Advocacy Plan: International Olympic Committee consensus statement on pain management in elite athletes and Blurred lines: Performance Enhancement, Common Mental Disorders and Referral in the U.K. Athletic Population

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Introduction

Advocacy is defined by Alliance for Justice (AJ) (2016) as, "any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others" (AJ, 2016). Advocacy as it pertains to the field of sport psychology advocates for the rights of the athletes and their best interest in regard to ethics in sports. Heil (2016), in his article Sport Advocacy: Challenge, controversy, ethics, and action, emphasizes the importance that sport psychologists should consider advocating for athlete's rights. He continues with stating that there is a demonstrated need, solid science, and clear direction through the American Psychological Association's ethical principles (Heil, 2016, p. 281). Advocacy is an important call to action and professionals should take great responsibility to advocate for all of the individuals that they have a responsibility for in the field, especially in regard to ethical questions and concerns. The areas that will be explored are *pain management and injury prevention in elite level athletes* and the challenges of *Blurred lines: Performance Enhancement, Common Mental Disorders and Referral in the U.K. Athletic Population;* after thorough review an advocacy plan will be developed to best address any areas of concern.

Advocacy Topics

The advocacy topics in exploration, as mentioned above, are pain management and injury prevention in elite level athletes and the challenges of blurred lines of performance enhancement, common mental disorders and referral in the U.K. Athletic Population. The first advocacy topic that will be delved into is pain management and injury prevention in elite level athletes. While occasional pain and injury are inevitable in almost all sports, the elite levels, such as the

Olympics, offers its own distinct level of potential pain and injury. The pain and injuries that are prevalent in the elite levels of sports need appropriate pain management and injury prevention. There are currently ethical concerns in question, such as autonomy, beneficence, informed consent and nonmaleficence, which will be further discussed in the following paragraphs. Further, most relevant to this advocacy topic and plan is the role sport psychologists can play with addressing pain, pain management, and injury prevention in athletes.

The topic of pain management and injury prevention is introduced in Hainline et. al. (2018), *International Olympic Committee consensus statement on pain management in elite athletes* (2018):

> *"*There are currently no evidence-based or consensus-based guidelines for the management of pain in elite athletes…pain management consists of the provision of analgesics, rest and physical therapy. More appropriately, a treatment strategy should address all contributors to pain including underlying pathophysiology, biomechanical abnormalities and psychosocial issues, and should employ therapies providing optimal benefit and minimal harm… The International Olympic Committee attempted to address the multifaceted aspects of pain physiology and pain management in elite athletes through the lenses of epidemiology, sports medicine, pain medicine, pain psychology, pharmacology and ethics" (Hainline, et. al. 2018).

As mentioned in the article, treatment strategy should provide optimal benefit and minimal harm, which is congruent with the American Counseling Association ethics code principles,

beneficence and nonmaleficence. As defined in the ACA (2014), “Beneficence: the service provider, counselors are to do good for the client, such as acting in the best welfare of the clients; Nonmaleficence: is the principle to not cause harm to others; above all do no harm. If there is harm in question with an action, refrain if possible” (ACA, 2014). This beneficence and nonmaleficence will be maintained and the ACA and Association for Applied Sport Psychology (AASP) ethics codes will be implemented in this advocacy plan in the process of addressing ethical concerns in pain management and injury prevention in order to best support and advocate for the athletes.

While the research article discussed pain management in regard to epidemiology, sports medicine, pain medicine, pain psychology, pharmacology and ethics, the areas of particular interest to this advocacy plan, as it relates to sport psychology, are in regard to pain psychology and ethics. The concepts of pain are relevant to mention, as they relate to psychology, and are defined thoroughly in Hainline et. al. (2018)

> “Pain is unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain can be classified as Nociceptive-clearly associated with tissue damage or inflammation… most commonly associated with sport injury; Inflammatory pain- results from the activation and sensations of nociceptors by inflammatory mediators and is common in acute traumatic sport injury with associated swelling and inflammation. Neuropathic pain- results from a lesion or disease in the somatosensory nervous system and is common in Paralympic athletes with spinal cord injury. A third type of pain is common among individuals with chronic pain, it is neither nociceptive nor neuropathic but

> associated with clinical and psychophysical findings (hypersensitivity) that suggest altered nociceptive functioning (e.g., as in fibromyalgia, non-specific low back pain)… Para-athletes can experience more pain than their able-bodied counterparts, perhaps because of an increased incidence of injuries in their sports, or the nature of a specific impairment. Although pain or discomfort in para-athletes can be a common clinical feature among those within each of the 10 recognized impairment categories, more severe pain can occur in those experiencing stump pain, phantom limb pain, spasticity-related pain or in those who have suffered spinal cord injuries" (Hainline, et. al. 2018).

The areas of interest as it relates to the role of psychological intervention are "emotional experience, hypersensitivity, and nociceptive functioning (e.g. non-specific low back pain)." Indicating that there are potential psychological reactions occurring corollary with or without actual "reasons" for pain. Further, pain associated with sport injury highlights relevant psychological issues and ethical concerns that will be addressed in the advocacy plan.

Sport Injury is defined by Hainline, et. al., (2018), "new or recurring musculoskeletal complaints incurred during competition or training that require medical attention, regardless of the potential absence from competition or training…*Acute traumatic injury* refers to a single event that leads to a singular macro-trauma on previously healthy tissue" (Hainline, et. al. 2018). It is important to consider acute traumatic injury, as it relates to sport psychology, as mentioned in Hainline, et. al (2018), "Acute traumatic injury in the athlete may be accompanied by fear, anxiety and heightened cognitive focus on the injury" (Hainline, et. al, 2018). This is an area that would need to be addressed in order to help the athletes recover more effectively, minimize psychological distress, as well as prevent future associated injury.

In continuation, Hainline et. al. (2018) defines Overuse injuries as,

> "injuries that occur from repetitive submaximal loading of the musculoskeletal system when inadequate recovery has not allowed structural adaptation to occur. Injury, then, is the outcome of the difference between the volume and intensity of the stress or force applied to the body and the body's ability to dissipate this stress or force. Injury may result from repetitive microtrauma imposed on otherwise healthy tissue or repeated application of lesser forces to already damaged tissue. In essence, athletes are not training at an optimal workload to build physical capacity and resilience to the demands of the sport… Subacute recurrent injuries and chronic degenerative conditions may form a continuum with overuse injuries. A recurrent injury is an incident of the same type and at the same site linked to an index incident, which occurs after an athlete's return to full function and participation from the recorded index incident. Although degenerative conditions may develop independent of sport injury, some result from prior acute or repetitive overuse injuries and manifest as a chronic overuse injury" (Hainline, et. al 2018).

