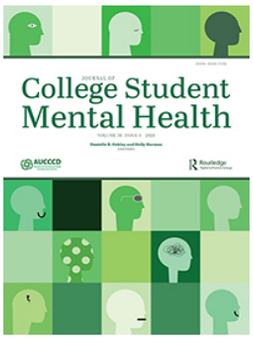

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Navigating a Path Forward for Mental Health Services in Higher Education

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ABSTRACT

This position paper reviews four intersecting trends impacting the burnout and turnover of clinical staff in counseling centers in the 2020s: ever expanding service demand, mismatched clinical models, the emergence of third party vendors, and uncompetitive salaries. The authors provide a framework and make recommendations for institutions to take deliberate steps to align the mental health needs of a campus, the resources offered, and the services provided.

KEYWORDS

Counseling centers; higher education; mental health services

How to respond to increased utilization and students with a higher level of mental health needs has become the conversation about university mental health since the COVID-19 pandemic, even though this conversation started over a decade earlier. Counseling centers have played a significant role in student well-being since their inception in the 1930s (LaFollete, 2009), but only recently have their contributions come into sharper focus. Starting in the late 2000s and early 2010s, clinicians working in higher education began to notice and respond to greater demand and increased acuity of student mental health concerns. By 2019, 80% of university presidents stated mental health had become a greater priority than even three years before, with significant amounts of staff and faculty time devoted to addressing student concerns (Chessman & Taylor, 2019). The pandemic has magnified these concerns.

There is a growing awareness in higher education that how institutions respond to the increased importance of wellbeing and mental health concerns within the context of other factors including demographic shifts, expectations for the college experience, questions about value and affordability, and enrollment challenges, will shape their success over the next decade. Divisions of Student Affairs in particular are feeling the pressure of increased demands to address well-being and mental health in their students while managing the impact of record levels of burnout and turnover in staff (National Association of Student Affairs Professionals [NASPA], 2022). The impact of these factors

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on the systems and people that deliver mental health services is especially profound. The business interests of institutions, our responsibilities to our students and employees, and the continued growth and development of the field demand change. Higher education is renowned for taking a reactive stance in response to issues (e.g., Silbaugh, 2015) predicated on the needs of the moment and what peer institutions are doing. The authors of this report are encouraging a proactive approach to addressing these issues because a campus-wide problem requires a campus-wide approach. This report focuses on how institutions can develop such an approach.

BACKGROUND

In higher education, overall employee dissatisfaction has led to staff leaving (or considering leaving) at higher rates than ever before; employees cite lack of fair pay, lack of opportunities for advancement and dissatisfaction with the work environment as primary drivers for leaving the job (Bichsel et al., 2022). Nearly a third of higher education professionals surveyed in 2022 indicated they might leave the field within five years (NASPA, 2022). Employees in higher education also state their roles are changing and becoming more demanding (e.g., non-traditional hours, after hours calls, never ending e-mails) and it seems reasonable to connect dissatisfaction with workload and work environment to these evolving duties. An especially relevant shift within this workforce is responding to mental health needs: 70% of those higher education professionals surveyed in 2022 stated they anticipate "crisis management for students" will become an increasing part of their roles over the next five years (NASPA, 2022).

These changing roles have impacted mental health providers in higher education especially hard. In 2018, for example, Holly (2018) indicated 70% of mental health staff in higher education reported high or very high levels of stress with 25% of those sampled indicated experiencing burnout often or very often. The pandemic did not cause cracks in work satisfaction, but it certainly revealed and amplified them. While counseling center staff were responding to dramatic increases in demand for mental health services, the pandemic brought isolation, loss (e.g., family/friends, financial losses, and shared rituals/events), and financial challenges to an environment already rife with racial trauma and oppression and a polarizing politics. Counselors had to navigate these challenges for themselves while also responding to students impacted by these traumas. Recent surveys of counseling center staff suggest over 90% are experiencing burnout that is negatively impacting their satisfaction and, alarmingly, the quality of the care and risk management they provide to students at their institutions (Walden et al., 2021, 2022).

