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Original Research

Experiences of Athletic Trainers in Tactical Athlete Settings When Managing Patients With Mental Health Conditions

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Context: Researchers have demonstrated that job demands impair tactical athletes' mental health. Mental health stigmas in this population and limited resources may prevent individuals from receiving care. Athletic trainers (ATs) are often the first, and sometimes the only, contact for mental health concerns. Previous literature indicated that ATs desired more psychosocial training and experience.

Objective: To investigate ATs' preparedness and experiences managing patients with mental health conditions in the tactical athlete setting.

Design: Consensual qualitative research study.

Setting: One-on-one, semistructured interviews.

Patients or Other Participants: Fifteen ATs (men = 7, women = 8; age = 36 ± 10 years; experience in tactical athlete setting = 4 years [range, 6 months–20 years]; military = 12, law enforcement = 2; fire service = 1).

Main Outcome Measure(s): Interviews followed a 9-question protocol focused on job setting preparation, mental health training, and perceived role managing patients with mental health concerns. Interviews were audio recorded and transcribed verbatim. A 3-person coding team convened for data analysis following the consensual qualitative research tradition. Credibility and trustworthiness were established using a stability check, member checking, and multianalyst triangulation.

Results: Four domains emerged surrounding ATs' mental health management experiences with tactical athletes: (1) population norms, (2) provider preparation, (3) provider context, and (4) structure of job responsibilities. Most ATs felt their educational experiences lacked comprehensive mental health training. Some participants described formal employer resources that were optional or mandatory for their job, whereas others engaged in self-education to feel prepared for this setting. Participants shared that unfamiliar experiences, such as divorce and deployment, influenced their context as providers. Most ATs had no policy related to mental health care and referral, indicating it was outside their responsibilities or they were unsure of role delineation.

Conclusions: For ATs working with tactical athletes, our respondents suggested that additional mental health education and training are necessary. They also indicated that improvement is needed in job structure regarding role delineation and the establishment of policies regarding behavioral health.

Key Words: military athletes, qualitative studies, behavioral health

Key Points

- In the tactical athlete setting, athletic trainers lacked the educational background to evaluate, manage, and refer patients for mental health concerns.
- Policies to help manage patients with mental health conditions in tactical athlete settings were unavailable.
- Athletic trainers were unsure of their role related to mental health management and the resources available to assist patients with these concerns.

Mental well-being is a multifaceted state with many definitions, depending on the point of reference. The American Psychological Association defines *mental health* as

> a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life.[1]

However, many organizations are rethinking the definition, including the European Psychiatric Association, which in 2015 proposed a new definition:

> a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal

values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium.[2]

As noted in these definitions, mental health can be viewed positively, negatively, or both and is influenced by social, environmental, and personal factors. Because these factors affect individuals differently, it is critical to evaluate mental health effects in various populations.

Previous researchers[3] have identified that shift work (eg, bartending, chauffeuring, construction, tactical positions) with hours outside the typical 7 AM to 6 PM period drastically increases rates of poor mental health and mental health disorders (70.6% increase) compared with non–shift workers. A *tactical athlete* (TA) is an individual employed in a military, law enforcement, firefighting, or rescue occupation necessitating physical preparedness for high work demands as well as tactical and technical abilities in order to face both environmental and human risks.[4] These individuals participate in rigorous physical training and extreme occupational demands (eg, 2-mile run tests, standing power throws, sprint-drag-carry, aerobic interval tests, and stair climbs) using equipment that is often heavy, with ladders weighing 55 to 130 lb (25–59 kg), hoses creating forces ranging from 80 to 110 lb (36–50 kg), and load carriages (eg, rucksacks) carrying up to 100 lb (45 kg) of supplies.[5–7] These physical demands place great stress on the body, which may result in prolific injury rates and affect the individual's mental health.[8] According to a study[9] of rescuers who had worked a 24-hour shift, significant measures of recovery were recorded after 48 to 72 hours of rest. However, long working hours and abnormal shifts may affect the individual's ability to obtain adequate rest from the physical and psychological stresses of work.[3,9]