Overuse injuries indicate ethical concerns as they relate to nonmaleficence and beneficence. Nonmaleficence is in question, in reference to its ACA (2014) definition, "do no harm, and to refrain if harm is in question," due to the fact that athletes can be subjected to such demanding training that they are not always able to have optimal recovery and can sustain overuse injuries, which indicates that the coaches and trainers are not operating with the well-being of the athlete in mind (i.e. not taking appropriate measures to avoid harm to the athletes). Further, the coaches and trainers are not conducting themselves with ACA (2014) beneficence, "do good for the

client," since they are subjecting the athletes to athletic training that can be detrimental to their mental and physical health. In addition, these overuse injuries can occur for a number of reasons, including but not limited to the following, heightened pressure to perform close to qualifications for the Olympics, playing in consecutive tournaments, compensating for other teammates being down and out with their own injuries, or pressures to perform due to obligations to owners and sponsors.

The numerous preceding reasons for overuse injuries is an opportunity for sport psychologists to advocate for the rights of the clients in regard to injury prevention. Athletes may not admit their pain or susceptibility to injury due to the pressures that they are experiencing as professionals, such as to qualify for the Olympics, to perform in tournaments, to help carry the load of other team members, and pressures to honor their performance contracts. The implementation of guidelines that define appropriate pain management and injury prevention, in respect to the ethics codes, will be further discussed in the following paragraphs.

Current concepts of pain and different forms of pain management are discussed in Hainline, et. al. (2018): "Pain is a subjective experience dependent on complex interactions of neurobiological, cognitive, affective, contextual and environmental factors. Thus, pain management depends on identifying contributory factors from biological, psychosocial and contextual domains and addressing them through various evidence-based techniques. Educating the athlete regarding the role of the central nervous system in pain, especially in chronic pain, can increase receptivity of the athlete to a biopsychosocial approach to pain management" (Hainline, et. al. 2018). In order to address these areas of pain management sport psychologists can implement techniques mentioned in Hainline, et. al (2018), "muscle relaxation and imagery, as well as indirectly by identifying and addressing an athlete's worries and concerns, any

comorbid mental health disorders and environmental factors relevant to recovery and return to play (RTP)" (Hainline, et. al., 2018). In addition to pain management strategies, Hainline, et. al. (2018), defines suggestions for sports rehabilitation.

Sports rehabilitation is supported through different psychological interventions, as mentioned in Hainline, et. al., (2018),

> "skills training in goal setting, imagery, relaxation and positive self-statements. Stress inoculation training was shown to reduce anxiety, pain and days to recovery after arthroscopic surgery for meniscus injury. Other interventions relevant to athletes include cognitive restructuring (identifying and challenging negatively biased appraisals) and developing plans for maintaining treatment gains and coping with setbacks and pain flare-ups…Psychologically informed physical therapy, which incorporates cognitive and behavioral principles and strategies (e.g., techniques to reduce fear-avoidance, use of graded activity and exposure techniques), and education about pain during physical rehabilitation, is a promising approach with some evidence supporting its use. Psychological assessment and intervention by a specialist should be normalized by the treatment and coaching team, so that it can be implemented when necessary and without stigma" (Hainline, et. al. 2018).

Hainline et. al. (2018) attempts to address many of the associated psychological challenges in pain management and injury prevention and the integral role sport psychologists can play in supporting athletes.

In addition, Hainline, et. al. (2018), discusses issues with poor treatment adherence. As mentioned in Hainline, et. al. (2018),

> "Key psychosocial factors associated with poor treatment adherence and outcomes after sport injury include mood disturbance, fear of reinjury, concern about not achieving preinjury level of proficiency and feeling disconnected from coaches and teammates. Other more general psychosocial influences include anxiety, stress, catastrophizing (excessively negative appraisals of pain and its implications), depression and maladaptive fear of pain and re-injury and consequent avoidance of activities believed to increase pain, cause physical harm or both. Finally, other mental health problems (e.g., eating or substance use disorders) can also impede recovery and require a psychologist's intervention (Hainline, et. al., 2018).

These areas of concern outline by Hainline, et. al. (2018), implicate the significance of advocating for guidelines to address these areas of pain management and injury prevention.

In addition to the identified ethical issues of nonmaleficence and beneficence briefly explored above, Hainline, et. al. (2018), highlights numerous ethical issues. As mentioned in Hainline, et. al. (2018),

> "the principle of respect for patient autonomy is codified in procedures for informed consent. These processes seek to assure the patient's comprehension and his/her voluntary decision making. It is not always clear when an athlete makes an informed choice to 'play through pain' and when he/she may be under duress from stakeholders within their sports environment. The principle of non-

> maleficence (do no harm) must guide the clinician's actions and recommendations to the patient in acute pain. In chronic pain contexts, however, there are broader opportunities for discussions with the patient, including an evaluation of short-term and long-term goals, the potential for emotional conflicts that may arise with prolonged suffering and the possibility of more pronounced external influences on ethical decision making. Therefore, an informed and well-documented discussion should occur between the clinician, the broader healthcare team and the athlete when considering approaches to the management of chronic pain" (Hainline, et. al. 2018).

The concerns of autonomy and informed consent are in question with the athletes' decision-making to play, especially when they are accompanied with potential pain or injury risk. As mentioned in Hainline, et. al. (2018), it is not always clear the judgment the athletes are exercising when they decide to play "though" different types of pain, they may be experiencing undue pressure by their stakeholders and coaches, and/or peer pressure from other athletes. The advocacy plan seeks to address these concerns. First, an ethical analysis will be conducted and the blurred lines in regard to performance enhancement, common mental disorders, and referrals in the U.K. athletic population will be explored in the following.

In the article, *Blurred lines: Performance Enhancement, Common Mental Disorders and Referral in the U.K. Athletic Population* by Roberts, et. al. (2016), the concerns of the prevalence of common mental disorders (CMD) in the athletic population and whom is qualified to work with these athletes is delved into. Some of these concerns are mentioned in Roberts, et. al. (2016) in the following:

> "Among personnel in the sporting domain, there is a perception that the sport psychologist or sport psychology consultant is best placed to assist athletes seeking assistance for CMD. However, sport psychology as a profession is split by two competing philosophical perspectives; one of which suggests that sport psychologists should work exclusively with athletes on performance enhancement, and the other views the athlete more holistically and accepts that their welfare may directly impact on their performance. To add further complication, the development of the profession of sport psychology varies widely between countries, meaning that practice in this field is not always clearly defined. This article examines case studies that illustrate the blurred lines in applied sport psychology practice, highlighting challenges with the process of referral in the U.K. athletic population" (Roberts, et. al., 2016).

Due to the supportive dynamic Sport Psychology professionals offer athletes, they are perceived as the most adept professionals to support clients with different CMD. However, the differences in approaches and the qualifications required to support different CMD, brings up the ethical questions of competence.

