When to Refer Out

In 2012, over 19 of 43 million adults who experienced an episode of mental illness were between 18-25 years old--typical college-age range (Van Raalte, Andrews, Cornelius, Diehl, & Brewer, 2015). Between 2004-2008, suicide was the third leading cause of death for National Collegiate Athletic Association (NCAA) student-athletes (Van Raalte et al., 2015). Mental healthcare is important to society in general, but especially in consideration of the special student-athlete demographic. Student-athletes face more stresses and demands (mental, emotional, physical, social, logistical, etc.) than non-student-athletes (Van Raalte et al., 2015). Issues that athletes face may include: performance pressure; pressure to hide or "work through" injuries; undiagnosed mental disorders; substance abuse; eating disorders; poor support systems; publicity pressure; pressures as a role model; and pressure to conform (Dean & Rowan, 2014). This student-athlete demographic brings along special ethical concerns: identifying the real client; the role of the sport psychologist; and scope of practice--when to refer out.

At all levels of athletics, it may be difficult to identify who the real client is (and the client's privacy) as opposed to key stake-holders and their "need to know". This is an even more difficult situation if one is employed as a consultant for the team, employed by the department and/or school (Etzel & Watson, 2007). Because a certain amount of publicity is involved and "part of the job" of an athlete, stakeholders may include coaches, team staff, other medical personnel, and financial investors. Etzel and Watson (2007) noted that Principle B in the Fidelity and Responsibility of APA Ethics Code makes it clear that the individual athlete is the client; any mental health or medical professional serves the individual client. In order to avoid confusion and breaching the "trust-gap", boundaries regarding "whose well-being", privacy, security, knowledge, and confidentiality must be established from the onset; these boundaries also need to be clarified (to all parties) in any kind of referral situation (Etzel & Watson, 2007).

Identifying the real client is the first step in providing care, and understanding one's role and professional responsibility to that client--duty of care (Hodgson, 2010). A "sport psychologist" (particularly at a school) may perform multiple functions within the school and may not be clinically-trained or experienced in other areas of psychology/social work; a sport psychologist's duties focus on the athlete's performance (health and exercise psychology, performance psychology, and social psychology regarding athletes, coaches, teams, and spectators) (Dean & Rowan, 2014). The athlete's performance may be affected by more serious issues involving other domains including (but not limited to) overall mental health, family, work, spirituality, and school; being an athlete is just one domain of a whole-person approach (Dean & Rowan, 2014). A sport psychologist may not be well-equipped to deal with the "whole-person"; ethically, the sport psychologist must refer out (Dean & Rowan, 2014; Hodgson, 2010; Tod & Anderson, 2010). If a professional practices outside of their scope, they may be subject to various legal liabilities and including the Bolam test (measuring duty of care and responsibly discharging/passing-along duty of care) (Hodgson, 2010). Hodgson (2010) advised: "work within your own professional competencies at all times and discharge your duty of care responsibly" (p. 18). For example, situations involving [domestic] violence, alcoholism, drug use (substance abuse), eating disorders, or gambling would need to be referred out.

When referring an athlete to another healthcare provider (or service/agency), the sport psychologist may serve as a facilitator of a larger "team" that is more adequate to deal with the athlete's issues (Tod & Andersen, 2010). A "team" mindset is appropriate because it is necessary to address the whole-person athlete--whole-person (multiple domains of a person requiring multiple "types" of professional help) wellness. The sport psychologist (working with established trust/relationship) could aid in introducing/transitioning the athlete to other service-providers; the athlete may even be more open/receptive due to the sport psychologist's endorsement (Tod & Anderson, 2010). One should approach an athlete sharing observations and concerns about his/her behaviors while respecting the athlete's autonomy. One should try to facilitate the athlete to come to the desired-outcome on their own (i.e. lead the athlete to make his/her own decisions). However, if the athlete poses a real danger to him/her-self, then the sport psychologist would have to intervene and act to safe-guard the individual (those types of intervention laws vary from state-to-state and could involve the police).

References

Dean, C., & Rowan, D. (2014). The social worker's role in serving vulnerable athletes. *Journal Of Social Work Practice, 28*(2), 219-227.

Etzel, E. F., & Watson, J. I. (2007). Ethical challenges for psychological consultations in intercollegiate athletics. *Journal Of Clinical Sport Psychology, 1*(3), 304-317.

Hodgson, L. (2010). Working in sport and exercise medicine--Be prepared! Part 1. *Sportex Medicine,* (46), 17-22.

Tod, D., Andersen, M. B. (2010). When to refer athletes for counseling or psychotherapy. In Williams, J. (Ed.), *Applied sport psychology: Personal growth to peak performance* (6th ed., pp. 443-462). New York, NY: McGraw-Hill.

Van Raalte, J. L., Andrews, S., Cornelius, A. E., Diehl, N. S., & Brewer, B. W. (2015). Mental health referral for student-athletes: Web-based education and training. *Journal Of Clinical Sport Psychology, 9*(3), 197-212.