Earlier investigators[10] found that 70% of military members developed a mental health disorder (eg, depression, anxiety, posttraumatic stress disorder) after injury. Apart from their physical demands, TAs also experience tragic events throughout their careers that can further affect their psychological well-being. In an examination of volunteer and career firefighters, 96% had experienced a traumatic or critical event on the job; of the most commonly reported types were scenes involving multiple critical injuries (81%); direct exposure to blood, body fluids, or both (80%); corpse removals (77%); protection by police required (67%); and a seriously injured victim trapped for a long duration (64%).[8] Furthermore, 34% of career firefighters described experiencing a coworker's death on the job,[8] and firefighters stated that continual traumatic exposures took a psychological toll on their mental health, personal well-being, job operation, and family life.[11] Additional literature[9,12] has shown that ambulance services tend to be more mentally demanding than firefighting services and that the density of incidents to which firefighters respond can influence the psychological cost. Moreover, in 2019, mental health conditions (MHCs), regardless of the specific type, were named the second leading diagnosis among military training instructors (10.4%).[13] However, mental health and associated health care are continually stigmatized in TA settings; therefore, numerous barriers to receiving care have been identified: stereotypes, nonsupportive leadership, judgement from peers, disclosures not remaining confidential, and adverse career consequences.[14–16] Although the military has implemented intentional efforts to investigate and mitigate mental health stigma, obstacles persist that need to be overcome relative to resources and experience with providers.[17] In an exploration[14] of mental health care barriers among firefighters and paramedics, all participants reported a need for improved mental health literacy. Thus, health care providers must be able to recognize, refer, and educate individuals regarding MHCs in TA settings.

Researchers[18] examining facilitators of and barriers to collegiate athletes' access to and interaction with mental health services determined that athletic trainers (ATs) did not have structured protocols for referring athletes to these services. Moreover, some athletic departments lacked the resources necessary to provide mental health care, and some individuals providing these services might have been inadequately educated to do so.[18] Additionally, newly certified ATs described being inadequately prepared for the psychosocial aspects of their jobs.[19] A recent study[20] of ATs with current or previous experience in military settings indicated that most were skeptical that their athletic training programs (ATPs) prepared them to work in this setting. Tactical athletes are known to be at risk of developing MHCs from occupational stresses, but the training, education, and comprehension of psychological interventions by ATs for effectively managing MHCs in TA settings have not been addressed.[8,10] Therefore, the purpose of our study was to evaluate ATs' preparedness and experiences managing patients with MHCs in the TA setting.

METHODS

Study Design

A phenomenologic approach was used to perform this qualitative research study. We investigated the perceptions, beliefs, and experiences of ATs working in the TA setting regarding their abilities to identify, refer, or help patients with MHCs in order to assess AT preparedness to manage such conditions. This study was approved by the University of South Carolina Institutional Review Board.

Participants

Participants were individuals who were currently working as ATs in a TA job setting.[20] In total, 25 ATs expressed interest in the research. Data saturation was achieved after interviews were completed with 15 participants. Demographic data, including participant pseudonyms, are provided in Table 1.

Interview Protocol

As no existing protocols addressed the objectives of this study, we created a custom semistructured interview protocol comprising closed- and open-ended questions.[20] The protocol was initially developed by 2 authors and then sent to 3 authors for revision and external review. The semistructured interview approach permitted data to be flexible and allowed for follow-up questions to better capture the experiences and beliefs of the participants.[21] We asked 5 demographic questions to collect background

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Table 1. Demographic Information

Pseudonym	Age, y	Gender	Job Setting	Years of Certified Experience	Highest Degree Earned
Andrew	33	Man	Law enforcement	2	Master's
Bambi	28	Woman	Public service	2	Doctorate
Drew	60	Man	Law enforcement	20	Bachelor's
Bobby	35	Man	Military	2	Bachelor's
Brooke	33	Woman	Military	2	Bachelor's
Carrie	30	Woman	Military	1	Master's
Danni	37	Woman	Military	3	Master's
Elizabeth	28	Woman	Military	1.5	Master's
Fang	60	Man	Military	1	Specialist[a]
Grace	38	Woman	Military	9	Master's
Lily	28	Woman	Military	4	Master's
Mateo	35	Man	Military	1.5	Master's
Mikey	41	Woman	Military	1	Master's
Pat	33	Man	Military	1	Master's
Theod	28	Man	Military	0.5	Master's

[a] Participant identified as having a specialist degree but did not provide additional information.

information, followed by 9 interview questions regarding their experiences and perceptions pertaining to the management of MHCs in the TA setting. The complete interview protocol used for this research study appears in Table 2.[21]

Procedures

Participants were recruited via email. The email addresses of ATs actively working in the TA setting were obtained through the National Athletic Trainers' Association research database. An initial email was sent to all potential candidates (n = 274) with a description of the purposes of the study and a link to an online survey where they could provide their contact information if interested. The primary investigator (PI) sent a follow-up email to all who provided contact information to schedule their one-on-one interviews via teleconferencing (Zoom Video Communications).