Higher education has always enjoyed remarkable consistency in employees, with attrition often in the single digits (Dolezal, 2022). However, the sheer

number of mental health providers leaving higher education now is a stark contrast to that history and is representative of the impact of the "Great Resignation" during the COVID-19 pandemic (Parker & Horowitz, 2022). In 2017–2018, nearly half of the counseling centers (51.8%) experienced turnover (LeViness et al., 2019). In 2020–2021, this increased to 61.3% (Gorman et al., 2022). Researchers report staff are perceived to be leaving primarily because of low salaries and work conditions (Gorman et al., 2022; Parker & Horowitz, 2022). Additionally, the total *number* of positions turning over is increasing as well. In 2017–2018, only 10% of centers had three or more positions turnover in a year. By 2020–2021, that number had increased to 17%. More troubling, of those 61.3% of centers who had turnover in one or more positions, nearly 70% reported trouble filling the opening or failing the search. Finding qualified applicants and completing search processes is becoming increasingly difficult.

It is a deep irony that mental health in higher education has arguably never had a higher profile but employment positions within institutions of higher education have never been less competitive in the job market. It is very easy for a college mental health professional to transition into private practice where they can control the flow of clients simply by not accepting additional clients and/or into other organizations that offer much higher compensation. For these clinicians, finding other jobs or clients for a private practice has been increasingly easy. If our systems do not change, replacing those staff will become increasingly more difficult.

We have highlighted the current conversation about burnout and turnover, as that is where much of the current conversation has shifted. We understand that burnout and turnover are one of the consequences of the shifts that have been occurring in counseling centers over the past two decades. In this paper, we outline these shifts in service demand, service delivery models, use of third-party vendors, and staff compensation and offer proactive considerations to address them.

FOUR INTERSECTING FACTORS WITHIN COLLEGIATE MENTAL HEALTH IN THE 2020S

Service Demand

Utilization of counseling center services has risen over the last decade as institutions pushed for higher enrollment and developed intentional efforts to decrease stigma and increase awareness of mental health. The Center for Collegiate Mental Health ([CCMH] (2016) reported for every 1% increase in student enrollment at an institution, a counseling center could expect to see a 5% increase in utilization. In 2011, the average utilization rate (percent of a study body utilizing on-campus services) of a college counseling center was

about 10%; by 2020, the average rate had increased to 13%. More significantly, the *upper range* of those rates increased from 18% in 2010 to 39% in 2021 (Barr et al., 2010; Gorman et al., 2021). These rates indicate many institutions have been responding to dramatic shifts in demand. While this represents an astounding success representing decades of efforts to lower stigma and increase help seeking among students, counseling centers have struggled to keep up.

This increase in utilization occurred alongside higher reported rates of serious mental illness for 18–25 year-olds (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020) and increases in distress and threat-to-self risks (Twenge et al., 2019), especially among students seeking services from counseling centers (CCMH, 2016; 2019). The percentage of students who had seriously considered suicide over their lifetime, for example, increased from 23.8% in 2011 to 36.9% in 2019 (CCMH, 2020). In short, more students with significant mental health needs and with less barriers to seeking help have been entering college systems over the past decade.

These increases were not met with a parallel increase in the number of full time staff working in counseling centers. In 2014, counseling centers in the United States employed an average of 7.97 full time equivalent (FTE) staff and served, on average, 10% of enrolled students (Reetz et al., 2014). By 2020, prior to the pandemic, the average size of staff had not changed (7.96 FTE) even though utilization was much higher at 13% (Gorman et al., 2021). The impact of these realities has been felt by almost every employee on individual campuses (e.g., Egan, 2019; McKoy, 2021; Sontag-Padilla et al., 2018).

Given this interplay of demand and distress, it is no surprise that institutions have had difficulty in charting a sustainable path with respect to providing mental health services. These converging trends resulted in a dilemma for staff in counseling centers who felt internal and/or external pressures to "make it all work." In many cases, this meant staff shifting their work to see more students overall, managing more clients with significant symptoms and risk, and/or seeing students for fewer sessions (Gorman et al., 2021). Many of these changes were reactionary to demand, often resulting in centers moving further away from traditional treatment and to shorter term models of care (see next section for more information on these models). Such changes can result in students, campus partners, and upper administration being less satisfied with campus mental health services while also maintaining contradictory and unrealistic desires for what a center can do with existing resources.

