



Why Peer Support and Outsourced Telehealth Work for Cash-Strapped Athletic Departments

The strongest research-backed version of this thesis is not simply that “outside care is always better.” It is that student-athletes engage more when care feels **independent, confidential, easy to access, and culturally credible**. In sport settings, the biggest barriers to help-seeking are low overall formal help-seeking, team culture, fear of deselection, stigma, and concerns about confidentiality. That makes an external, neutral option especially attractive because it reduces the sense that care is tied to roster status, coach perceptions, or athletic-department visibility. What buyers often call “app fatigue” is real in the data: digital mental health tools routinely struggle with long-term retention, and engagement improves when there is human contact, not just software. A stepped model that starts with lower-intensity human support and escalates to therapy, psychiatry, and crisis care is therefore both clinically sensible and economically rational. [1]

For athletic departments under budget pressure, that matters because the alternative is usually either under-serving athletes or trying to solve the problem by hiring one more clinician into an already strained system. Publicly available wage data and compensation data from U.S. Bureau of Labor Statistics[2] show that specialist clinicians cost far more than support-tier behavioral health roles, while NCAA[3] guidance explicitly permits schools to use providers who sit outside athletics, off campus, or via telehealth. In other words, the policy environment and the labor economics both point in the same direction: outsourced, human-integrated telehealth can give departments broader coverage at a lower fixed cost than building the whole stack in-house. [4]

Why independence and confidentiality increase participation

Athletes do not avoid care because distress is rare. They avoid care because the sport environment changes the **social cost** of being seen getting help. A 2024 systematic review and meta-analysis found that athletes’ formal mental health help-seeking rate was only 22.4%, and that sport-specific barriers included team culture, fear of deselection, and concerns about confidentiality in sport settings. The same review found

that athlete role models and normalization from within sport can improve help-seeking. That is exactly why a neutral delivery model matters: the more an athlete fears that care is entangled with selection, playing time, or stigma, the more valuable independent access becomes. [5]

Older but still directly relevant collegiate research points in the same direction. A national study of Division I student-athletes found that major barriers included lack of time, fear of stigma, fear that teammates would find out, and fear of being considered weak. The same paper warned that if counseling is delivered inside the athletic department, privacy and confidentiality have to be deliberately protected because information about athletes is often expected to flow among staff and coaches. The authors also noted that simply being seen entering counseling can create perceived risk around privacy, performance, and coach confidence. That does not prove every athlete prefers off-campus care, but it does show why **neutrality and privacy are not extras; they are participation drivers**. [6]

Current NCAA policy reinforces that interpretation. NCAA health-care guidance centers independent medical authority, and its updated mental health best practices state that licensed mental health care may be delivered by providers in athletics, by units outside athletics such as counseling or student health, or by local off-campus and telehealth providers. The same document emphasizes student-athlete trust, privacy, provider accessibility, and choice, and recommends that schools audit wait times and improve timely access to care. That is important for Onrise's story: outsourced telehealth is not outside the NCAA model. It fits squarely within it. [7]

There is also evidence that student-athletes will use care that sits outside athletic departments when it is accessible and credible. A 2022 analysis from the Center for Collegiate Mental Health found that at Division I schools, student-athletes used university counseling centers at rates very similar to nonathlete students, and athletes who entered care showed strong outcomes, with greater symptom reduction than matched nonathletes in depression, generalized anxiety, social anxiety, and academic distress. That is not a direct test of outsourced telehealth, but it is a strong signal that when care is **outside the daily athletic chain of command**, athletes will still use it and can do very well. [8]

Why app-only tools underperform human-integrated support

The engagement problem in digital mental health is no longer speculative. In a real-world analysis of 93 popular mental health apps, median 15-day retention was 3.9% and median 30-day retention was 3.3%. Median daily open rate across apps was just 4.0%. The notable exception was not a cleverer self-help interface, but more relational models: peer-support apps showed higher open rates and better 30-day retention than several other app types. That is a practical definition of "app fatigue": download is not the same thing as sustained use. [9]

A newer meta-analysis in *JAMA Psychiatry* reached a similar conclusion from trials rather than app-store behavior. Across 79 randomized trials of depression and anxiety apps, uptake was high but adherence was only 61.8%, while posttest attrition averaged

18.6% and follow-up attrition 28.4%. The most important design finding for buyers was simple: attrition was lower in trials that included reminders, human contact, and no gamification features. In other words, software alone does not fix engagement; human connection helps. [10]

That pattern generalizes beyond apps to digital mental health more broadly. A 2023 meta-review of 31 meta-analyses found that 48% of reported effect sizes favored human-supported digital mental health interventions over unsupported versions, while only 9% favored unsupported versions. The authors stopped short of saying human support is always better in every context, but they concluded that human support has meaningful potential, especially among people with elevated symptom severity. A 2026 mixed-methods study of a large youth platform sharpened the mechanism: sustained engagement was associated with feeling understood, validated, normalized, and connected to community, while cognitive overload and low motivation contributed to disengagement. For athletic departments, that is the key strategic point. Technology works best as **connective infrastructure** that gets athletes to people faster, not as “one more app” asking for daily homework from an already overloaded population. [11]

Why peer support belongs in the model

Peer support is not a substitute for therapy or psychiatry. Its value is that it expands the **front door** to care, lowers the social threshold for first contact, and can absorb lower-acuity needs that would otherwise consume scarce clinical capacity. That is especially relevant in sport, where role modeling and shared identity matter. The 2024 athlete help-seeking review identified athlete role models as a facilitator because they normalize care in ways that generic wellness campaigns often do not. [5]