In addition to the preceding examples of the current challenges associated with CMD among athletes is the stigma associated with mental health issues among athletes. According to Roberts, et. al. (2016),

> "there are claims of sporting governing bodies attempting to downplay the significance of mental ill-health in the athletic population thereby raising concerns over the culture of these organizations… "suggests that the culture of sport

> dictates that “mental toughness and mental health are seen as contradictory terms in the world of elite performance…” These suggestions are reinforced by recent research commissioned by the Football World Players' Union, FIFPro, which confirmed that the reporting of mental ill-health in professional football is still considered taboo and therefore prevalence rates are likely to be vastly underestimated” (Roberts, et. al., 2016).

These issues bring in ethical questions of beneficence and nonmaleficence as they relate to the welfare of athletic participants and their mental health in sport participation. In the advocacy plan these issues will be addressed.

Common mental disorders and their prevalence in athletics is attributed to the following, as mentioned in Roberts, et. al. (2016),

> “early sport-specialization, a loss of personal autonomy and disempowerment, no opportunities to develop psychological coping skills, sport-related stress, living away from home, limited social support due to relocation, disordered eating as a result of esthetic and weight-dependent sport, and high injury risk…young elite athletes are faced with over 600 different stressors within their sport environment…leadership, personal, team, cultural, environmental, and logistical issues... Notwithstanding the socio-contextual characteristics of competitive sport that may generate these mental health challenges…the sporting environment may exacerbate pre-existing mental ill-health as the full range of psychopathology is likely to exist within the athletic population suggests that mental ill-health that

> began prior to involvement in sport may "become more evident when athletes are faced with stressors associated with elite sport." (Roberts, et. al., 2016).

The innumerable stressors in elite sports implicates the potential for such associated CMD, whether from predispositions or the compounding effects of such stressors. The guidelines laid out in the advocacy plan will seek to address these concerns.

In continuation, CMD is defined in Roberts, et. al. (2016) as "symptoms that relate to distress, anxiety, depression, suicide, eating disorders, substance abuse or dependence" (Roberts, et. al. 2016). Further, the mentioned CMD are reported in Roberts, et. al. (2016) to be most prevalent amongst the athletic population with "performance failure" and on retirement. Sport psychologists are certainly some of the most qualified, and certainly would be considered in their area of competence, when it comes to addressing the associated experiences with "performance failure" and challenges associated with sport retirement, however the more pressing concerns of suicide, eating disorders, and substance abuse may begin to place ethical concerns of competence in question.

The AASP (2020) defines competence as,

> "AASP members maintain the highest standards of competence in their work. They recognize the boundaries of their professional competencies and the limitations of their expertise. They maintain knowledge related to the services they render, and they recognize the need for ongoing education. AASP members make appropriate use of scientific, professional, technical, and administrative resources. They provide only those services and use only those techniques for which they are qualified by education, training, or experience. AASP members are cognizant of the fact that the competencies required in serving, teaching,

> and/or studying groups of people vary with the distinctive characteristics of those groups. In those areas in which recognized professional standards do not yet exist. AASP members exercise careful judgment and take appropriate precautions to protect the welfare of those with whom they work" (AASP, 2020).

Guidelines laid out in the advocacy plan will seek to address the areas of competence amongst the associated professionals working with the clients in order to best support them.

It is relevant to consider that sport psychology professionals should expand their competence to support athletes as they navigate CMD, due to the fact that some of the associated CMD effect sport performance, which is an area that sport psychology professionals are qualified to address. For example, Roberts, et. al. (2016), mentions the negative impact depression can have on the sport performance. Further, as mentioned in Roberts, et. al. (2016), "given that one in four British adults will suffer with mental ill-health during the course of their lifetime, and comparatively around 18% of the adult population in the United States of America, combined with the suggestion that athletes are as (if not more) susceptible to mental ill-health as the general population, it is highly likely that practitioners in elite sport will encounter individuals suffering from CMD at some point in their career" (Roberts, et. al., 2016). These statistics further implicate the need for sport psychology professionals to be provided the opportunity to expand their competencies to work with supporting athletes suffering from CMD.

There are discussions on what sport psychology consultants should focus on as they support athletes especially in regard to the concerns of CMD and the associated blurred lines of competent practice. Roberts, et. al., (2016) suggests, "a well-rounded sport psychology service acknowledges a breadth of approach which may or may not encompass competing priorities between an athlete's performance and their well-being… purely focusing on performance may

severely constrain the effectiveness of the sport psychologist" (Roberts, et. al., 2016). In other words, sport psychologists should be provided the competencies to expand their knowledge base to advocate for the mental health of their athletes through proper qualifications that will be laid out in the guidelines discussed in the advocacy plan.

Sport psychology consultants may be asked to wear multiple hats to best support the clients, with beneficence and nonmaleficence at the forefront. Roberts, et. al., (2016) emphasizes this consideration as he quotes the following,

> "Herzog and Hays (2012), documented the complex "balance and shift" (p. 495) of psychotherapy and mental skills training in athletic consultations and highlight that the practitioner cannot always accurately predict the course that consultations will take, and that some will often require a change in tack. This mirrors the commentary by Morton and Roberts (2013) who discussed their experiences of working in high performance sport exposing them to situations where the distinction between performance-related and mental health concerns in athletes was somewhat blurred. To add weight to this argument, a large-scale survey of sport psychology services provided to athletes at the U.S. Olympic Training Centre (USOTC) highlighted that in 85% of cases, sport psychology staff provided personal counseling to athletes" (Roberts, et. al., 2016).

The current competencies of many sport psychology professionals all over the world do not meet the competencies to fully support elite level athletes.

Currently, as mentioned in Roberts, et. al. (2016)

> "the competencies laid out in the Association of Applied Sport Psychology (AASP) certification criteria…the International Society of Sport

> Psychology (ISSP) competencies position stand…the APA Proficiency in Sport Psychology checklist…and the first study to explore the competencies of applied sport psychologists by Ward et al. (2005), conclude that the documentation available for the training and development of sport psychologists 'does not adequately prepare trainees in all the necessary competencies'… suggesting that there were six generic limitations, one of which was the lack of distinction between work focused on performance enhancement and therapeutic work with athletes…the "traditional" focus on performance enhancement and mental skills training was not adequate enough to meet the needs of the client in elite sport" (Roberts, et. al., 2016).

The various competencies that would be required for sport psychology professionals to best support their clients are addressed in the advocacy plan.

The need for sport psychology professionals to expand their competencies, is in regard to the current ethical codes that require sport psychology professionals to refer clients to clinical psychologist as soon as concerns of CMD are present. The issues with this referral process are innumerable. For one, clients who are experiencing CMD are particularly vulnerable and will likely only want to confide with a professional who they trust, such as their sport psychologist, which brings into question the ACA (2014) ethical consideration of *fidelity*, "or honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in professional relationships" (ACA, 2014, p. 4). Further, order to best support the client, a referral may be the last thing a professional would want to do. For instance, the referral process can seem

impersonal, can make the client feel rejected by the sport psychologist, especially when they are feeling particularly vulnerable, and once the client has been referred to a clinical psychologist, there are chances that the clinical psychologist has little to no athletic experience, making it more difficult to appropriately support the client, and the process can be extensive.