Data were collected through semistructured online interviews with the PI and each participant following the custom interview protocol. Participants supplied informed consent before the interview.[21] Interviews were conducted at the participants' convenience and lasted 20 to 30 minutes.[22] The audio of each interview was recorded, transcribed verbatim using artificial intelligence transcription (Otter.ai), and verified by the PI.[22] Each transcript was sent to the corresponding participant to review and confirm accuracy through member checking.[22]

Data Analysis

We followed the consensual qualitative research tradition, a practical and established process for analyzing participant responses in qualitative research.[23] As part of the consensual qualitative research construct, 3 researchers (A.M.L., K.E.G., Z.K.W.) formed the coding team to minimize biases.[23] Data analysis underwent 4 phases, as illustrated in the Figure.[23] To identify the initial domains, the coding team initiated the phase 1 process by individually reviewing 4 transcripts to select the core ideas and then grouped like ideas together into domains to establish the preliminary codebook.[23] Next, the coding team read 2 transcripts from phase 1 and 2 new transcripts to confirm the consensus codebook during phase 2. In phase 3, the coding team then applied the codebook (domains and categories) to all transcripts using multianalyst triangulation: each person coded 5 transcripts individually and then swapped with the other members for an internal review process. After independently reviewing each other's coding, the research team met to discuss disagreements and reach consensus on these discrepancies. An AT on the research team but not on the coding team (M.E.S.) acted as the external auditor to confirm the work of the coding team by reviewing 3 transcripts. Finally, cross-analysis was performed to group like quotes together, followed by calculation of a frequency count for each category. For frequency counts, a category was considered *general* if it was reported in all or all but 1 (n = 14) transcripts, *typical* when reported in 8 to 13 transcripts, *variant* when coded in 4 to 7 transcripts, or *rare* when reported in $\leq$3 transcripts.[23] Trustworthiness of the data was assured through verbatim transcription of interviews, transcript confirmation by participants, and multiple-researcher triangulation.

RESULTS

Four domains emerged regarding ATs' perceptions, experiences, and preparedness related to MHCs among patients after the interviews: (1) population norms, (2) provider preparation, (3) provider context, and (4) structure of the job. Categories emerged to support the domains in illustrating the participants' thoughts and feelings more clearly from their interview responses. Our participant sample was homogeneous, with general or typically similar experiences, as indicated by the frequency counts in each category (Table 3). Supplemental quotes for each category that emerged from each domain are available in Table 4.

Population Norms

Participants described cultural and organizational aspects of TA settings related to mental health. Two categories emerged in support of the domain: (1) stigma and (2) mental health concerns.

Stigma. Twelve ATs reported stigma in the TA setting that affected mental health and mental health care among patients. Participants explained that TAs tended to be less open to discussing and seeking care for MHCs because of perceptions of weakness and judgement. Additionally,

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Table 2. Interview Protocol[a]

Category	Question
Demographic questions	1. What is your age? 2. What is your gender? 3. What job setting do you work in? a. Military, police, fire, public safety, other 4. How long have you worked in the tactical athlete sector? 5. What is your highest degree earned?
Experience questions	1. Overall, why did you choose to enter this job setting? a. Describe your preparation working in the tactical athlete sector as you transitioned into this job setting. 2. Tell me about your education and training relative to mental health from your professional or postprofessional education. 3. Specifically, tell me about your preparation managing mental health aspects as you started in the tactical athlete settings. a. Has this changed over time? If so, how? 4. Describe what on-the-job training you were provided specific to recognizing or referring mental health conditions in the tactical athlete setting. a. Do you believe these trainings or any other specific training you have done should be integrated into athletic training programs to better prepare future athletic trainers entering the tactical athlete setting? 5. In your current role, have you managed a patient with a mental health condition? a. If yes: i. Describe your role. ii. Did you feel prepared to help the patient(s)? iii. What other providers did you interact with in your setting to help the patient(s)? iv. What resources were available and/or provided to these patient(s) at your clinical site? v. Was there a policy in place to help guide your decision making? b. If no: i. If a patient were to present, what do you think your role would be? ii. Do you feel prepared to help future patient(s)? iii. What other providers do you believe you would interact with in your setting to help these patient(s)? iv. What resources do you believe are available to these patient(s) at your clinical site? v. Do you have a policy in place to help guide your future decision-making? 6. What do you believe is the main difference in addressing mental health issues for traditional athletes when compared to tactical athletes? 7. Tell me what you believe is the area you were least prepared to do relative to mental health specific to tactical athletes. 8. What advice would you give future athletic trainers wanting to work with tactical athletes relative to mental health?
Conclusion	1. Is there anything else you feel I should know about either your current job working with tactical athletes or the role of the athletic trainer specific to mental health that we have not covered?

[a] The protocol is reproduced in its original format.

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participants described concerns patients had regarding how disclosure of psychological struggles might affect their careers. Elizabeth illustrated the stigma in this setting, explaining, "[TAs] also seem less likely to seek care and associate it with weakness." Fang shared feelings surrounding societal views on mental health: "It is just a societal dogma. . . . I think there is still a dark, condescending view if you need mental health assistance. . . . That is on society as a whole." Pat addressed mental health in TAs:

> I think that overall, at least in the Marine Corps, it used to be seen and is still seen as a weakness. For example, we are moving our resource team to a place where the command deck does not see them, so Marines who think there is a stigma do not miss their appointments because they think they are going to be judged.

