

**Counselor Educators' Engagement in Mental Health Services in Higher Education  
Institutions**

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Doctor of Philosophy  
Degree  
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## DEDICATION

*To my partner and my Samwise, **Jon**,*

*Thank you for carrying me when the weight became too much. I love you- you know. We can now go back to our regularly scheduled programming of late-night nachos, reading books on the couch, and nerding out in new adventures. I believe I owe you a few vacations.*

*To my children, **Jon Forest and Sylvia Anne**,*

*Thank you for overlooking my chaos, imperfections, and oft neglect during this process. I love you both so much and you deserve to know your parents fought to change their futures and that you can, too.*

*To my mother, **Peggy**,*

*While it is annoying to admit, you may now say your oldest daughter is both an author and a doctor. Thank you for believing so much in me and seeing things in me I cannot always see. I love you, mommy.*

*To my beautiful **Therafriends**,*

*Thank you to my fellow mental health professionals, whom I call friends, and my own Counselor, for walking with me on this journey. You believed in, encouraged, supported, and held space for me to cry, rant, and laugh. We are a good lot, and I need you like you need me and like we are needed. May your Fridays always have cake!*

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*This dissertation is meant to reflect my sincerely held belief that counselor educators are continually supporting the mental health of their students in their programs and their universities, often because of their own moral and ethical sense of advocacy. I want to thank **all the faculty in my program** for their determination to see me succeed in this endeavor. Each of you has shown your support and dedication to my future, my family, and my mental health throughout my time in this program. You have all fiercely advocated for this three-time high school dropout, punk rock counselor, to get her doctoral degree. In a time of chaos and uncertainty, a global pandemic, systemic violence, political unrest, and economic crisis, you were kind, thoughtful, and willing to be flexible with all of us. I sincerely and humbly thank you for your time, hearts, and continued work to make our program safe for all. You are the ones I see in this dissertation.*

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## **ABSTRACT**

In campuses across the U.S., especially in the wake of the global pandemic, concern for student mental health is increasing. Descriptions of disparity between service provision and demand are making national headlines as reports of student depression, anxiety, substance use, and suicidality rise. Additionally, several marginalized groups, among them: racial, ethnic, and cultural minorities, continue to have mental health needs that go unaddressed and unmet. As the world's future workforce, students' mental health support remains a crucial priority. This is not to discount the wealth of campus resources that exist, but merely to advocate for the need for increasing and diverse service provision. Counselor educators serve as vital leaders in training future mental health professionals, providing programming and support that bridges education to practice. This two-manuscript dissertation begins with an exploration of this problem. The purpose of manuscript one is to identify the current campus mental health climate, recognize existing resources available to students, and provide concrete steps in which counselor educators can engage in their community of campus mental health service. The second manuscript explores the characteristics of counselor educators who participate in addressing mental health issues in their HEI, including whether their identities as professional counselors, organizational stewards, or multicultural and social justice advocates influence their participation. Participant survey data from a quantitative study of these variables are measured using Point Biserial Bivariate Correlations, and Standard Logistic Regression analyses were conducted to assess if professional identity development, organizational stewardship, and social justice advocacy related to CE engagement level (no engagement, engagement). Taken together, these manuscripts summarize counselor educators' continued efforts to engage in intentional leadership strategies to address gaps in mental health advocacy and address social justice disparities in their campus communities.