As mentioned in Roberts, et. al, (2016),

> "There are no guarantees that the clinical psychologist will have experience in working with the athletic population. Anecdotally, being referred to specialists with no knowledge of the sporting environment can lead to athletes being somewhat resistant to seeking such support for fear of not being understood. Additionally, the initial appointment with the clinical psychologist can take some time to occur, due to the length of waiting lists in the NHS. In some cases, this can take up to 12 weeks" (Roberts, et. al., 2016).

While there are certainly appropriate times to refer clients, the considerations mentioned in the preceding further emphasizes the point that value in expanding the competencies for sport psychologists. Further, if the competencies of the sport psychologist are expanded it will minimize the issues of the blurred lines, minimize ethical questions of violations of the bounds of competence, and decrease the needs for referrals, ultimately permitting the sport psychologist to more effectively support the clients and act in congruence with beneficence.

Some of the issues regarding competence in sport psychology are in reference to the different educational systems and philosophical differences among countries, highlighted in Roberts, et. al. (2016). As mentioned, in Roberts, et. al. (2016), the philosophical differences and educational systems among different countries "has led to great variation in the developmental

patterns, certification, registration, licensure, accreditation, and process for the delivery of sport psychology services internationally…the failure to address the requirement for a consistent set of competencies within the profession leads to "diverse methods of service delivery and training which may result in the blurring of the boundaries regarding what practice in the field is…" (Roberts, et. al 2016). The issues with the differences among the various countries and their requirements for sport psychologists will be addressed in the advocacy plan in order to best support the clients.

Ethical Case Analysis:

While exploring the articles regarding pain management and injury prevention and the challenges of addressing blurred lines in performance enhancement, common mental disorders, and referrals in the UK athletic population, there are several ethical questions that arise. The ethical questions in pain management and injury prevention are associated with AASP ethic codes and ACA codes, beneficence, nonmaleficence, autonomy and informed consent. The ethical questions present in *Blurred lines: performance enhancement, common mental disorders and referrals in the UK athletic population,* primarily have to do with AASP and ACA ethic codes in regard to competence, referrals, nonmaleficence and beneficence. These ethics codes and their references, as they relate to the advocacy topics will be explored in the following.

To begin, Autonomy, as it relates to pain management and injury prevention is in question when Hainline, et. al., 2018, mentions athletes may have their autonomy in question when they "choose" whether or not to play through pain, due to the pressures from stakeholders. According to the ACA (2014), Autonomy is defined as, *"*fostering the right to control the direction of one's life" (ACA, 2014, p. 3). Hailine, et. al. (2018), illustrates that athletes often do

not feel this sense of autonomy, indicating that this is an ethical area that is in need of advocacy. Sport psychologists are in a position to advocate for this autonomy. The same autonomy is associated with informed consent.

Informed consent is in question in Hainline, et. al., (2018) when discussing whether the athletes are in a position to make informed consent to get back in a game after experiencing pain or an injury. There is question due to the pressure stakeholders may hold over athletes to play and perform per their agreement. As mentioned in ACA (2014), A.2.d. Inability to Give Consent: "When counseling minors, incapacitated adults, or other persons unable to give voluntary consent, counselors seek the assent of clients to services and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf" (ACA, 2014, p. 4). The athletes could be considered "persons unable to give voluntary consent" due to undue pressure from stakeholders.

In continuation, according to AASP (2020) ethical code 17: Informed consent to practice states "has freely and without undue influence expressed consent" (AASP, 2020). As mentioned in Hainline, et. al., (2018), athletes often experience this undue influence from stakeholders and team owners to play, even with pain and injuries present. Hainline, et. al. (2018) adds that athletes may even deny their experience of pain in order to play. This highlights another area a sport psychologist can advocate for in the beneficence of the client. In addition to the ethical issues present with concerns of pain management and injury prevention, there are relevant ethical

issues in reference to the ACA and AASP ethics codes, such as competence, referrals, nonmaleficence and beneficence.

The ethical concerns of competence are present in *blurred lines: performance enhancement, common mental disorders (CMD), and referrals in the UK athletic population* in regard to how to best support elite athletes who experience common mental disorders. Sport psychologists support athletes in primarily two ways, performance enhancement as well as addressing them holistically as a person. The boundaries of competence and the professional lines sport psychologists walk with clients become blurred when CMD disorders start to arise in athletes. Roberts, et. al., (2016), expresses the challenges sport psychologists are confronted with when the lines get blurred, such as to how far a sport psychologist can "competently" delve into supporting elite level athletes with common mental disorders. The AASP (2020), ethics code 2. Boundaries of Competence, states

> "(a) AASP members represent diverse academic and professional backgrounds. These different training histories provide different competencies. Those trained in clinical and counseling psychology must be aware of potential limitations in their sport science competencies. AASP members trained in the sport sciences must be aware of their limitations in clinical and counseling psychology. Individuals from different training backgrounds must deliver services, teach, and conduct research only within the boundaries of their competence" (AASP, 2020).

Athletes may be confronted with CMD and may confide in their sport psychologists, which potentially puts the sport psychologists beyond their boundaries of competence.

In continuation, sport psychologists are recommended to refer clients as soon as they have an indication that their clients may be taking their work beyond their boundaries of competence, such as with any CMD, which presents the concerns of ACA (2014) nonmaleficence, do no harm, in two instances. Firstly, if there is question that a client may need support beyond what a sport psychologist is capable of supporting them in regard to AASP, ethical code 2: Boundaries of Competence, they could potentially cause undue harm to the client if they failed to refer them to someone appropriately competent. On the other hand, if a sport psychologist is likely able to support a client with a CMD and do no harm, they could still be acting out of the boundaries of competence and whether or not the referral is necessary, comes into question. Further, the concerns arise that the referral may cause more harm than good, considering that the referral process can be disruptive to the client, take up to 12 weeks, and clients can be matched with unsuitable counselors.

The AASP (2020) ethic code 11. Consultations and Referrals attempts to provide means to address these ethical concerns as it states "(a) AASP members arrange for appropriate consultations and referrals based principally on the best interests of their patients or clients, with appropriate consent and subject to other relevant considerations, including applicable law and contractual obligations." (AASP, 2020). The ACA (2014) adds to the AASP ethic code in its ethical code, A.11.a. Competence Within Termination and Referral "If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship" (ACA, 2014, p. 6). Sport Psychologists are

encouraged to refer clients to clinic psychologists as soon as they experience signs of CMD from the client, which can cause potentially more harm than good. As mentioned in Roberts, et. al., (2016), many of the clinical psychologist referrals can take up to 12 weeks and many clinical psychologists do not have experience with athletes. This ethical question presents another area for sport psychologists to advocate in the welfare of the clients.