Mental Health Concerns. Respondents expressed that cultural factors, including work hours and job demands, affected patients' mental health. Furthermore, ATs described outdated concepts of handling MHCs in the population, expressing that TAs tried to be mentally tough and hide psychological concerns. Participants felt that mental health and associated care should be brought into a

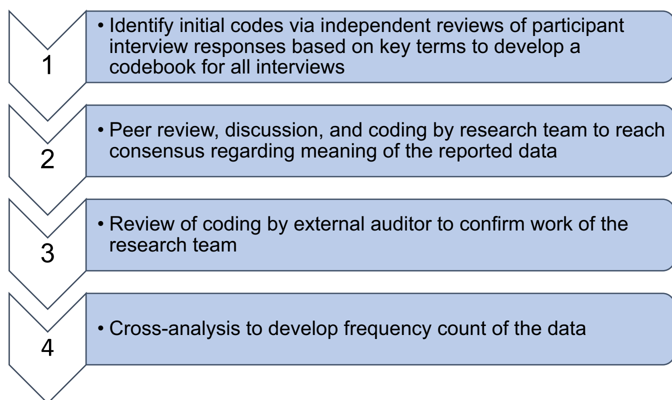

Figure. Consensual qualitative research process.

more common and positive light in TA settings. Bobby said: "As much as the Armed Forces has put resources towards dealing with [mental health], it honestly has not been enough, because these are systemic cultural problems that require more than just a class or a certification or a behavioral health referral."

Mikey conveyed career-related fears in the setting:

> [TAs] have a paranoia about their careers—it is very competitive, and they can very easily lose their spot on the squadron. When I first started, I had a few people say I could ruin their lives with anything that I do or say or write down.

Brooke depicted pandemic effects on mental health in TAs:

> The thing with TAs and mental health is that you are always going to face it in some way. COVID-19 was a huge struggle for TAs. The stresses . . . of not knowing—are they deploying? If not, when are they coming home? Are they not going home? When are they going to get to see their families again because they have to quarantine? So, mental health was a very big issue this last year within our population. It is something that needs to be brought to more normalcy. I think ATs are going to be great assets in the coming years for helping with mental health because . . . we are the melting pot [in health care].

Provider Preparation

Participants described their educational experiences, including optional sessions and elective courses. Participants portrayed the resources available at their current TA job site and proposed ideas for future professional development. Four categories emerged to support the domain: (1) educational experiences, (2) formal employer resources, (3) self-education, and (4) suggested professional development.

Educational Experiences. Three participants felt they had in-depth education related to mental health from their educational programs, mostly their postprofessional programs. The other 12 ATs felt their mental health education was minimal to none, being overall brief and general in nature. Drew stated, "We did not have mental health training back then [20 years ago]." Pat noted, "I got a little bit with my master's, but I would not say that it was extensive. I do not have a ton of mental health training." Bambi characterized the mental health training throughout her ATPs:

> In my professional education, there was not much. And I would say the same about my master's program. My doctorate program is what provided me the most educational experience with mental health. We had coursework, clinical experiences, and simulations where mental health was involved. So, I think that is where I really got my feet wet in dealing with mental health and being educated on how to even go about asking those questions to a patient or how to incorporate holistic health care into my evaluative process—it definitely came from my doctor of athletic training program.

Formal Employer Resources. Participants reported various levels of psychological resources available at their clinical sites, which ranged from no knowledge of available resources to few accessible to the AT. Additionally, 66% of participants did not have any formal on-the-job education or training relative to MHCs, resources accessible for patients and staff, or referral for such conditions.

Lily outlined her accessible mental health resources, commenting, "We have a clinical psychologist working within our program, which I do a lot of referrals to, even if there are no red flags per se." Carrie depicted her lack of resources regarding a patient case:

Table 3. Frequency Counts by Domain and Category

Domain	Category	Count (n = 15)	Label
Population norms	Stigma	12	Typical
	Mental health concerns	11	Typical
Provider preparation	Educational experiences	15	General
	Formal employer resources	15	General
	Self-education	13	Typical
	Suggested professional development	15	General
Provider context	Unfamiliar experiences	13	Typical
	Comparative competency	15	General
Structure of the job	Lack of policy	14	General
	Role delineation	14	General
	Collaboration	13	Typical

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Table 4. Supplemental Quotes Continued on Next Page