Adding to these dynamics, the term "mental health" is being used more ubiquitously by students to communicate distress at any level (CCMH, 2021). While this may indicate a comfort in talking about mental health, the paradox is that as it is used so broadly, faculty and staff have become more heightened and reactive when students mention their mental health and immediately refer or escort the student to counseling services. These referrals, oftentimes

considered emergent, have impacted increased utilization at centers and added to the expectation that students should be seen immediately as well as inadvertently reinforcing students' conceptualization of the severity of their concerns. Where the term "mental health" is being used more broadly, we have not similarly broadened the understanding that many resources can be utilized to address mental health concerns in addition to the clinical services from a counseling center.

Developing a Strategic Focus

A reflexive stance that institutions often take in response to these factors is a question about how to meet clinical demand. In some cases, as an institution has decided that there is no way to meet demand, they declare that they simply cannot hire their way out of the situation. This response often limits the ability to see possible avenues forward, and contributes to a feeling of hopelessness that exacerbates the challenges with managing demand and supporting staff effectively. There is a value in the question about meeting demand and a grain of truth in the statement about staffing needs, but both are outdated and misleading. We are proposing institutions ask different questions. The questions must be *what demand are we going to meet?* and *what resources do we need to do that?* This implies intentionality and nuance. This requires decisions on the part of administrative teams about the focus of that institution's approach to and resourcing for mental health care. Related, it is not the case that institutions cannot "hire their way out of this;" rather, it is incumbent upon institutions to resource appropriately around deliberate decisions regarding what demand is going to be met and to make intentional and strategic decisions that establish a sustainable and meaningful workplace that mitigates burnout and turnover.

Identifying the specific demand that will be met is a hard choice. We are advocating institutions ask key questions, such as: *what population(s) are we trying to serve?* and *what key indicators or concerns are the most important to address?* A natural and common response of "all of them" is not realistic without appropriate resourcing to meet that demand. Developing realistic goals is critical to being able to focus the efforts. We are advocating institutional administrative teams, in consultation with the counseling center director, make clear decisions about priorities. This seems relatively straightforward but requires institutions to acknowledge they cannot be everything to everyone and attempting to do so only reinforces for campus constituents the erroneous belief that meeting all needs is possible.

Reconsidering Resource Allocation

Institutions must also change the way they think about resourcing counseling centers. To date, institutions have assessed a counseling center's resources by considering the full-time equivalent (FTE) of clinical providers. FTE totals are

often used to determine how well resourced a center is and FTE comparisons are often used to benchmark with peers. However, an institution with 13,000 students, 10 staff members, and an 8% utilization rate serves the same number of students as a 3,000 student institution with 2 staff members and a 35% utilization rate. Both counseling centers are serving about 1050 students each year, but these institutions are not bringing an equivalent level of resources to their students. At the first institution, one staff member would have a caseload of 105 students; at the second, one staff member would have a caseload of 525. The key is to measure clinical resources *relative to utilization rates* or to *a targeted goal* (e.g., reducing symptoms of depression or serving a specific student population). Thinking in this way allows institutions to accurately assess what can actually be provided to a campus population.

The CCMH Clinical Load Index (CLI) (Center for Collegiate Mental Health, 2020) is an example of measuring resources relative to the number of students served at an institution. The CLI should *not* guide an institution's decision making around what demand is to be met in what ways but is a valuable assessment tool to determine if those decisions can be supported given existing resources and levels of utilization. Again, it is critical that institutions decide what they are going to provide a student body and then turn to tools that can appropriately assess what is needed to fulfill those goals. Approaching demand and distress in that way is much more likely to result in success (and less stress on staff members, students, and other community members) than using metrics that have less of a direct bearing on actual clinical capacity.