Advocacy Plan

According to the National Biotechnology Center Information (NBCI) and the World Health Organization (WHO) (2008), "An advocacy plan should factor in goals and objectives, target groups and the specific activities to be undertaken, as well as set out stakeholder roles and responsibilities, time frames, expected short-term and long-term outcomes, and available and needed resources." (WHO, 2008). The advocacy plan, regarding *pain management and injury prevention in elite athletes* and *blurred lines: performance enhancement, common mental disorders, and referrals in the UK athletic populations,* will address the ethical issues regarding autonomy, informed consent, beneficence, nonmaleficence, referrals, and competence, by providing guidelines for sport psychology professionals to address the issues discussed and advocate in the best interest of the clients.

To address pain management and injury prevention in elite level athletes this advocacy plan will seek to address informed consent, autonomy, beneficence and nonmaleficence with a set of guidelines to support the welfare of the clients. The guidelines will be integrated as ethical athletic protocol for pain management and injury prevention, for all athletics, leagues, associations, and Olympic committees to abide by, within the next five years. The guidelines will address the role sport psychologists currently play with the athletes, such as supporting athletes

in their athletic performance, often receiving confidential information and potentially more honest experiences from the athletes and their current athletic performance. The preceding puts sport psychologists in a suitable position to advocate for elite athletes in numerous ways, especially in regard to pain management and injury prevention.

Further, the guidelines will seek to address that when there are questions of autonomy and informed consent violations, especially in regard to the undue pressures of stakeholders on athletes, Sport psychologists can hold the position to advocate for the athlete and stand in to decide whether or not an athlete is suitable to play. More specifically, in regard to honoring the ethical concerns of informed consent and autonomy, sport psychologists will provide the athlete the option for the sport psychologist to advocate on their behalf or assist them in developing their own "advocacy plan" to determine whether or not they can play and when they can play, in order to guide them in advocating for their own best interest and honor their autonomy and informed consent.

Additionally, the guidelines will clarify, while missing a few games may be costly to the sports team, owners and stakeholders, an athlete experiencing significant pain or sustaining a serious injury will end up being more costly. An athlete experiencing significant pain or sustaining a serious injury can be more costly, due to more time lost from not being able to perform, as well as the costs of associative treatment to remedy the distress. The guidelines will provide a measurable, pros versus cons list for owners, stakeholders and coaches to reference, when the sport psychologist determines an athlete is unsuitable to play; this will aim to minimize any criticisms or negative experiences for the athlete, due to any perceived loss the team may incur due to the missing teammate.

The pros and cons list will consist of relatable cons (e.g. financial and league costs) of the player missing the game and the pros of the player missing the game (e.g. preventing consecutive missed games due to serious injury from not "recovering" to avoid injury), as well as the costs of the player staying in the game (e.g. sustaining a serious injury that takes them out for the season, leading to more detrimental costs, such as psychological distress and associated psychological costs playing through the pain or injury). The list will be visible, with respect to athlete confidentiality. The AASP (2020) ethic codes 18-Maintaining confidentiality, states "(c) AASP members do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their patients, individual or organizational clients, students, research participants, or other recipients of their services that they obtained during the course of their work, unless the person or organization has consented in writing or unless there is other ethical or legal authorization for doing so" (AASP, 2020). Athletes will be involved in the process of the pros and cons list and can decide what information is relevant, which will also honor the ethical concern of autonomy and informed consent. The pros and cons list will be objective and only include quantitative data collected from physical therapists, sports medicine staff and data charts reflecting elevations in emotional distress when pain is experienced (e.g. heart rate elevations, increased respiration), that will be referenced to weekly updated baseline data of each athlete, minimizing misinterpretation and subjective inquiry.

In addition, the guidelines will provide the opportunity for coaches and trainers to work with sport psychologists to develop "back-up plans" and strategies for coping with missing team members, due to any pain management and injury prevention. The strategies will include concentration techniques, progressive relaxation techniques, breathing exercises, and others suitable strategies, as mentioned in Williams & Kane (2015), for the athletic sport in question, to

best support the team while other members are out of the game. The collaboration of sport psychologists and coaches, supports team cohesiveness and minimizes the distress experienced from the perceived loss of the game due to critical players being out of the game, as a means of pain management or injury prevention. This guideline is congruent with ACA (2014) D.1.b. Forming Relationships and D.1.c. Interdisciplinary Teamwork, which are defined in the following.

Further, the advocacy plan guidelines will be congruent with the ACA (2014) ethics codes: "D.1.b. Forming Relationships- Counselors work to develop and strengthen relationships with colleagues from other disciplines to best serve clients…D.1.c. Interdisciplinary Teamwork- Counselors who are members of interdisciplinary teams delivering multifaceted services to clients remain focused on how to best serve clients. They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines" (ACA, 2014, p. 10). The guidelines will indicate that in addition to the coaches and trainers mentioned in the preceding paragraph, sport psychology professionals will work alongside physical therapy and other sports medicine professionals to come to a supportive consensus in the best interest of the athletes in regard to pain management and injury prevention, such as with appropriate data charts relevant to the status of athletes and their athletic condition.

Additionally, the guidelines will provide distinctions for the different types of pains and injuries athletes can experience and sustain, as well as the ways of measuring such distinctions. These distinctions will be made in collaboration with the expertise of the physical therapists and sports medicine staff. These pain and injury distinctions will be followed up with appropriate protocol for sport psychologists to best support the athletes, with methods defined in Williams &

Kane (2015), including but not limited to, using appropriate imagery and visualization techniques, changing thought patterns (negative to positive), adjusting pain appraisals, muscle relaxation and progressive relaxation techniques, as well as acknowledging and providing supportive methods to address any concerns, anxiety, and/or worries, such as with different confidence and concentration techniques. This protocol will provide team owners, stakeholders, and coaches assurance that athletes pain management and injury prevention are taken seriously and adequately handled in order to minimize loss in play time as well as ensure athletes are ethically taken care of.

Further, the guidelines will ask that the numerous sport associations, organizations, leagues, as well as the United States Olympic Committee, and other relevant members, meet yearly, or bi-yearly initially, to discuss and address these guidelines, including evaluations of the success of these guidelines with provided opportunities to amend any challenge areas in the best interest of the athletes. Sport psychologists and the associated sport psychology governing bodies should hold regulatory positions, especially in regard to any amendments to any challenge areas, since they play such an integral role with the athletes, with respect and knowledge of ethical codes and standards. Additionally, athletes will be regularly involved in the implementation of the guidelines and their input will be dutifully considered, especially in regard to any challenge areas, in order to honor the autonomy and informed consent of the athletes.