Domain	Category	Participant Pseudonym	Quote
Population norms	Stigma	Lily	"Yes, I think there is a little bit more of a stigma, and something that can affect the stigma is that it can affect their careers. It is not just being able to be physically active."
		Mateo	"I think there is an element of having to tough through things and not admit weakness. I would say that it is enhanced in the tactical population compared to your athletic population. The hesitancy to seek care again, having to be tough, and get through situations."
	Mental health concerns	Bambi	"We know from the research that there is [*sic*] very specific mental health ailments or issues that tactical athletes tend to deal with at a higher rate than a different population . . . anxiety, depression, PTSD, alcoholism."
		Bobby	"There is a cultural problem—very high levels of stress, poor sleep, and dietary habits. There is an off-tempo battle rhythm for them, so there is a lack of consistency. They are also expected to be very high performers. There is the normal anxiety that goes along with that."
Provider preparation	Educational experiences	Mikey	"The mental health preparation when I was a student way back when was very minimal. It was a chapter in a book and that is not true to life."
		Theod	"In my bachelor's degree, I would say mental health was not really ever discussed in terms of provider health care. We were told to be aware of it, but never went in depth on what that means. Then, with my master's program, there was never really any direct education on it either. It was more discussed in bits and pieces in other classes, where we were talking about understanding patient demographics and how that affects you working as a provider. It was never really directly discussed."
	Formal employer resources	Pat	"[The tactical athletes] get full spectrum as far as athletic training. They get general medical-type stuff, and they get mental health."
		Danni	"I do not think I was really provided with any training here. When I was at [location], we went through a suicide prevention course, which we did annually there, but as far as being [at my current job], I was not provided with any resources."
	Self-education	Carrie	"A lot of my preparation was mostly personal relationships and communicating with individual people about the setting."
		Danni	"When I got to base, no one talked me through it. It is all research that I needed to do on my own."
	Suggested professional development	Lily	"Be prepared. Be open to still learning and keep up to date with the steps that need to be taken or red flags that are indicators. Then, building rapport with your tactical athletes and knowing all the resources that can possibly help."
		Mateo	"I do not think mental health training specific to the tactical setting would be appropriate for athletic training programs as a whole. I think keeping it to more general populations would be good. But the unique demands of the tactical setting changes [*sic*] a lot from what most athletic trainers are going to see. So, I think specific mental health training should fall more within the military or possibly even the contracting companies to prepare you for that."
Provider context	Unfamiliar experiences	Grace	"You are hearing them talk about self-harm, you are hearing about alcoholism and how they are coping, whether it be drugs, or alcohol, or guns, or tattoos, or multiple sexual encounters, and it is just so far out of the wheelhouse and is just uncomfortable talking about it because I do not know how to help them."
		Drew	"As far as the tactical setting, they are older. This is going to be career related and could be life-threatening."
	Comparative competency	Andrew	"Tactical athletes can possibly kill people. Athletes, in most normal situations, unless it is something crazy, they do not. With athletes, it is more accidental death, like a football player lowers his head and has a cervical spine fracture that can result in paralysis or death. Tactical athletes are put in situations where they have to rely on their training, their instincts, and they have more of a possibility to experience PTSD because they might have to shoot someone or tase someone."
		Fang	"I would never have to ask a coach to have the athlete go see the sports psychologist. Whereas here, you would have to ask and inform the sergeant major that this guy needs to go see a mental health provider."

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Table 4. Continued From Previous Page

Domain	Category	Participant Pseudonym	Quote
Structure of job	Lack of policy	Pat	"I think if we got together and had a set plan, 'If I see this or I see that, how do I report that to you or how do I get that to you,' it would be pretty beneficial."
	Role delineation	Brooke	"It is recognizing the signs that someone is in mental distress and trying to quickly decide whether it is life-threatening mental distress or if it is just something that we can hit that was just smaller and then locating who is the best person to get ahold of."
		Elizabeth	"Yes, just referral out and [the patient] works with their provided counselor. Then, I would do check-ins with [the patient] with certain questions to ask how they are doing in regard to their injury. But other than that, there is really not that much of a crossover between us and the counseling practices we have in place . . . I would really like to see there be more communication."
	Collaboration	Andrew	"I think a department of athletic training should actually have on staff counselors that have been taught the 3-year degree that you get in a master's program and then you graduate, and you have to take your boards and get licensed. I do think they should have 2 or 3 of those people."
		Brooke	"I always work within a team. I never try to take something on like that by myself."

Abbreviation: PTSD, posttraumatic stress disorder.

> I realized that I did not have a whole lot of resources listed or have a good understanding of what those referral points looked like. I did not feel like I knew the resources that were available, who to send them to, and did not have really any preparation to have a good idea of how to help.

Grace portrayed different trainings at various job sites:

> In the Army, we were given quarterly training in mental health and factors to recognize. Working for the Air Force, it was a lot heavier—we had to do 2 to 3 classes every quarter in recognition of [mental health]. And in the Navy, they brought in a mental health professional who sat down twice a year so you could understand why certain individuals would not be allowed into Special Warfare based on their mentality issue that may have popped up.