## TABLE OF CONTENTS

|                                                                                            |     |
|--------------------------------------------------------------------------------------------|-----|
| Introduction.....                                                                          | 1   |
| Chapter I: Counselor Educators and Campus Mental Health Services.....                      | 5   |
| Abstract.....                                                                              | 6   |
| Counselor Educators and Campus Mental Health Services.....                                 | 7   |
| The Current State of Mental Health in HEI.....                                             | 9   |
| General Statistics .....                                                                   | 10  |
| Risk Factors for Special Populations .....                                                 | 14  |
| MH Service Provision in the HEI .....                                                      | 16  |
| Implications for Counselor Educators .....                                                 | 19  |
| Conclusion .....                                                                           | 25  |
| References.....                                                                            | 26  |
| Chapter II: Counselor Educators’ Engagement in Mental Health Services in Higher Education  |     |
| Institutions.....                                                                          | 51  |
| Abstract .....                                                                             | 52  |
| Counselor Educators’ Engagement in Mental Health Services in Higher Education Institutions |     |
| .....                                                                                      | 53  |
| Mental Health Services at HEI .....                                                        | 53  |
| Counselor Educators .....                                                                  | 56  |
| Professional Counselor Identity.....                                                       | 56  |
| Leadership through Organizational Stewardship.....                                         | 58  |
| Social Justice Advocacy .....                                                              | 59  |
| Method .....                                                                               | 61  |
| Participants.....                                                                          | 61  |
| Results.....                                                                               | 66  |
| Discussion .....                                                                           | 70  |
| Limitations of the Present Study.....                                                      | 74  |
| Implications for Counselor Educators .....                                                 | 74  |
| Conclusion .....                                                                           | 77  |
| References.....                                                                            | 79  |
| Appendices.....                                                                            | 104 |
| Appendix A. Sample Recruitment Letter.....                                                 | 104 |
| Appendix B. Survey of CE Involvement in On-Campus Mental Health Services (SCEMHS)          |     |
| .....                                                                                      | 105 |
| Appendix C. Professional Identity Scale in Counseling Short Form (PISC-S).....             | 106 |
| Appendix D. Organizational Stewardship Subscale, Servant Leadership Questionnaire (OSS-    |     |
| SLQ).....                                                                                  | 108 |
| Appendix E. Advocacy Competencies Self-Assessment (ACSA) Survey© .....                     | 109 |
| Appendix F. Demographics Questionnaire.....                                                | 112 |
| Appendix G. Gratitude Remarks and Optional Survey Request.....                             | 115 |
| Appendix H. The Covid 19 Quality of Life Scale* (COV19-QoL) .....                          | 116 |
| Conclusion .....                                                                           | 122 |
| Vita.....                                                                                  | 124 |

## LIST OF TABLES

|               |     |
|---------------|-----|
| Table 1 ..... | 117 |
| Table 2 ..... | 118 |
| Table 3 ..... | 119 |
| Table 4 ..... | 120 |
| Table 5 ..... | 121 |

## **Introduction**

With more than 21 million students enrolled in four-year colleges around the U.S., adapting higher education institutions (HEI) to the changing demands and societal fluctuations that influence students' wellbeing is profoundly significant (American Council on Education, 2018). Many factors impact how students navigate the stressors of their academic environments. The season of emerging adulthood is an established time of exploration, experimentation, and shifting social influences from parental to peer and academic (Faas et al., 2020). Historically, the needs of these students have been marked by challenging transitions through cultural, developmental, and professional identities, which influences students' mental health (Arnett, 2015). For many first-time students, moving away from their family and friends disrupts their feelings of stability or grounding. This also creates opportunities to experience new cultures or ideas that help shape their growing adult identities (Chow & Healey, 2008). Transitioning between locations with support and beginning to rely on their decisions concerning time, finances, and relationship responsibilities impacts their levels of distress and anxiety (Thurber & Walton, 2012). For some students, it will be the first time they experience the autonomy and agency to direct their romantic, friend, and roommate interactions (Zarrett & Eccles, 2006). These novel experiences require rapid adjustment to the awareness that they hold responsibility for their choices and the consequences of their decisions.

Young adulthood is also a time when mental health diagnoses become recognizable, and demand for mental health services increases based on these needs (Ebert et al., 2019; Eisenberg et al., 2011; Oswald et al., 2020). Left untreated, mental health issues among college populations impact student wellbeing, professional success, program retention, grades, and future earning potential (Lipson et al., 2015; Sontag-Padilla et al., 2018). The global pandemic further disrupted

students' lives with physical displacements, health and wellbeing concerns, academic pressures, and abrupt transitions (Broner et al., 2022). The pandemic also increased awareness for special populations of students who were made more vulnerable by the increase in cultural anxiety and panic that resulted in racial- and ethnicity-based violence, sexuality- and gender- based discrimination, increased experiences of domestic violence, and threats of poverty and homelessness for a variety of students (Agüero, 2021; Conrad et al., 2021; Gilbert et al., 2021; Gonzales et al., 2020; Gratz et al., 2021).