In conclusion, the advocacy plan and the laid-out guidelines seek to advocate in the best interest of elite level athletes, especially in regard to pain management and injury prevention. Sport psychologists hold an integral role with athletes and therefore they are in an advantageous position to advocate in the best interest of the athletes. The defined guidelines will take pain management and injury prevention in the right direction by addressing the ethical issues of

autonomy, informed consent, beneficence and nonmaleficence. The advocacy plan in regard to the ethical issues identified in *blurred lines: performance enhancement, common mental disorders and referrals in the UK athletic population,* will be addressed and laid out in the following paragraphs.

The ethical concerns of the boundaries of competence are of the utmost importance as it relates to blurred lines and referrals in the UK athletic population. When competence is in question, there are associated issues of beneficence and nonmaleficence, such that professionals are to do good and do no harm to the clients. As mentioned in the advocacy topics and ethical analysis, Roberts, et. al., (2016) discussed the concerns that sport psychologists competence are put into question, when the role they play in supporting the client becomes blurred, such that they start to cross over from supporting athletes with performance enhancement and holistic approaches, and begin to delve into addressing common mental disorders that can prevalent amongst athletes.

In continuation, as soon as common mental disorders arise in clients it is suggested that they be referred to clinical psychologists. However, sport psychologists are often confronted with the question of whether or not this is in the best interest of the client, and ultimately may not refer the clients, due to some of the following reasons mentioned previously: clinical psychologists do not necessarily have athletic experience and may be unsuitable to holistically support the athletes and the referral process can take up to 12 weeks and during this time athletes can suffer and not receive the care and support they need. In this advocacy plan the issue of competence will be further addressed, the associated accreditations to remedy this competence will be discussed, and the process to move through these considerations will be defined.

The advocacy plan addresses the concerns of competence first and foremost with the beneficence of clients in mind. Roberts, et. al., (2016), acknowledges that part of the concerns of competence is attributed to the variations in certifications, registration, licensures, accreditations and process for the delivery of sport psychology services across different countries, regions, and states.

> "For instance, in the UK the regulation of the psychology profession is governed by law in the UK. Practitioner psychologists are licensed and regulated through the Health and Care Professions Council (HCPC), a quasi-autonomous non-governmental organization (Quango). Training routes for sport psychologists typically involve a 3 year undergraduate degree accredited by the British Psychological Society (BPS), a BPS accredited master's degree in sport and exercise psychology, or the BPS qualification in sport and exercise psychology (QSEP) stage 1 and a further period of around 3 years of supervised practice through the QSEP stage 2 (British Psychological Society, 2014). This differs from clinical and counseling psychologists who typically undertake a 3 year professional doctorate at the end of their studies (e.g., McEwan and Tod, 2015). In the U.K. there is an alternative training route for those who do not wish to become practitioner psychologists. The British Association of Sport and Exercise Sciences (BASES) offers individuals accreditation as a sport and exercise scientist if they have completed a BASES endorsed undergraduate degree and a relevant MSc in a sport and exercise science-related discipline (e.g., sport and exercise psychology) and a further post-

> master's period of between 2 and 6 years of supervised experience. Through the BASES route, accredited sport and exercise scientists may work as mental skills coaches/trainers, sport performance consultants and sport psychology consultants. For further information on routes to practicing as a sport and exercise psychologist in the U.K" (Roberts, et. al., 2016).

In order to address the preceding, the advocacy plan asks that in a span of five years, by coming together virtually and personally to the integral aspects of the field of sport psychology and associated competencies, certifications, etc., the various countries, regions and states develop accreditations, licensures, and certifications that are in compliance with one another for professionals in the field of sport psychology to practice under the same boundaries of competence with multicultural competence in mind.

Multicultural competence refers to the competence to work with diverse populations. Welfel (2015) acknowledges two important references in the ACA codes to multicultural competence:

> "The first is in the section explaining the boundaries of one's competence, and it states, "Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse population" (ACA Code, Section C.2.a). The second reference extends that responsibility to continuing-education experiences and advises counselors to continue to update their knowledge of work with diverse groups (ACA Code, Section C.2.f)." (Welfel, 2015, p. 65).

In addition to addressing multicultural competence, the professional body's currently supporting sport psychology professionals will be asked to develop compatible protocol, to best assist sport psychology professionals as they support athletes, within the next five years, which will allow ample time to come to a consensus of ideals for the field. For instance, as mentioned in Roberts, et. al., (2016),

> "the primary professional body supporting applied sport psychologists is the Association of Applied Sport Psychology (AASP). AASP runs an online support system for continuous educational development including webinars and a platform for sharing resources… AASP resources include an annual conference, an established certified consultant's program and opportunities for student and professional development. AASP is the only professional body to detail what is considered to be *outside of the scope* of the service provided by a certified consultant (sport psychology practitioner). This is communicated clearly in their Internship and Practicum Experience Database Manual (IPED; AASP, 2013), which states that the following activities are exempt: 'diagnosis or treatment of psychopathology, treatment of substance abuse disorders (including alcoholism and other types of chemical dependencies), eating disorders, obesity, and any marital and family therapy…' useful guidance for practitioners in delineating their role by stating that if an appropriate referral is not made when consulting with a client with such issues, the practitioner's behavior may be deemed to be unethical" (Roberts, et. al., 2016).

By providing congruent protocol across supportive professional body's, sport psychologists will be better suited to advocate and operate in the best interest of the clients.

Currently different countries have various positions on addressing the issues of competence in the field of sport psychology, for instance, as mentioned in Roberts, et. al., (2016),

> "The European Federation of Sport Psychology (FEPSAC) has issued a position statement on ethics and an accompanying ethical checklist, the detail of which puts the onus on the practitioner to judge whether they are practicing within their qualifications, expertise and experience. If they conclude that they are unable to assist their client with a specific problem, a referral is recommended… the Australian Institute of Sport (AIS) raises the question of whether it is appropriate for a sport psychologist to help an athlete with a mental health problem. Wensley (2013) states that in Australia, sport psychologists are trained to work with people with the most common mental health problems, including depression, and anxiety. However, she suggests that they may choose to refer the athlete if the conclusion was that they would be better served by a mental health specialist. Regardless of this slight difference of approach, no guidelines for referral practices were evident" (Roberts, et. al., (2016).

In continuation, when the different countries, regions and states convene to address accreditations, licensures, and certifications, as mentioned earlier in this advocacy plan, they will also address the areas of competence, as well as the proper referral process, followed by a formal consensus on the best protocol.