Athletics-specific peer-support evidence is still emerging, but it moves in the same direction. A 2025 pilot study of college student-athletes’ peer-support training found significantly higher post-training well-being scores and qualitative evidence of greater connection among participants. Earlier NCAA-backed work on Athletes Connected reported significant improvements in knowledge and attitudes toward mental health and help-seeking. These are not definitive cost-effectiveness trials, but they do support the strategic idea that peer support can reduce stigma, strengthen connection, and improve the probability that athletes step into care earlier. [12]

Outside sport, the economic case is already more direct. A 2025 matched-cohort analysis of digital peer support found that participants required an average of 2.07 fewer therapy sessions in a five-session EAP model. That study was not conducted in college athletics, so it should not be overstated. But it is highly relevant to the workforce problem: if lower-intensity human support can safely reduce specialist utilization upstream, then peer support is not just a clinical “nice to have.” It is a capacity-management tool. [13]

Why stepped care and outsourced telehealth are financially rational

Stepped care works because it matches the **least intensive effective intervention** to the athlete's level of need, then escalates when clinically indicated. A 2024 umbrella review of stepped-care meta-analyses found improved depression response and remission rates, and positive effects for anxiety as well. A separate review of economic evaluations found empirical studies in which collaborative stepped care was more effective and less costly than usual care, with savings driven by lower downstream service use and broader productivity gains. The evidence base is not athletics-specific, but the model logic transfers cleanly: start with the right level of care, add intensity only when needed, and preserve specialist time for specialist work. [14]

That logic lines up with NCAA best practices, which call on schools to build mental health systems that cover the full spectrum: identification, referral, ongoing treatment, follow-up, reentry, and emergency mental health action plans. NCAA guidance also makes clear that qualified care may be delivered by providers in athletics, outside athletics, off campus, or through telehealth. The implication is that athletic administrators are not being asked to choose between best practice and outsourcing. Properly built outsourced telehealth can be one way of meeting best practice. [15]

The labor-cost piece is equally important. BLS does not publish a standalone national wage for "peer support specialist," so the cleanest public comparison uses support-tier behavioral-health roles as proxies. In May 2024, median annual pay was \$41,590 for psychiatric aides and \$42,590 for psychiatric technicians, compared with \$94,310 for psychologists and at least \$239,200 for psychiatrists. BLS also reported that wages and salaries represented 70.1% of private-industry compensation, with benefits making up the remaining 29.9%. Using that compensation mix, a psychologist's fully loaded employer cost is roughly \$135,000, a support-tier mental health role is roughly \$59,000 to \$61,000, and a psychiatrist is well above \$340,000 before recruiting, coverage, supervision, and turnover costs. That spread is the economic rationale for peer-support-first triage plus clinical escalation. [16]

The budget pressure is not theoretical. In a 2022 content analysis of Division I athletic departments, 70.8% of FBS departments reported some mental performance and/or mental health services, versus only 29.2% of FCS departments; the authors explicitly linked the gap to lower revenue and fewer resources. Cash-strapped departments are the ones least able to hire multiple full-time specialists, yet they still need broad access, after-hours response, and crisis coverage. That is precisely where outsourced telehealth has leverage. [17]

What the public record supports about Onrise

Publicly accessible Onrise materials describe a model built around same-day setup, peer support from retired athletes, licensed clinicians, 24/7 crisis care, unlimited confidential sessions, and family coverage. The company's public positioning is also explicit that the offering is not a "light-touch wellness app," but clinically governed infrastructure for stabilization, early intervention, and prevention. That architecture maps

closely to what the external literature suggests departments actually need: a fast front door, human support, escalation capacity, and continuous access without forcing athletes into app-centric engagement loops. [18]

The public outcome story is promising, though not all of it is equally verifiable from open sources. Onrise's public website states that athletes report feeling "very much improved" after engaging in care, that athletes consistently rate their improvement as "much improved," and that among athletes with moderate-to-severe symptoms, sessions reduced peak distress by an average of 6 points on a validated 12-point scale. Public marketing materials also claim a lower cost than one in-house FTE and, in one public LinkedIn post, cite 66.7% "much improved" outcomes while arguing that the service costs less than half an internal hire. Those are directionally consistent with the research case for a stepped, human-integrated model. [19]

The one claim I would treat more carefully in an external-facing report is the exact statement that "in 2025, Onrise saw 80% of athletes report 'Much Improved' or 'Very Much Improved' with peer support." I found public Onrise materials supporting strong improvement claims, but I did **not** find a publicly accessible source that independently documents that exact 80% figure, the denominator, the measurement window, or whether it refers to all users, peer-support users only, or a subset. If Onrise uses that number in a board deck, investor memo, or sales collateral, it should be labeled as **company-reported 2025 outcomes** and ideally footnoted to an internal methods memo. [20]

What athletic directors should take from this

For an athletic director, the practical takeaway is that the best buy is usually **not** a standalone self-help app and not necessarily one more in-house clinician. It is a system that gives athletes a confidential, low-friction first touch; uses peer support and fast triage to absorb lower-acuity demand; escalates to therapy, psychiatry, and crisis response when needed; and does all of this without making the department carry full fixed staffing cost across every level of acuity. The literature supports each piece of that logic even if no single study tests the entire package in one athletic-department RCT. [21]

That framing also makes the Onrise value proposition sharper. The company does not need to win the argument by claiming that every athlete distrusts internal providers or that apps never work. The more defensible argument is stronger anyway: athletes seek help more when care is private, independent, culturally credible, and available fast; digital mental health works better when humans are integrated into it; peer support can widen access and conserve clinician time; and a stepped outsourced system can cover more of the care continuum at a lower fixed cost than trying to build the same infrastructure with new full-time hires. [22]

Thank you!

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