Collaboration Across Campus

Determining overall campus mental health goals and making hard decisions requires input and buy-in from multiple constituencies. We are advocating that institutions include key players in the development, implementation and management of a comprehensive, campus-wide strategic approach to mental health. This plan should include specific goals, identified objectives, necessary resources, and how "success" will be assessed. This alignment of strategic goals and resources then allows a counseling center to identify a model of operation that is intentional, realistic, and achievable. This, in turn, reduces burnout and overextension of staff, reducing turnover and improving job satisfaction. Coordination of these efforts requires individuals who know the most about the concerns, tensions, and history of mental health on that campus and have a background in collegiate mental health. It also requires someone to lead institutional efforts specifically focused on mental health, which is distinct and different from the somewhat larger portfolios of associate vice president/chancellor positions focused on overall health and wellness. Institutions should identify an individual for this leadership role and ensure that these job

responsibilities are reflected in their job description so that it can help inform other duties and compensation. These individuals are often given the title "Chief Mental Health Officer," and in nearly every instance the most knowledgeable and appropriate person for this role is the Director of the Counseling Center.

Counseling Center Clinical Services

Counseling centers provide multiple services to campus communities. Outreach and consultation, along with key partnerships related to accommodations, medical leave processes, risk assessment, education, and training are all part of the contribution centers make to an institution. Nested within those resources is an articulated or unarticulated model that guides the *clinical* or *treatment* focused services a center provides; in other words, a model that dictates what an institution does with its most financially intensive resource: direct service time of clinicians. Given the consistent rise in utilization rates and increased acuity of mental health concerns emerging on college campuses over the past decade (Demers & Lipson, 2022), counseling centers have been exploring a variety of treatment options and alternatives (highlighted below) to address demand since the early 2010s. These approaches have produced limited success. As Abrams (2022) noted, prior to the pandemic the surge in demand for care was far outpacing capacity and this only highlighted the traditional clinical service model in counseling centers was ill-equipped to address the increased utilization.

To address ever increasing demand, and to reduce the risk of potential undesirable consequences and the liability of waiting lists, counseling centers started to implement a variety of strategies. For example, counseling centers started to dedicate more time and resources to models that emphasized same day access and assessment. In this "triage" model, students receive consultation and are then either offered treatment through the counseling center, placed in a therapy group, referred to a provider in the community, or offered other campus resources. In a "stepped-care" approach, resources would be allocated dependent on perceived level of need: more intensive resources (i.e., individual care) offered to those with the greatest acuity and less intensive resources (i.e., self-guided psychoeducation) offered to others (Cornish et al., 2017). Another option that counseling centers have explored is the single session/solution focused model, where a student is guided to address a singular issue and is not given a follow-up session but is free to return at a later date for another appointment (Hymmen et al., 2013). In many cases, the impact of these shifts in models have been to allocate more clinician time to infrequent, singular contacts with more students rather than to more frequent, ongoing contacts with fewer students. A parallel impact has been that

counseling centers have had to provide more crisis management services with less time for preventative efforts.

These shifts have impacted burnout and turnover among center staff. Workload is a significant factor cited by higher education professionals in general (NASPA, 2022) and counseling center staff specifically (Walden et al., 2022) that drives burnout. It is no surprise that the adaptations made by counseling centers to attempt to meet demand led to increased workloads and decreased work satisfaction. A complicated and complex piece of this puzzle is that the shorter-term, symptom-focused models adopted by many counseling centers in an attempt to "meet demand" are incongruent with the training of clinicians and with the type of services those counselors know will be beneficial to treat the concerns for that student. Providing case management and responding to continuous crises can bring a specific kind of satisfaction, but regular contact with students that engages the skills and abilities of clinical staff that leads to observable and lasting improvement is often a more effective recipe for satisfaction and remedy for burnout.

Treatment Outcomes

It is an unfortunate reality that many of the decisions made about counseling centers' clinical service models have been driven by a desire to respond to the volume of demand rather than to known factors from decades upon decades of research about outcomes in therapy. This would be similar to a cancer treatment center, for example, predicating their medication protocols and treatment on the number of people seeking services rather than what research literature and practical experience has found to be effective for actually treating cancer.