Currently the referral process is not followed effectively. In order to address the referral-process the advocacy plan incorporates Tod & Andersen's (2015) guiding questions and principles:

> "How long has the issue existed? What is the severity of the issue? What role does the issue play in the person's life? Are there displays of unusual emotions or behaviors around the issue? How well are the athlete's existing coping strategies developed? Does the practitioner have the competencies, knowledge, skills, and experience to address the issue? Issues that are recent, not severe in their emotional implications, and do not have substantial overlap with other aspects of a person's life are less likely to require referral. Unusual emotional reactions that are out of character, or out of place, may also warrant consideration for referral. For example, an athlete who is facing a tough competition and who experiences mild to moderate anxiety and negative self-talk is not likely to require referral. A person for whom each athletic competition is an all-or-nothing battle for self-identity, whose emotional state is dependent on performance outcomes, and where strong anxiety, depressive states, or substance abuse may also be involved, is more likely to need a referral. In such cases, however, performance or sport psychology practitioners can still address performance-related issues" (Tod & Andersen's, 2015).

Further, the advocacy plan emphasizes Roberts, et. al., (2016) point, in the instances where a referral is necessary, "sport psychologists should seek counsel from mentors, supervisors, or colleagues for constructive direction." (Roberts, et. al., 2016). Referrals can be challenging and seeking guidance can ease the transition for both the client and the professional.

The advocacy plan also addresses the stigma associated with gaining support for psychological issues. The advocacy plan shares examples of successful, elite athletes who embrace their CMD challenges, such as Michael Phelps, 28-time Olympic medal winner, to decrease some of the associated stigma. As quoted from Michael Phelps' Twitter account: "I struggled with anxiety and depression and questioned whether or not I wanted to be alive anymore. It was when I hit this low that I decided to reach out and ask for the help of a licensed therapist. This decision ultimately helped save my life" (Michael Phelps, 2019). In the instances that athletes may need referrals, minimizing this stigma will help athletes to get support where they need it. However, this also supports the need for expansion of competence in sport psychology professionals. The expansion of competence would decrease the instances where referrals may be needed, which would help athletes who are only comfortable with confiding with sport psychologists and deter them from avoiding the help that they may need to best support them. As mentioned in Roberts, et. al., (2016),

> "It may have been a huge step for athletes to share sensitive material with sport psychology practitioners, who may be among the few trusted people they feel able to confide in. When faced with referrals that do not appear to be working well, sport psychologists can still keep in contact with athletes. Avoiding the perception that the sport psychology practitioner's continued help is conditional on the athlete meeting with the external helper will help maintain a close relationship. It is inadvisable and impractical to force athletes to meet with other professionals, except in situations where there is a threat of harm to self or others (where there are

> then ethical and legal obligations to uphold). Sport psychologists can continue to provide performance enhancement assistance and can initiate the referral process in the future if athletes change their minds" (Roberts, et. al., 2016).

While Roberts, et. al., (2016) attempts to remedy these ethical areas, the advocacy plan seeks to provide opportunities for sport psychologists to more readily support and advocate for their clients with expansion of certain competencies.

Through the expansion of certain competencies, with appropriate education, accreditations, certifications, and licensures, sport psychology professionals will be better suited to assist athletes in both performance enhancement and the prevalent CMD encountered amongst elite level athletes. As mentioned in Roberts, et. al., (2016), "one in four British athletes have a CMD and 18% of the United States athletic population has CMD, and these are less than the actual statistic." (Roberts, et. al., 2016). Due to the numerous elite level athletes that can experience CMD, and the likelihood that sport psychology professionals will encounter athletes with CMD, the expansion of the boundaries of competence for sport psychologist would best support the athletes. The advocacy plan seeks to incorporate this idea, following some of the guidelines mentioned in Roberts, et. al., (2016),

> "Given the evidence presented in the current manuscript, it is realistic that practitioners will come across athletes displaying the signs and symptoms of the CMDs that the general population also experience. Regarding the education of current and future trainees, professional bodies, such as the British Psychological Society and education providers could help students prepare for their careers and provide clients with high quality services by ensuring that information about

> CMDs and the skills needed to provide a minimum level of help in such cases are included in educational pathways…The definition of the phrase above "provide a minimum level of help" will vary. All practicing sport psychologists and sport psychology consultants might be expected to be able to (a) identify the signs and symptoms of CMDs, (b) talk to clients about their observations, and (c) help athletes obtain the assistance they need to cope with or resolve their issues. Some practicing sport psychologists may have the training and experience needed to assist directly, whereas others may need to implement referral procedures. Given the difficulties and relationship strains that can arise during referral, sport psychology practitioners who have the skills to assist clients with CMDs, may be better placed to provide that support" (Roberts, et. al., 2016).

Due to the nature that sport psychologists encounter innumerable clients with CMD, it is in the clients' best interest that sport psychology professionals advocate for the expansion of the boundaries of competence in order to best support the athletes.

The expansion of the boundaries of competence would include the requirements and associated education to allow sport psychologists to effectively support clients with CMD. These adjustments are to be made within the next five years. In order to assist in the expansion of the boundaries of competence, the advocacy plan incorporates the ideas mentioned in Roberts, et. al., (2016),

> "Consultants develop the necessary skills and knowledge to be able to help athletes with CMD in some way…through research, theory, diagnostic and treatment manuals, and biographical accounts of people living with issues such as depression, eating disorders, and anxiety, along with others associated with sport

> and exercise contexts. The American Psychiatric Association's (2013) Diagnostic and Statistical Manual-5 (DSM-V) is useful for gaining an overview of diagnosable mental health disorders…Such reading should be supplemented with supervision and training in current research, theory, and practice on helping people (see below). Practitioners will also benefit from realizing that clients who are not displaying signs and symptoms sufficient to warrant a formal diagnosis may have sub-clinical levels of disorders for which they need help. In addition, athletes may have mental health or emotional concerns that fall outside of diagnosable problems. Examples include identity issues, sexual orientation and abusive environments, sexual health issues, alcohol, drug and substance use, anger and aggression control, romantic and family involvement, and abuse of power in the sporting context…To supplement empirical and theoretical literature, biographical accounts and case studies of individuals experiencing mental ill-health may help practitioners appreciate what life is like for these individuals and the social contexts they may live within. Practitioners might also consider recommending these often fascinating and moving accounts to their clients if they believe the individuals will benefit. Example benefits might include finding comfort in learning how other people have coped, that they are not unique, and that there can be reasons for hope. Also, clients might gain practical ideas and strategies for coping and resolving issues" (Roberts, et. al., 2016).

In addition to the ideas mentioned above, the licensing and certifications will require that sport psychology professionals meet appropriate criteria prior to practicing, through proper

accreditations and certifications, much like that of the clinical psychologists who are within the boundaries of competence to support individuals with CMD.