The past several years have been marked by disastrous events moving across the world, with few remaining systemically unaffected by the impacts of the COVID-19 global pandemic. Across communities, coinciding life stressors have increased, such as climate change, poverty and insufficiency, and political instability (Department of Economic and Social Affairs (DESA), 2020). The U.S. Census Bureau identified the pandemic as profoundly affecting access to resources, including mental health services, during the global pandemic because of isolation, shutdowns, unemployment, and rising living costs (Panchal et al., 2021). Isolation also affected rates of violence due to prolonged exposure to abusive people and disconnection from safety and protective services (Ali et al., 2021). Similarly, reports of hate crimes also rose, including systemically sanctioned offenses against minority or marginalized identities (i.e., BIPOC, LGBTQAI+, AAPI; Jones, 2021; Salerno et al., 2020; Tessler et al., 2020; Van Hout & Wells, 2021). In addition, with losses in employment and financial security, food shortages and homelessness increased and the psychological impact of that led to hoarding, panic, and despair (Food, D. G. E., 2021). Overwhelming shared grief from friend and family losses and anxiety from the threat of death also affected peoples' sense of well-being (Bell et al., 2021). These

problems drastically increased mental health crisis rates, diagnosis, and treatment needs (Parrish, 2020).

College students are influenced by the same societal instabilities as the general population but have additional risk factors related to their experiences in the HEI environment (Cohen et al., 2020; Zhai & Du, 2020). In addition to the developmental challenges of emerging adulthood of heightening emotional awareness, changing social relationships, and increased financial responsibilities, students face additional concerns trying to balance academic stress, career performance pressures, and culture shock (Cohen et al., 2020). Emerging adulthood is also a time when more serious mental health symptoms are first noticed and reported (Pedrelli et al., 2015). The pandemic occurring during the developmental stage of emerging adulthood may result in even longer-term mental health impacts (Parrish, 2020). Reports of students' experiences of displacement, academic stress, and interpersonal relationships seem to substantiate this theory.

For over a hundred years, HEI have relied upon the services of college counseling centers to meet their students' mental health needs (S. Hodges, 2001; Kraft, 2011). Throughout that time, the centers have evolved to provide various resources, from life skills training and career preparation to treatment of serious psychiatric diagnoses like PTSD and suicide (S. J. Hodges, 2015). Although funding and respect for these institutions have been increasing in recent years, student population and demand require more than these services can provide (Kraft, 2011; LaFollette, 2009; Statista Research Department, 2022). As a result, many HEI are considering more varied approaches within the campus and the surrounding communities and adding technologically driven services such as telehealth (Eisenberg et al., 2012; LaFollette, 2009). HEI need to offer various services to demonstrate the HEIs continued commitment toward the overall

wellbeing of their student population and establish a foundation of mental health destigmatization, which remains a prioritized goal of the World Health Organization (World Health Organization, 2005).

Counselors and counselor educators have an education grounded in addressing mental health through attention to human development throughout the lifespan, engagement in preventative care, and a holistic orientation that focuses on strengths and wellness (Kaplan & Gladding, 2011a; Mellin et al., 2011; Myers & Sweeney, 2008). Counselor educators (CE) are responsible for the training of future counselors using approaches to mental healthcare that are concerned with meeting the needs of diverse populations and modeling healthy relationships and communication skills (Calley & Hawley, 2008; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016; Ratts & Greenleaf, 2017). Additionally, CE have a strong history of building community partnerships and working to promote systemic change that benefits clients at all levels of advocacy (Chan et al., 2019; Farrell & Minton, 2019; Hays et al., 2019). The following two manuscripts represent my efforts to help demonstrate a more deliberate practice for CE to engage in that process and a research assessment of their current work towards these efforts.

## **Chapter I: Counselor Educators and Campus Mental Health Services**

## **Abstract**

In campuses across the U.S., descriptions of disparity between student mental health service provision and demand are making national headlines. Counselor educators serve as leaders in training future mental health professionals, providing training that bridges education to practice. This manuscript aims to identify the current campus mental health climate, recognize existing resources for students, and provide concrete steps in which counselor educators can engage in their campus mental health community.

*Keywords:* Counselor Educators, Leadership and Advocacy, Mental Health Services, Higher Education Institutions

## **Counselor Educators and Campus Mental Health Services**

With more than 21 million students enrolled in four-year colleges around the U.S., adapting higher education institutions (HEI) to the changing mental health demands and societal fluctuations that influence students' wellbeing is profoundly significant (American Council on Education, 2018). Many factors impact how students navigate the stressors of their academic environments. The season of emerging adulthood is an established time of exploration, experimentation, and shifting social influences from parental to peer and academic (Faas et al., 2020). Historically, the needs of these students have been marked by challenging transitions through cultural, developmental, and professional identities, which influence students' mental health (Arnett, 2015). Transition activities may include leaving home, exposure to new ideas, oversight of finances, and new relationships (Chow & Healey, 2008; Zarrett & Eccles, 2006). These novel experiences require rapid adjustment to the awareness that they hold responsibility for their choices and the consequences of their decisions.