Researchers have consistently found positive changes in psychotherapy are largely driven by the relationship and connection with the therapist (Hubble et al., 1999; Lambert, 1992; Wampold, 2001). Relationships thrive under consistency rather than discontinuity; any barrier to an investment of time in those relationships will negatively impact outcomes. Similarly, dose-response effect literature points to the impact the number of sessions provided has on outcome. For example, Hansen et al. (2002) reviewed randomized clinical trials over two decades and found only 20% of people who received around five sessions experienced improvement or recovery. Coincidentally, in 2021, counseling centers averaged six sessions per student (Gorman et al., 2022). Research suggests between 13–18 sessions are required for the majority (50–60% of clients) to improve (Hansen et al., 2002) which is within the range of weeks allocated to a regular academic semester at most institutions. More sessions are also needed for clients with higher levels of acuity (Nordmo et al., 2021). More sessions that occur weekly result in faster trajectories of change and a greater likelihood of recovery, with these clients achieving recovery sooner (Erekson et al., 2022).

Institutional practices have driven a spectrum of models that frame the kinds of clinical services an institution provides. In many instances, this has been done without consideration of the impact of decisions on treatment outcomes. The research cited above is not meant to guide an institution toward a particular model or to suggest that one is better than another. However, the outcomes cited do illustrate the importance of using existing research to guide decision making, as different models have different outcomes. It is important to note that for some institutions, the counseling center's clinical service model is nested within a number of other services (e.g., outreach, consultation, wellness services, and training) that also benefit a campus. Thus, institutions must consider how the treatment model fits into this larger understanding of the mission of the counseling center.

Strategic Plan for Determining a Clinical Services Model

The dialogue about models has centered on a spectrum: on one end are "access/absorption" models, and on the other end are "treatment" models. Both models provide for the immediate availability of crisis management or risk assessment, but differ on the provision of ongoing services. Access models tend to provide briefer contact or therapy visits spaced out over periods of weeks; common approaches here are the utilization of single-session therapy, 30-min sessions, or approaches that otherwise limit the provision of regular 50-min therapy sessions (CCMH, 2016). In doing so, providers have contact with more students, the duration and frequency of contact is just less. Treatment models tend to provide access to all students through triage processes or other initial contact mechanisms and only offer regular 50-minute therapy sessions to a limited or defined portion of the student population. CCMH (2019) data suggests the latter more effectively reduces clinical symptoms in students who seek and/or are referred to counseling center services.

Intentional decisions must be made about the mix of treatment services an institution wants to provide along with other clinical services such as triage, crisis services, or consultation services. Driving these choices are the two sometimes contradictory responsibilities of a counseling center: (1) the obligation to provide meaningful and effective services to students who seek services (i.e., to practice in ways consistent with training, ethics codes, and knowledge of what works), and (2) the responsibility to the institution to provide ongoing access to students. It is important to acknowledge that unlike private practice clinicians, counseling center providers are not able to refuse to see a client even when caseloads are full.

We are advocating institutions intentionally and deliberately choose a clinical services model tailored to institutional goals rather than to the desire of "meeting demand." We are also recommending that institutions ground these decisions in known facts about mental health services outcomes. Furthermore, institutions must consider local (e.g., on-campus) data

and expertise about what concerns are reasonable to address, what populations are in need, and what is possible given existing staffing levels and skills.

Again, it is important to remember a counseling center's clinical services exist within the larger value that a center brings to its campus. On-campus providers bring local knowledge and expertise, along with established collaborative relationships to the campus community, that outside providers cannot. These connections are invaluable for tailoring clinical services to a population as well as managing higher risk situations and providing critical support to different campus constituencies; by itself, support provided to campus partners when managing higher risk situations validates the need for on campus mental health resources. Counseling centers also provide valuable outreach to the campus community along with consultative resources for staff, faculty, and parents. Finally, counseling center staff provide critical training to campus staff and faculty on identifying and responding to students in distress.

Third-Party Vendors for Mental Health Services

Beginning in the late 2000s and early 2010s, counseling centers began to utilize third-party platforms as an adjunctive service, often as a way to space out sessions for counseling center staff. The COVID-19 pandemic played a significant role in expanding this space and changing how counseling centers operate and provide care to their students. The necessity to continue operations made virtual clinical services instantly appealing by making therapy possible across geographic or pandemic enforced discontinuities. From March 2020 through June 2021 academic year, most counseling centers were offering only virtual care (Gorman et al., 2021). During this time, third-party services flourished and significant investments in this sector increased across the board (Bellows, 2022).