The advocacy plan addresses the concerns of competence in *Blurred lines: performance enhancement, common mental disorders, and referrals in the UK athletic populations*, by: acknowledging the need for all sport psychology professionals in the various countries, regions and states be certified, accredited and licensed under the same qualifications and prerequisites to ethically practice in the field of sport psychology with respect for multicultural competencies; defining and acknowledging a more effective referral process when referrals are deemed necessary; addressing the stigma associated with CMD by sharing stories about successful athletes who sought appropriate help when they needed it, such as Michael Phelps, and by expressing the importance and significance of the value of expansion of the boundaries of competence within the next five years for sport psychology professionals to best support the athletes. The advocacy plan provides a clear protocol to appropriately navigate advocacy in the best interest of athletes confronted with CMD. By following the advocacy plan the potential for ethical violations in regard to ineffective referrals and the boundaries of competence will be minimized and the athletes will be supported most effectively.

Summary

Advocacy, defined by Alliance for Justice (2016), “any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others.” As mentioned, sport psychologists are in a unique position to advocate for the welfare of their athletes on different occasions. The two advocacy topics highlighted in this advocacy plan are two of these potential instances. The advocacy topics, *pain management and injury prevention in*

elite level athletes and *Blurred lines: performance enhancement and common mental disorders and referrals in the UK athletic populations,* were introduced to provide a baseline of the ethical concerns and areas that the advocacy plan aspired to address to best support the athletes.

Further, the advocacy topics were thoroughly explored in order for a proper ethical analysis to be conducted to develop the most effective advocacy plan. The advocacy plan provided guidelines and protocol for the areas needing advocacy, with the best interest of the athletes in mind. The detail and thoroughness laid out in both advocacy plans provided a clear direction to advocate effectively for elite level athletes and their pain management and injury prevention, as well as how to navigate in the best interest of athletes when there are potentially blurred lines with athletes faced with CMD. This advocacy plan paper was a great introduction into the value of advocacy as well as the proper application of the advocacy process. This advocacy plan provided the opportunity to approach advocacy in the future with more experience and knowledge to best assist others in need of advocacy.

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Advocacy Plan Grading Rubric

Criterion	Excellent	Proficient	Developing	Below Expectations	Not Present
Structure, Grammar, and APA Style **(10 points-due to proper APA formatting,**	Thoroughly follows the required outlined structure as well as the APA formatting	Adequately follows most of the required outlined structure as well as the APA	Minimally follows the required outlined structure. The writing needs revision to	Inadequately follows the required outlined structure and requires substantial	Does not follow the required outlined structure. There are more than 8 errors in spelling, grammar and/or

following the required structure, and the paper shows a coherent flow of thoughts with precise, concise and descriptive writing, with no errors in spelling or grammar).	guidelines. The structure of the paper shows a coherent flow of thoughts with precise, concise, and descriptive writing. There are no errors in spelling or grammar. *(10 points)*	formatting guidelines. There are 2-3 errors in spelling, grammar, and/or APA formatting. *(9 points)*	improve the flow of thoughts. There are 4-6 errors in spelling, grammar and/or APA formatting. *(8 points)*	revision to improve the flow of thoughts. There are more than 7 errors in spelling, grammar and/or APA formatting; writing is difficult to follow. *(7 points)*	APA formatting or there is no assignment submission. *(0 points)*
Introduction **(10 points-due to addressing all of the 3 following components).**	The introductory paragraph thoroughly addresses all 3 of the following components: introduces the subject matter, describes the importance of the subject matter, and provides an overview of what is to come in the paper. *(10 points)*	The introductory paragraph adequately addresses and includes 2 of the 3 required components. *(9 points)*	The introductory paragraph minimally addresses and includes 1 of the 3 required components. *(8 points)*	The introductory paragraph is inadequately developed and provides minimal introduction to the paper. *(7 points)*	Paper is missing an introductory paragraph or is significantly lacking in content. *(0 points)*
Advocacy Topics **(15 Points-due to thoroughly describes each topic and thoughtfully explains why advocacy is needed. Explains related ethic, rule, statue, or law in question).**	Thoroughly describes each topic (one from each topic and thoughtfully explains why advocacy is needed for the topic. Explains related ethic, rule, statute, or law in question if applicable. *(15 points)*	Adequately describes each topic (one from each topic) and states why advocacy is needed for the topic. Outlines related ethic, rule, statute, or law in question if applicable. *(13 points)*	Minimally describes each topic (one from each topic) with 1-2 errors and superficially mentions why advocacy is needed for the topic. Applicable ethic, rule, statute, or law is listed. *(12 points)*	Incompletely addresses the prompt by inaccurately describing the topic, missing a topic from one of the categories, missing the explanation for the need for advocacy, or not referencing applicable ethic, rule, statute or law. *(10 points)*	Paper is missing the Advocacy Topics section or is underdeveloped to the point of missing several key components aiding in clarity and understanding. *(0 points)*

Ethical Analysis **(15 points- due to thoroughly analyzes how potential conflicts of interest might occur as a result of advocacy which ethical codes encourage these behaviors).**	Thoroughly analyzes how potential conflicts of interest might occur as a result of advocacy and which ethical code(s) encourage these advocacy behaviors. *(15 points)*	Adequately analyzes how potential conflicts of interest might occur as a result of advocacy and describes which ethical code(s) encourage these advocacy behaviors. *(13 points)*	Minimally analyzes how potential conflicts of interest might occur as a result of advocacy and identifies which ethical code(s) encourage these advocacy behaviors. *(12 points)*	Incompletely analyzes both components in the prompt. Analysis is undeveloped. *(10 points)*	Paper is missing the Ethical Analysis section or is significantly lacking in content. *(0 points)*
Advocacy Plan **(15 Points-due to describes a detailed advocacy plan that covers all 6 required components, who the student will work with, how much time will be devoted, what time of work will be done, how advocacy will be recorded, how the student will reflect on and apply what is learned).**	Thoroughly creates and describes a detailed advocacy plan that covers all 6 required components including: information on who the student will work with; how much time will be devoted; what type of work will be done; how advocacy work will be recorded; how student will reflect on and apply what is learned. *(15 points)*	Adequately relates and describes an advocacy plan that includes 5 of the 6 required components. *(13 points)*	Minimally relates and describes an advocacy plan that includes 4 of the 6 required components. *(12 points)*	Incompletely creates and describes an advocacy plan that includes 3 of the 6 required components. *(10 points)*	Paper is missing the Advocacy Plan section or describes a plan with 2 or fewer of the required components. *(0 points)*
Summary **(10 points- Thoroughly summarizes key sections and describes overall learning of the assignment. Includes a**	Thoroughly summarizes key sections and describes overall learning of the assignment. Includes a thoughtful summary statement about	Adequately summarizes key sections and mentions overall learning of the assignment and importance of the topic	Minimally summarizes key sections of the paper but is missing either a description of student learning or the	Incompletely summarizes key sections and paragraph simply restates the main points of the paper without describing overall student	Paper is missing a summary or is significantly lacking in content. *(0 points)*

thoughtful summary statement about the importance of the topics).	the importance of the topics *(10 points)*	*(9 points)*	importance of the topic *(8 points)*	learning or the importance of the topic. *(7 points)*	
Total 75 points	75 points				