Self-Education. Most participants expressed that they had invested in self-education before or during their employment in the TA setting. Several opted to make connections with providers at their clinical site independently, whereas others invested in further training, conferences, and literature regarding MHCs. Brooke reflected: "Everything that I chose to do is optional." Mateo described his self-education to prepare for transitioning into this setting:

> There is no specific preparation, and there is going to be a variety . . . depending on what assets are available locally—whether it is embedded assets or relying on base or medical group assets. So, learning what is available. A lot of that was self-directed and just working through situations as they present.

Bambi described her experiences with self-education:

> Once I got here, I went to the wellness unit. I did that on my own—it was not a required element. I also have taken the Behavioral Health First Aid course for young adults. I did that before I was in the TA setting. So, I did get some information there that was outside of school and work. But it was not specific to TAs.

Suggested Professional Development. Fourteen participants felt additional psychological training should be integrated into ATPs to better prepare future ATs, specifically how to reduce stigma and how to approach patients with MHCs. Theod construed the importance of additional training: "I think any type of training geared towards helping clinicians understand mental health would be good to just feel comfortable having open conversations with your patient." Grace indicated the need for more training and education:

> No matter what setting you are in, [it is important] being able to recognize when someone needs help or when someone is in trouble and how to approach that person as a medical provider. I have been out of school for 15 years, but the training that I received did not prepare me for people that were uncomfortable being touched because of traumatic experiences or mental disorders, and it certainly did not prepare me for the types of experiences among the patients that I work with [in the TA setting].

Danni discussed suggestions for future professional development within ATPs:

> We are usually the first people that have a trusting relationship with [the TA] so they do come to us. I think that [mental health education] should be a core piece of the curriculum because we need to be able to recognize it. But we should also have a basic understanding for encompassing all the different settings and how it can affect individuals and what we should be looking for.

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Provider Context

Participants noted differences between traditional and TA settings and how unique features of the TA setting affected them as clinicians. Two categories emerged in support of this domain: (1) unfamiliar experiences and (2) comparative competency.

Unfamiliar Experiences. Thirteen ATs (86%) spoke of unfamiliar experiences that influenced their clinical context in the TA setting, many (n = 9) reporting that they related to the population's culture, job demands, and deployments. Drew detailed the uniqueness of the TA setting, recognizing he might find himself "dealing with a person who is trained and has access to a firearm." Theod addressed TAs' career and family aspects: "The biggest part is understanding their work stresses, a lot of that being their schedule, as well as understanding their family dynamic." Elizabeth recognized the burden of psychological concerns she saw in TAs:

> Since I see a much higher number of soldiers compared to collegiate athletes, the volume I have seen with mental health in the setting took some getting used to. I was not prepared to have as many soldiers as I did have suicidal thoughts or anxiety issues.

Comparative Competency. Participants had various responses when comparing their experiences in the TA setting and the traditional setting. Bobby acknowledged the contrast between TA and traditional settings with respect to schedules:

> It is like being on a sports team [in] that they do not have an off-season—there is always the chance that they [will] need to go. So, there is this attitude of "Yes, we will get you . . . help. However, the mission comes first. So, if you [TA] get pulled on mission, then put those issues in your back pocket, and we will come around to those when there is time. And sometimes that can result in their care being delayed for years.

Grace voiced distinctions between traditional athletes and TAs:

> There is a very big difference in . . . active duty versus the students coming straight from basic military training. Active duty [TAs] has [*sic*] seen combat, have seen team members die or been on missions with the utmost of secrecy. I honestly think the biggest difference is recognizing that a TA is always putting their life on the line, every time they deploy. In athletics, it is the mentality of focus and drive and doing the best that you can and being the best that you can and winning.

Lily commented on differing demographics: "I do not think there is a huge difference with athletes versus TAs per se but definitely within age groups."

Structure of Job

Respondents shared experiences working with other health care providers, job duties related to MHCs, and policies associated with mental health referral and care. Three categories emerged in support of this domain: (1) lack of policy, (2) role delineation, and (3) collaboration.

Lack of Policy. One participant reported having established policies regarding recognition, management, and referral for patients with MHCs. However, overall uncertainty or conflict appeared to surround the AT's role in mental health care management in TA settings. When asked his role in managing a patient with psychological concerns, Mikey replied, "I have to be honest, I do not really know." Many ATs, when asked about policies in place, echoed Andrew, who stated, "I do not have a written policy." Carrie shared her thoughts on barriers related to policies:

> As far as it being an actual policy, the likelihood of that is low because of the contract standpoint. So, a lot of the processes that I create are not reviewed through the Air Force. It is more of a personal policy as a contractor.

Role Delineation. Fourteen participants discussed role delineation in the TA setting. Several specified that mental health management was not within the AT's scope of practice, clearly identifying the need for mental health resources. Bobby declared: "As an AT, it is not within my scope to make that diagnosis or to be the primary caretaker for that." Fang mentioned the difficulty in caring for patients with MHCs, explaining, "[It] just depends on if the patient got orders to see the person. I do not have the ability to set up orders to see a mental health provider." Andrew talked about practicing as an AT:

> I think the biggest thing is we are not mental health specialists. My [spouse] is a mental health clinician that works with kids suffering from anxiety disorders. I do not think we should do that. We find them the appropriate means to help themselves, which I think would be to refer to a mental health clinician that has . . . trained years to be qualified and help that person through that situation.

