific state standards (ASWB 2019). The clinical licensure process generally involves obtaining an MSW, completing thousands of supervised post-graduate hours, and passing a national exam. Notably, in some states, post-undergraduates with a BSW can also obtain licensure, such as a Licensed Bachelor of Social Work (LBSW) (ASWB 2019). Typically, the minimum requirement for total supervised clinical hours is approximately 3,000 hours of post-MSW supervised experience, completed over a minimum of 2 years, though some states may impose a maximum time limit. This period also requires a minimum of 100 hours of face-to-face clinical supervision (ASWB 2019).

Clinical Examination and Continuing Education

The standardized exam required for clinical licensure is the ASWB Clinical Exam (ASWB 2022). This is a four-hour, computer-based test comprising 170 multiple-choice questions that assess the knowledge and skills necessary for independent clinical social work practice, covering areas like assessment, diagnosis, treatment planning, psychotherapy, and professional ethics (ASWB 2022). Having passed this exam prepares clinicians to work with student-athletes in mental health diagnosis and treatment planning, much like LPCs. To maintain an active clinical license, social workers are required to complete Continuing Education Units (CEUs) every two years, with a common requirement being approximately 30–40 hours (ASWB 2019). Most states mandate a minimum

number of hours dedicated to social work ethics, and some states, like South Carolina, now require specific training, such as at least 1 CEU in suicide prevention for every renewal cycle (ASWB 2019; SC Board of Social Work Examiners n.d.).

Social Worker Role and Person-in-Environment Perspective

The social worker's professional identity is rooted in the person-in-environment (PIE) perspective, a core foundation of the profession (CSWE 2022). This perspective views the individual as constantly interacting with and influenced by surrounding social, economic, and physical systems, providing a comprehensive framework for understanding human well-being. The PIE approach requires Social Workers (SWs) to focus simultaneously on two interdependent areas: individual well-being and broader social systems (analyzing the impact of family, community, culture, policies, and systemic issues like oppression and discrimination) (CSWE 2022; NASW 2021). Client distress is often viewed as a manifestation of the struggle between their needs and the resources of their environment (NASW 2021), mandating that intervention occur at multiple levels of a client's system. Looking at a student athlete holistically is beneficial to ensure their basic needs are met along with anything else of concern.

By utilizing the PIE perspective, SWs engage in a unique role that extends beyond clinical therapy to create tangible change at both the micro (individual) and macro (systemic) levels. This includes advocacy, where social workers are professionally mandated to advance human rights and social justice by advocating for clients within existing systems and for broader policy changes (CSWE 2022; NASW 2021). A significant function is resource connection, acting as a broker or case manager to link clients with essential resources such as housing assistance, financial aid, medical services, and support groups, which helps stabilize immediate environmental needs (CSWE 2022). Social workers can play a vital role on a college campus to help student-athletes with resources, particularly those who may experience issues with food insecurity, basic hygiene supplies, or access to school supplies, even if they have some scholarships or stipends. Lastly, SWs specialize in systemic interventions, engaging at the organizational and community levels to assess, intervene with, and evaluate policies and programs. This focus on changing the environment distinctly sets social work

apart from other mental health professions (CSWE 2022).

Ethical Framework (NASW Code of Ethics)

The ethical practice of SWs is governed by the NASW Code of Ethics which is built on six fundamental values: Service, Social Justice, Dignity and Worth of the Person, Importance of Human Relationships, Integrity, and Competence (NASW 2021).

Social workers have broad ethical responsibilities to multiple parties. To clients, they must uphold Self-Determination (1.02), promoting the client's right to make choices while balancing this with the duty to protect their interests. In the context of working with student athletes, while the SW may disagree with a client's choice (e.g., to ignore medical advice and return to sport prematurely), they must note that clients can make decisions they deem fit for their lives. Confidentiality (1.07) is a fundamental duty, requiring social workers to clearly define and communicate its limits to the student-athlete, coaches, and staff, especially in collaborative environments mandated by standards like those from the NCAA, which require coordinated care (NCAA 2020). Furthermore, cultural competence (1.05) is essential for ensuring services are relevant and respectful to diverse student-athletes. Additional ethical responsibilities extend to colleagues, practice settings, the profession, and the broader society (NASW 2021).