Young adulthood is also a time when many mental health diagnoses become recognizable, increasing demand for mental health services (Ebert et al., 2019; Eisenberg et al., 2012; Oswalt et al., 2020). Left untreated, mental health issues among college populations impact student wellbeing, professional success, program retention, grades, and future earning potential (Lipson et al., 2016; Sontag-Padilla et al., 2018). The global pandemic further disrupted students' lives with physical displacements, health and wellbeing concerns, and academic transitions (Broner et al., 2022). The pandemic also increased awareness of special populations of students who were made more vulnerable by the increase in cultural anxiety and panic that resulted in racial- and ethnicity-based violence, sexuality- and gender- based discrimination,

increased experiences of domestic violence, and threats of poverty and homelessness for a variety of students (Conrad et al., 2021; Gilbert et al., 2021; Gratz et al., 2021).

For over a hundred years, HEI have relied upon the services of college counseling centers to meet their students' mental health needs (Kraft, 2011). Throughout that time, the centers have evolved to provide a variety of resources, from life skills training and career preparation to treatment of serious psychiatric diagnoses like PTSD and suicide attempts (S. J. Hodges, 2015). Although funding and respect for these institutions has been increasing in recent years, student population and demand require more than these services can provide (Kraft, 2011; LaFollette, 2009; Statista Research Department, 2022). As a result, many HEI are considering more varied approaches within the campus and the surrounding communities and adding technologically driven services such as telehealth (Eisenberg et al., 2012; LaFollette, 2009). HEI need to offer various services to demonstrate the HEIs continued commitment toward the overall wellbeing of their student population and establish a foundation of mental health destigmatization, which remains a prioritized goal of the World Health Organization (World Health Organization, 2005).

Counselor educators (CE) have an education grounded in addressing mental health through attention to human development throughout the lifespan, engagement in preventative care, and a holistic orientation that focuses on strengths and wellness (Kaplan & Gladding, 2011a; Mellin et al., 2011; Myers & Sweeney, 2008). CE are responsible for training future counselors using approaches to mental healthcare that are concerned with meeting the needs of diverse populations and modeling healthy relationships and communication skills (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016; Ratts & Greenleaf, 2017). Additionally, CE have a strong history of building community partnerships

and working to promote systemic change that benefits clients at all levels of advocacy (Chan et al., 2019; Farrell & Minton, 2019; Hays et al., 2019).

Left untreated, mental health issues like depression, anxiety, and addictions among college populations impact student success, program retention, grades, future earnings, and labor force potential (Lipson et al., 2016; Sontag-Padilla et al., 2018). Therefore, the purpose of this manuscript is to examine the current literature on the specific problems college students face on campuses nationwide and how CE can be of service in helping to address mental health issues in their campus communities alongside established counseling centers.

### **The Current State of Mental Health in HEI**

The past several years have been marked by disastrous events worldwide, with few remaining unaffected by the impacts of the COVID-19 global pandemic. Across communities, coinciding life stressors have increased, such as climate change, poverty and insufficiency, and political instability (Department of Economic and Social Affairs (DESA), 2020). The U.S. Census Bureau identified the pandemic as profoundly affecting access to resources, including mental health services, during the global pandemic because of isolation, shutdowns, unemployment, and rising living costs (Panchal et al., 2021). Isolation also impacted rates of violence due to prolonged exposure to abusive people and disconnection from safety and protective services (Ali et al., 2021). Similarly, reports of hate crimes also rose, including systemically sanctioned offenses against minority or marginalized identities (i.e., BIPOC, LGBTQAI+, AAPI; Jones, 2021; Salerno et al., 2020; Tessler et al., 2020; Van Hout & Wells, 2021). In addition, with losses in employment and financial security, food shortages and homelessness increased and the psychological impact of that led to hoarding, panic, and despair (Food, D. G. E., 2021). Overwhelming shared grief from friend and family losses and anxiety

from the threat of death also affected peoples' sense of wellbeing (Bell et al., 2021). Collectively, these problems drastically increased rates of mental health needs (Parrish, 2020).

College students are influenced by the same societal instabilities as the general population but have additional risk factors related to their experiences in the HEI environment (Cohen et al., 2020; Zhai & Du, 2020). In addition to the developmental challenges of emerging adulthood, such as heightening emotional awareness, changing social relationships, and increased financial responsibilities, students face concerns trying to balance academic stress, career performance pressures, and culture shock (Cohen et al., 2020). Emerging adulthood is also a time when more serious mental health symptoms are first noticed and reported (Pedrelli et al., 2015). The pandemic occurring during the developmental stage of emerging adulthood may result in even longer-term mental health impacts (Parrish, 2020). Reports of students' experiences of displacement, academic stress, and interpersonal relationships seem to substantiate this theory.