While most institutions returned to offering a majority of their services in-person by the start of or during the 2021–2022 academic year, the impact of the shift to virtual care continued to shape mental health services. Many therapists left college counseling centers to work in a private practice, now made easier by technology, or to work for a telehealth company (Hochman, 2021). An explosion of investment in and increased normalization of virtual healthcare seems to be changing how institutions attempt to meet the needs of their students. Institutions that had not considered third party providers before are now strongly considering them to support the work of their counseling centers (Bellows, 2022). Institutions considering if and how to implement these services must clarify what these providers can deliver and evaluate how those services can be best utilized within the aforementioned strategic plan for mental health.

Types of Vendor Services

All third-party vendors are not the same, as they represent different types of services offered for students. Understanding these differences in the types of vendors is important. In general, third-party services tend to fall into the following categories:

- **Preventative**: Provide training for the campus to assist before problems occur (e.g., gatekeeper trainings, mental health first aid)
- **Well-Being**: Focus on overall wellness and health promotion (e.g., health-focused apps)
- **Intervention**: Provide direct clinical service as a supplement to counseling center resources (e.g., companies providing additional licensed clinicians)
- **Wrap around care**: Provide case management or referral avenues (e.g., providing access to clinicians through the students' insurance or fee for service)
- **Education**: Provide education on various mental health or wellness-related topics (e.g., virtual psychoeducation)
- **Peer Support**: Connecting to peers for support, often monitored for potential risk (e.g., providing peer-to-peer connection points)

Strategic Plan for Determining a Third-Party Vendor

Institutions need to make informed decisions about contracting with a third-party vendor and can do so by reflecting on the following questions:

(1) What category of resource is being considered?
(2) What needs are being targeted?
(3) Will this specific resource actually meet the desired need?
(4) How will you determine if your goals for contracting the service are met?

The first question identifies a key weakness for institutions when considering resources. The categories listed above are often confusing or not clear to decision makers. The frustration that results when students are not satisfied and administrators are left perplexed after selecting and paying for a new resource only feeds the narrative that "we can't hire our way out of this" and results in being overwhelmed by the seeming scope of the problem. Those familiar with mental health and well-being, including the counseling center director, are in the best position to be able to differentiate between these resources and to determine how they fit into existing on-campus resources and institutional goals.

The second question requires institutions to articulate why they are choosing a particular resource. It asks for clarity in making sure that the

selected resources are appropriate for identified needs. For example, if an institution is attempting to increase the number of available hours of therapy, any resource category other than intervention would not be useful. This is important because a decision-maker might read the advertising material for a wrap-around care referral service and mistake that for increasing actual therapy hours; that service will likely increase the pathways students could engage with a private practice clinician, but would not automatically add clinical hours to an institution's suite of services. Similarly, if the goal of an institution is to increase the overall wellness of their population, targeted clinical resources may help but will not be most aligned with that goal. Resources that focus on health promotion on a larger scale would be more appropriate. Additionally, institutions need to consider if the identified need might be better addressed by existing on-campus resources.

The third question is perhaps the most nuanced but the most critical. It is important to be honest about what specific services can realistically provide. That can be hard to evaluate, especially when a decision-maker is not a clinician or familiar with the field. For example, many treatment oriented services will promise to provide a certain number of individual sessions to all students each year. While this can seem like an incredible resource, the service may exclude seeing students who are deemed "at-risk," or "individual sessions" may not mean hour-long therapy or even a frequency of contact consistent with what we know to be effective about therapy. Similarly, the business model of the service may be obviously predicated on not fulfilling its promises. While attractive, it is not financially realistic for a third-party provider to promise a certain number of sessions for "all students" and then fulfill that promise. It is human nature to want to procure services that would seem to solve the complex problems that we face, but honest reflection on the realities of our challenges leads to understanding that complex problems realistically require nuanced and complex solutions.