Social Workers and Student-Athlete Support

Social workers operationalize the person-in-environment (PIE) perspective to support student-athletes by focusing on both internal struggles and external systems in the high-pressure collegiate environment (NCAA 2020). Excelling as brokers and case managers, SWs connect student-athletes and their families to critical resources, such as financial aid, housing, food security, and specialized medical care outside the university system, thereby addressing the non-clinical social determinants of mental health (CSWE 2022). Upholding the value of social justice, they advocate systemic changes within athletic departments or universities to ensure equitable mental health support, resources, and reduced systemic demands on athletes, potentially by advocating for better access to insurance coverage or less demanding schedules (NCAA 2020). This is helpful because there can be immense pressure on coaches to have high-performing student athletes. SWs are highly trained in crisis intervention and case management, providing

immediate stabilization and managing the long-term coordinated care for issues like suicidal ideation or acute psychological distress. Recognizing the importance of human relationships, they often facilitate family communication and strengthen support systems. Finally, their PIE lens allows them to focus on addressing social determinants of mental health (e.g., racism, financial stress), intervening at the systemic level to reduce environmental barriers and improve the athlete's long-term outcomes (CSWE 2022).

Interdisciplinary Collaboration and Systemic Change

The Necessity of Integrated Care and Observed Benefits

A siloed approach where professionals work in isolation risks fragmented care, missed signs, and athletes "falling through gaps" in the referral system. Integrated care, as advocated by the NCAA (2020), provides the best patient care by leveraging the complementary strengths of the interprofessional team: the AT's access, the LPC's clinical depth, and the SW's systemic advocacy. This holistic approach ensures that the athlete's physical, psychological, and environmental needs are addressed.

Qualitatively, the benefits of this integrated model are observed in improved athlete well-being and a more supportive athletic environment. For instance, co-located services, where an LPC or SW is housed within the athletic facility, are seen to reduce the physical and psychological distance an athlete must travel to seek help, thus normalizing mental health treatment alongside physical care. Furthermore, through shared case consultations, the AT can receive advice on managing and supporting an athlete who is hesitant to seek formal therapy, without compromising the athlete's privacy, thus preventing the necessity for professionals to struggle with how to handle a patient in isolation.

Necessity of Collaboration

The intricate and multifaceted challenges facing student-athletes ranging from performance anxiety and identity distress to trauma and clinical depression underscore why a siloed approach to mental health care is fundamentally insufficient. No single professional, regardless of their expertise, can effectively navigate the full spectrum of an athlete's needs. By failing to utilize the specialty skills of those around them, institutions risk fragmented care, where critical signs are missed, or athletes fall through gaps in

the referral system. Conversely, integrated care, as advocated by the NCAA Mental Health Best Practices, provides the best patient care by leveraging the strengths of interprofessional teams (NCAA 2020). The Athletic Trainer (AT) possesses unparalleled access and context, the Licensed Professional Counselor (LPC) offers clinical diagnosis and therapeutic intervention, and the Social Worker (SW) provides systemic advocacy and resource connection. Collaboration ensures that the athlete's physical, psychological, and environmental needs are addressed holistically, resulting in improved communication and comprehensive care.

Models for Collaboration

Effective collaboration among ATs, LPCs, and SWs requires clear structural and relational foundations to ensure comprehensive athlete care. Key collaborative models included shared case consultation, formal meetings where providers discuss complex or high-risk cases to coordinate care and decision-making. Joint programming and workshops further strengthen collaboration by allowing professionals to co-lead educational initiatives on topics such as stress management, substance use, and post-graduation life skills, promoting mental health literacy within the athletic community. Establishing clear, accessible referral pathways is also essential; gentle handoffs and early communication help facilitate timely appointments and ensure seamless follow-up after the AT initiates contact. Additionally co-locating mental health clinicians within the athletic training facility or department increases accessibility, fosters trust, and helps normalize mental health support as part of routine athletic care.