Collaboration. Eleven participants (73%) discussed collaboration in the tactical setting, and 3 subcategories emerged: (1) formal, (2) informal, and (3) limited. Regarding collaboration in the TA setting, Elizabeth proposed:

> I think that if procedures were put in place so communication is improved between the provider and AT, we can help the TAs succeed a little bit more quickly than they are with the current practices in place. Because when there is not communication between the health care providers, within reason to the rehabilitation process, I think it makes it hard to manage certain cases.

Bambi added:

> We have the wellness unit, so I have utilized that resource numerous times. I have handled numerous patients at different phases of their mental health. Sometimes I am the first person having that conversation that they are showing signs and symptoms of potential mental health impairments or struggles that they need to maybe have addressed if they would like to. Having that initial conversation and being the first person in their life who has told them that is extremely challenging, and so we are networking and using collaboration with the wellness unit.

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Overall, the participants had varied experiences when collaborating with others. Given the minimal and unclear resources at her clinical site, Danni noted: "If I did not seek it out as a medical provider, I do not know that I would have known what resources are available to the athletes." The lack of formal job structure for interprofessional collaboration was a concern for ATs.

DISCUSSION

By the nature of their occupation, ATs' frequent interactions with patients facilitate strong relationships, placing them in an optimal position to recognize the signs and symptoms of MHCs and expedite referrals, psychosocial interventions, or both for desirable patient outcomes.[24–29] However, our findings indicate that many ATs employed in the TA setting did not feel confident in their ability to recognize, refer, and manage patients with MHCs. This finding is similar to that of other researchers,[30] who observed that, although more than 90% of ATs believed facilitating referral for mental health care and recognizing the signs and symptoms of MHCs were parts of their occupational duties, they struggled to select the proper care strategies for patients experiencing psychological distress. Participants demonstrated several concerns specific to TA settings that influenced the mental health care patients received. Specifically, 4 domains were identified related to mental health care in the TA setting: (1) population norms, (2) provider preparation, (3) provider context, and (4) structure of the job.

Population Norms

Mental health is a popular topic globally.[31] Their abnormal work hours, career requirements, and occupational experiences put TAs at increased risk of developing MHCs.[3,8,10,11,13] We determined that cultural stigma surrounding mental health affected patients' willingness to acknowledge and discuss psychological concerns. Prior investigators[14–16,32] characterized similar results of and barriers to receiving mental health care among TAs: perceived ridicule from peers, lack of appropriate resources, associations with weakness, and concerns about negative career consequences. Stigma among TAs may relate to limited mental health literacy in the population, which plays an important role in patients pursuing mental health care.[33] The US military has taken the initiative through research and interventions to reduce mental health stigma and improve access to and use of mental health resources. A reduction in mental health stigma occurred when individuals believed that the organization supported and cared for their well-being.[17] Additionally, increased perceptions of organizational support were associated with a forecast of lessened posttraumatic stress disorder at all phases of deployment (before, during, and after). Mental health self-stigmatization was significantly minimized when individuals participated in an intervention program, which typically used cognitive methods to educate them about how to improve control of their emotions.[17] Although these efforts and interventions have shown promise for lessening mental health stigma in the military, further research is necessary to identify beneficial program structures and policies that ATs can implement.

Our participants expressed unique aspects of TA populations that influence behavioral health, including elevated stress levels, low-quality sleep, and lack of mental health resources, which coincide with earlier results.[14,16] Moreover, previous authors[18] indicated that the demands of collegiate athletics affected athletes' mental health when compared with nonathletes. Also, 1 participant mentioned that the COVID-19 pandemic further affected their patients' mental health. It is important to note that most of our participants had been employed in the TA setting for fewer than 5 years, many for only 1 to 2 years. Therefore, these ATs' experiences managing MHCs may have been influenced by COVID-19 and may not reflect typical experiences among the population. However, the pandemic may have shed additional light on health care gaps and cultural concerns in the TA setting, as it increased the prevalence of MHCs among adults, revealing where challenges in pursuing and receiving care lie.[34]

Preparation and Context of the Provider

Although the Commission on Accreditation of Athletic Training Education (CAATE) dictated that psychology is required in ATPs, it did not define the amount or detail this education must provide, resulting in disparities among ATs' preparedness to address psychological concerns.[30] Most participants had completed a master's degree, yet they described various levels of training related to mental health recognition, care, and referral. As was true in prior studies,[19,20,28–30] our participants overall commented that they had vague or little psychological education in their ATP and thus felt inadequately prepared to manage MHCs. This suggests that education specific to identifying concerning behavior and referral processes and incorporating psychosocial strategies into clinical practice is critical to implement in ATPs in order to facilitate holistic and exemplary care for patients struggling with MHCs.