Finally, institutions should create an assessment plan to determine service outcomes. This assessment plan should be tied to the needs identified in step two above. The plan should identify what goals will be targeted, what data is needed, who is responsible for providing the data and how often it will be monitored. An important element of this plan is to identify the expected outcome(s) to determine "success". For instance, if a third-party vendor is being used to provide services to students living in other states or territories, the assessment would indicate: (1) the goal (e.g., 60% of students using the service will be those living out-of-state); (2) the data (e.g., the location of the student at the time of the service); (3) responsible parties (e.g., the service will provide the data on a quarterly basis; and (4) the review plan (the Clinical Director will review this data on a quarterly basis). Creating this plan is important for two reasons: constructing the contract with the vendor so that

it stipulates what data will be shared and naming that outcomes will be reviewed prior to extending the contract with the vendor.

Additionally, it is important to be honest about what these vendors can give a campus *community*. Third-party vendors are, by definition, focused on models that are not grounded in the specific culture of individual institutions. They are structured to meet the needs of many institutions with vastly different individual needs and goals. These are supplemental resources and cannot be a substitute for on-campus providers who have local knowledge and working relationships with other units on campus. The range of services provided by a campus-based counseling center cannot be replicated by a third-party company. This is especially important as concerns related to risk, accommodations processes, medical leave processes, and overall campus health become more and more important to multiple stakeholders; mental health providers who are employees of the institution are critical to establishing and maintaining services that make sense for a particular institution.

Salaries

As job-related stress in counseling centers has increased, an additional pressure contributing to burnout and turnover is the fact that salaries of counseling center staff have remained below salaries of those working in other settings. Every point of comparison illustrates the disparity. In 2015, the American Psychological Association (APA), for example, listed the median annual salary for psychologists as $85,000 (Winerman, 2017). The U.S. Bureau of Labor Statistics (n.d.) lists the 2021 median salary for a psychologist at $81,040. In contrast, the average salary for psychologists in counseling centers was reported by the Association of University and College Counseling Centers Directors (AUCCCD) in 2021 as $72,400 (Gorman & Koenig, 2022).

The data that institutions often rely on for salary comparisons and decisions, from the College and University Professional Association (CUPA), is even more troubling. The listing for "student counseling psychologist" is $67,200. CUPA (n.d.) listings for "Counselor" are also lower than AUCCCD data, but there are no representative databases for master's level clinicians working outside a university and thus no basis for direct comparison. An internet recruitment company lists the national average salary for a social worker in private practice as $83,000 (Zip Recruiter, n.d.-a.) and the average for a licensed mental health counselor in private practice as $108,000 (Zip Recruiter, n.d.-b.). Whatever the comparison, salaries for mental health providers in higher education are often not commensurate with other options. This is risky; unlike many other departments on campus, counseling centers are competing with other higher paying markets such as private practices, Veteran Affairs, and hospitals to recruit and hire mental health staff. Furthermore, the increased use of teletherapy has created opportunities for

counseling center staff to build or expand an existing private practice, thereby affording them a much higher income and more flexibility in their work.

An additional concern about staff turnover is losing talented and dedicated staff needed to supervise and train the next generation of mental health clinicians. Counseling centers provide excellent training for masters and doctoral level students and training programs are mutually beneficial for the institution and the trainees. A teaching center provides a culture of growth and learning for all working there, connects current clinicians to trends in the field, is cost-effective, and is frequently a pathway for hiring more diverse staff of clinicians to meet the needs of the student body. Training programs necessitate having licensed staff to provide supervision for trainees. In many states/jurisdictions, licensure laws require a certain number of years of post-graduate experience. Thus, staff turnover may restrict the number of available supervisors at a center, leading to a decision to either add additional supervision tasks to those who can supervise or to a decision to eliminate the training program. Both choices have consequences. We suggest that institutions address the turnover by addressing the salary problem in counseling centers.

Strategic Plan for Determining Salaries

We suggest institutions reconsider the databases that are used to set salaries for mental health providers. Since CUPA aggregates salaries from other universities for similar position descriptions, this unfortunately means that institutions are comparing their low salaries to one another rather than to the salary that is being earned by those employed in similar positions *outside* of higher education. For counseling centers to attract and retain the talented staff needed to address the mental health needs of today's students, we must have competitive salaries. We suggest institutions reconsider the methods they use when establishing salaries for clinicians, including using other databases to set salaries; to keep doing otherwise risks continuing to lose employees to other sectors.