Benefits and Challenges

The benefits of this collaborative model are clear: improved communication across the care team, provision of comprehensive care, reduced fragmentation, and a significant enhancement of athlete well-being, resulting in a more supportive athletic environment. Early development of relationships among professionals allows each to understand the others' scope, eliminating the necessity for professionals to struggle with figuring out how to handle a patient in isolation. Despite the clear advantages, implementing interdisciplinary collaboration faces distinct challenges. One of the most significant barriers is resource limitations and financial restraints, particularly the lack of adequate funding and staffing. This directly reduces the availability of mental

health professionals, leading to long waiting periods for athletes; extended wait times severely lessen the willingness of athletes to be seen, undermining the goal of early intervention. Additional barriers include communication breakdowns and differing perspectives. Professionals from distinct fields, such as medicine (ATs), and clinical counseling (LPCs/LCSWs), may have differing ethical frameworks and communication styles. These barriers are often best addressed through dedicated, in-person discussions that allow professionals to discuss their perspectives and find common ground, ensuring the patient receives the best possible care. Finally, confidentiality concerns pose a constant challenge; navigating confidentiality while maintaining the flow of critical safety information (e.g., between an AT and a clinician during a crisis) requires the development of explicit, written, and institutionally approved policies and procedures that align with state laws and professional ethics.

Recommendations for Best Practice and Advocacy

To fully realize the benefits of this collaborative model and achieve systemic change, institutions must adopt a multi-faceted strategy. Some recommendations for implementation and advocacy are provided.

Education, Training, and Professional Cohesion

- Mandate Mental Health First Aid (MHFA) certification for all personnel (coaches, ATs, and administrators) to teach how to recognize, understand, and respond to signs of mental health challenges.
- Develop Collaborative Training to provide opportunities for ATs, LPCs, and SWs to collaborate on MHFA training to strengthen their knowledge base, network, and understand each other's professional scope.
- Institutions should create a clear diagram or framework showing the triadic relationship (AT–LPC–SW) within the broader institutional ecosystem to clarify the collaborative concept for staff and athletes.

Policy, Resource Allocation, and Advocacy

- Institutional leaders must advocate for adequate funding and staffing for mental health services. Objective data (e.g., number of athletes needing counseling, average wait time) should inform decisions.

- Formally adopt and integrate the NCAA Mental Health Best Practices into official handbooks and requirements to explicitly prioritize student-athlete mental health.
- The SW's role should extend to advocacy for broader systemic changes, such as partnerships with local non-profits for resource access, and advocating for less demanding athletic schedules or better insurance coverage for mental health (NCAA 2020).

Athlete Empowerment and Proactive Screening

- ATs, SWs, and LPCs must collaborate to establish the most effective and culturally appropriate proactive screening process for their specific campus culture and resources, which is fundamental for early identification (NCAA 2020).
- Implement strategies to teach athletes to recognize their own mental health needs, understand the resources available to them, and confidently advocate for their own well-being.

Education and Training

Ongoing mental health training is essential for all staff members involved with student-athletes, including coaches, ATs, and administrators. A key recommendation is mandating Mental Health First Aid (MHFA) certification for all personnel. Programs like MHFA teach how to recognize, understand, and respond to signs of mental health and substance use challenges. This training can be leveraged for professional development and to earn continuing education credits. Additionally, ATs can participate in various mental health continuing education programs to strengthen their knowledge base and network with others on management and referral. Providing an opportunity for ATs, LPCs, and LCSWs to collaborate regarding MHFA would be beneficial on the part of the university.

Early Identification & Intervention

Proactive screening, as recommended by the NCAA for collegiate settings, is a fundamental strategy for early identification. While the NCAA provides suggested screening tools, the best practice involves collaborating with a social worker and LPC to establish the most effective and appropriate screening process for the specific campus culture and resources. Early identification and screening can help connect student-athletes with SWs and LCPs to develop skills for management and coping. The goal is to create a

cultural shift in which help-seeking is normalized, rather than penalized.

Policy and Resource Allocation

Institutional leaders must advocate for adequate funding and staffing for mental health services. While student-athletes could utilize the services provided by regular counseling offices on campus, having their own clinicians housed with ATs and other services may be beneficial and could help them feel more comfortable with getting counseling. Objective data, such as the number of student-athletes in need of counseling, the average wait time for campus counseling services, and the necessity for virtual options in emergent situations, should inform resource allocation decisions. Furthermore, institutional policies must be developed that explicitly prioritize student-athlete mental health, which can be accomplished by formally adopting and integrating the NCAA Mental Health Best Practices into official handbooks and requirements.