As cited earlier, the CAATE standards did not clearly define psychological education in ATPs, which leaves individual programs to dictate the extent of education students receive.[30] Our participants discussed completing nonmandated training to improve their competency and confidence in managing patients with MHCs; this agrees with the results of previous investigators[18–20,28,29] who suggested that ATs may not become proficient in psychological recognition, psychosocial interventions, and appropriate referral during their ATPs. Yet researchers[29] have demonstrated that ATs expressed the desire for more thorough education pertaining to MHCs and management, with many electing to self-educate.

Psychological conditions are widely prevalent in various populations, which indicates the need for health care providers to understand the signs, management, and referral processes for patients with such conditions.[3,10,11,13,18] The educational outcomes from a single psychology course and occasional continuing education programs in athletic training are not sufficient for clinicians to adequately implement psychosocial interventions in patient care.[29] Our participants reinforced this, mentioning the need for additional mental health training, provided formally in ATPs and pursued

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individually, to effectively integrate psychosocial interventions into clinical practice. A potential solution to improving psychosocial education within ATPs is to facilitate collaboration between the primary organizational systems of athletic training and psychology. We recommend that the CAATE and the American Psychological Association Commission on Accreditation partner to allow ATs to become proficient and confident in psychosocial strategies during either their professional or residency program. This will, in turn, allow networking with psychology students who can become multidisciplinary assets in future patient care for TAs.[29]

Structure of the Job

Education, early detection, and appropriate referral are critical in caring for patients exhibiting psychological concerns.[35] Structured protocols for the management of MHCs are necessary, not only to improve recognition and referral of such concerns but also to improve overall patient care.[35] As was true in a preceding study,[18] our results demonstrated that few ATs employed in TA settings have these structured policies in place to assist in orchestrating appropriate and successful care for patients with MHCs. This may, in part, be due to the fact that many athletic training jobs in TA settings, specifically within the military, are offered through contracts with independent companies instead of directly by the site of employment, which may limit the AT's scope of practice and responsibilities.[20] Traditional settings, such as colleges and universities, typically reported having a written mental health policy in place.[28] Though college athletics considers updating policies regularly to be best practice, many institutions do not consistently review these documents, implying that athletic training overall needs organizational improvement for mental health management[28] and that a lack of policies or outdated policies can inhibit effective patient care. System-based factors also complicate collaboration between mental health providers and ATs, as providers tend to use different documentation programs to record care provided to the same patients.[27] This suggests that interprofessional collaboration may be limited in the TA setting and that attention should be paid to correcting these factors.

Various methods, including electronic records, can be used as resources for MHCs, allowing access at work, school, or home, which could be particularly useful in TA settings.[27,36] Our participants mentioned the minimal resources available at their clinical sites to care for and support patients with MHCs and felt they needed to seek resources or find options outside of their employer for patients in need of specialty services. Athletic trainers believed the availability of easily accessible mental health providers was a critical factor in supplying better care to patients. Moreover, the most successful workplace interventions to improve employee mental health were those aimed at reducing harassment, managing workload, and defining roles.[36] Further, interventions targeting improvement in communication and collaboration, return-to-work protocols, and psychotherapy are universally suggested.[36] Thus, the resources offered in TA settings and organizational structure should be enhanced for more efficient and effective patient care.

Limitations and Future Research

Limitations regarding generalizability and recall bias existed in this research study. The National Athletic Trainers' Association Research Database had 274 participants from all TA job settings, which included the military, law enforcement and government, police, fire, and public safety. Our participant sample was employed mostly in the military setting, which restricts the generalizability of their job experiences to other sectors of TAs. Additionally, the COVID-19 pandemic may have affected ATs' experiences working in TA settings, with possible increases in patients with MHCs and thereby influenced the results, as several participants had only recently begun working in this job setting. Finally, research volunteer bias may also be of concern, as the ATs who volunteered to participate may have been the most open to discussing mental health and health care, which may not reflect the introspective experiences of all professionals working in TA settings.

Intentional efforts focused on implementation research must be prioritized in the law enforcement, military, and public safety settings. These may include the integration of ATs who have completed residency training and are board-certified specialists in behavioral health. Future investigators should explore mechanisms for ATs to assist in and lead policy development related to mental health for TA settings to achieve optimal patient outcomes and offer guidance to providers in these jobs.

CONCLUSIONS

The ATs currently employed in TA settings did not feel completely proficient in implementing psychosocial techniques in health care plans for patients with psychological distress and concerns, and resources for these patients were insufficient. Because of these factors, ATs in TA settings require additional and advanced training in behavioral health management to apply to their clinical practice in collaboration with psychological health care providers.

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