SYSTEM ALIGNMENT

Whatever choices an institution makes in addressing the needs of its student population, we recommend that an alignment of messaging, expectations, and resources should be an overarching goal. Mismatched expectations are the source of a great deal of current distress around mental health in higher education, from student and staff stress to burnout and turnover experienced by mental health providers. For example, if prospective students and family members on a campus tour are told a counseling center is regularly available, that expectation will come to frame how they perceive what the institution's counseling center can actually provide. A mismatch here manufactures additional stress for the student, their parents, and the clinician who attempts to

meet their needs. The usual round of phone calls between students, parents, providers, and administration can be significantly mitigated by establishing expectations from the start. Counseling center models could be explained to parents and students during tours and orientation processes, and centers could advertise and search for clinicians who are attracted to that particular mode of practice.

Alignment is critical to the success of an institution's overall approach to mental health, and requires definitions of institutional identity. This approach is flexible, as one school might decide that it is important to provide access to all students through brief consultations and risk assessments while another institution might decide to focus the bulk of resources on providing regular treatment to a certain segment of the population. Whatever the case, that model should be clearly messaged to all constituencies and resources should be aligned with that messaging. That model should also not be reflexively based in an attempt to serve "all students." Not only would students and clinicians alike be drawn to the systems with healthy boundaries that meet their needs or conform to their training, we would likely see healthier student populations and less burnout and turnover in the field. Above all, we would succeed in redefining how higher education approaches the "mental health crisis," marshaling the talent and resources of institutions to shape the narrative rather than being shaped by it.

RECOMMENDATIONS

This paper has addressed a confluence of trends around mental health and counseling center utilization, the need for clear decisions and coordination of decision making, the use of third party vendors, salaries of mental health staff, and the need to align systems. We have highlighted how intentional choices may lead to positive outcomes, including mitigating mental health staff burnout and turnover. We believe this critical juncture necessitates a strategic approach to supporting the mental health needs of campus communities and supporting clinical staff who are tasked with managing those needs. In terms of specific recommendations, we are advocating that institutions:

(1) Identify key stakeholders who should be involved in developing a campus-wide plan, **coordinated and led** by an individual who has the most familiarity with the resources, needs, and realities of mental health concerns at that institution
(2) Define **institutional identity** around mental health, including developing a campus-wide strategic plan that defines the institution's approach and how that approach will be resourced

(3) Clarify **what demand** they want to meet and **what resources** are needed to meet that demand
(4) Measure **resources relative to utilization**, and to specific goals relevant to the institution
(5) Identify or develop a clinical services model for their counseling center that **does not attempt to meet every demand** but rather **chooses the demand to be met**
(6) Assess what third party services would be **consistent with institutional goals**, **be realistic** about what those services can provide, and **assess efficacy** on an ongoing basis
(7) Align messaging and resourcing **consistent with a defined approach to mental health**, and **communicate that to all campus constituents**-especially students and parents
(8) Utilize **additional salary databases** when determining counseling center staff compensation, such that the institution is competitive with all options available to providers
(9) Evaluate **workplace culture** and identify options for **flexibility and autonomy** for staff clinicians to increase retention and decrease burnout

CONCLUSION

This is truly a new era for mental health services on college campuses. Remaining a vital and sustainable space for students and staff alike should be a priority for institutions, and getting there will require good questions, intentional choices and dedicated leadership. Changing our approach is not just a matter of staying competitive with the world outside of higher education, it is a matter of articulating ourselves more clearly and moving forward with more agency into a future we define for our students, our staff, and all of the members of the communities we serve. As we noted at the beginning of this paper, how institutions respond to increased utilization and students with a higher level of mental health needs has become "the" conversation about university mental health. We are proposing that institutions not just "respond" but *evolve the conversation* about collegiate mental health. We hope that the framework provided here will help transform that conversation into action.

DISCLOSURE STATEMENT

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