Athlete Empowerment

Finally, a truly holistic approach empowers the athlete. Institutions must implement strategies that teach athletes to recognize their own mental health needs, understand the resources available to them, and confidently advocate for their own well-being within the demanding collegiate athletic system. Equally important, coaches, ATs, and administrators should foster a culture that normalizes help-seeking and prioritize mental health and wellness as much as physical performance. This could be done by having SWs and LCPs collaborate with these entities to show student-athletes there is collegiality and connection.

CONCLUSION

The rigorous environment of collegiate athletics demands a sophisticated and comprehensive response, recognizing that a siloed approach is fundamentally insufficient. This article has detailed the essential, distinct contributions of the AT (front-line gatekeeper), the LPC (clinical intervention), and the SW (systemic advocacy).

Crucially, the effectiveness of mental health support hinges entirely upon seamless interdisciplinary collaboration, which transforms a fragmented system into a holistic one. The implementation of collaborative models, particularly through co-located services that reduce logistical barriers, moves institutions from a reactive stance to a truly holistic, proactive system of care (NCAA 2020).

By systematically addressing mental health across the individual, relational, organizational, and macro levels of the Social-Ecological Model, this triadic approach facilitates institutional transformation of the athletic micro-community and builds community-level resilience. Prioritizing student-athlete mental health is not merely an ethical obligation; it is an investment in the foundational well-being that sustains peak performance, academic achievement, and successful personal development, both on and ultimately, off the field. Future research should focus on empirically testing the efficacy of different collaborative models and evaluating the long-term impact of mandated training and policy advocacy on athlete outcomes.

FUNDING

This article does not have a specific funding source; rather, it is part of the professions in athletic training, counseling, and social work of the authors. The athletic training professional is a faculty member at Texas Tech University Health Sciences Center in Texas, while the counseling and social work professional is a faculty member at Winthrop University in South Carolina. Neither Texas Tech University Health Sciences Center nor Winthrop University funded, wrote, edited, approved, or decided to publish this article.

LIST OF ABBREVIATIONS

ACA	= American Counseling Association
ASA	= American Sociological Association
ASWB	= Association of Social Work Boards
AT	= Athletic Trainer
BOC	= Board of Certification
BSW	= Bachelor of Social Work
CAATE	= Commission on Accreditation of Athletic Training Education
CACREP	= Council for Accreditation of Counseling and Related Educational Programs
CSWE	= Council on Social Work Education
DC	= Dual Career
ED	= Eating Disorder
LBSW	= Licensed Bachelor of Social Work

LCPC	= Licensed Clinical Professional Counselor
LCSW	= Licensed Clinical Social Worker
LISW-CP	= Licensed Independent Social Work-Clinical Practice
LMHC	= Licensed Mental Health Counselor
LMSW	= Licensed Master of Social Work
LPC	= Licensed Professional Counselor
MHFA	= Mental Health First Aid
NASW	= National Association of Social Workers
NATA	= National Athletic Trainers Association
NCAA	= National Collegiate Athletic Association
NCMHCE	= National Clinical Mental Health Counseling Examination
NCE	= National Counselor Examination
PIE	= Person-in-Environment
QPR	= Question, Persuade, and Refer (for suicide prevention)
SUD	= Substance Use Disorder
SW	= Social Worker

CONFLICT OF INTEREST

Neither author has any possible conflict of interest. There was no funding for this research.

ACKNOWLEDGMENTS

Both authors have devoted substantially to the conception, execution, analysis, and summarization of the work. The author, who identifies as an athletic trainer, completed work on sections relevant to athletic training. The author, who identifies as a counselor and social worker, completed the sections pertinent to counseling and social work. The remaining sections were a collaborative effort between the two authors.

UNETHICAL BEHAVIOR

Authors declare no unethical behavior. All references should account for what is included in the body of the paper and be adequately cited through in-text citation and on the references page using

American Sociological Association (ASA) formatting. The use of Copilot in Microsoft Word and other AI tools helped tighten up sections of the paper for clarity and conciseness.

CONSENT FOR PUBLICATION

No individual's specific data was used, including personal details and audio-video material. The authors consent to have this published.

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Received on 18-09-2025

Accepted on 20-10-2025

Published on 07-11-2025

<https://doi.org/10.65879/3070-6335.2025.01.06>

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