### **General Statistics**

On average, around 40% of college students utilize mental health services from their HEI (Statista Research Department, 2022). Reasons for help-seeking range from transitioning between households and adjustments to independent living to emergent mental health symptoms associated with young adulthood (Arnett, 2015). Stress, sleeplessness, fear, and lack of appetite, all indicators of mental health issues, are some symptoms that help students identify that they might need support (Eisenberg et al., 2012). Pressure to perform academically and to remain competitive in a global job market also impacts student stress levels and perceptions of self-efficacy (Pascoe et al., 2020). When students seek services, about 65% report counseling services were essential to their wellbeing (LeViness et al., 2018). Although manageable with

awareness and support, mental health issues that are left untreated risk developing into more serious mental health illnesses. These problematic mental health concerns include eating disorders, bipolar disorder, and PTSD, which can interrupt students' abilities to perform in their school studies and lead to more drastic consequences such as hospitalization or college attrition (Arnett, 2015; World Health Organization, 2005).

There has been consistent reporting that around one in five students will experience a severe mental health issue during their college experience (Gruttadaro & Crudo, 2012). Before the pandemic, HEI saw a rise in mental health issues, which continued following relocation efforts (American Council on Education, 2018). In the aftermath of the pandemic, students reported increased social anxiety, depression, and familial distress (Lederer et al., 2021). They also noted that their need for services rose throughout and following the pandemic, but that need was unmet (Martinez & Nguyen, 2020). This need is reflected in reports from mental health service providers external to the HEI that students sought treatment for anxiety (25.7%) and depression (17%; Statista Research Department, 2022).

### **Key Problem Areas for Student Populations**

The research regarding college students' mental health shows a significant trend toward specific mental health issues like depression, anxiety, substance use, and suicidality. Major depressive disorder can interrupt students' ability to concentrate, retain information, commitment to class and study schedules, and retention in school (Cooper et al., 2020). The impaired global functioning of a major depressive episode during a time in life when decisions are likely to carry more weight is an express concern especially given the rising costs of college and living in general (Martinez & Nguyen, 2020). Reports vary widely from institution to institution. However, research consistently places depression in the top three concerns for students' mental

health in HEI spanning decades (Lipson et al., 2019). During the pandemic, those rates have been reported from around 17% to 34%, depending on the source (Chirikov et al., 2020; Martinez & Nguyen, 2020; Statista Research Department, 2022).

Anxiety continues to be the most frequent diagnosis given to college students, and around 63% of surveyed students name it their highest mental health concern (Duggan & Kozsela, 2022; Lee et al., 2021). Reasons for feeling anxious in college can vary from performance worries to relationship dynamics. Still, there is a clear correlation between high anxiety and the high cost of education in the HEI (Stolzenberg, E.B. et al., 2018). While very treatable with medication, therapy, or both, without intervention, untreated depression and anxiety are strongly correlated with substance abuse, addictions, and suicide (Li et al., 2020; National Institute on Drug Abuse, 2020).

### ***Substance Use and Addictions***

Emerging adulthood is a time of unsupervised exploration and potentially high-risk-taking behavior. Much of this is developmentally appropriate for the neurological stage of prefrontal cortex formation that occurs between 18-25 years old (Pharo et al., 2011). However, it is also when exploration and risk-taking can lead to the development of substance use addictions (NIDA, 2020; Pharo et al., 2011). What makes addiction particularly problematic for students is they often report behaviors that start as social activities with little awareness of the long-term consequences of repeated use (Pedrelli et al., 2015). During this crucial time of executive brain development, the dangers of recreational substance use and binge drinking can progress to more severe addictions, which can derail educational and vocational goals (Davis 2015).

Distraction, erratic sleeping patterns, and even traumas associated with substance use impact students' participation in health and wellness work, school, and class work. When

students' grades begin to suffer and consequences become more distressing, substance use can become unhealthy coping behaviors that add further problems. Currently, around 20% of college students meet the criteria for alcohol dependence, while approximately 30% meet the requirements for binge drinking (SAMHSA, 2019). Adults aged 18 to 24 have the highest rates of co-occurring alcohol and substance addictions (NIDA, 2020). However, many studies that detail these levels note that it is more likely that rates are much higher than reported.

With many addictions, the cooccurrence of mental health issues can make students feel hopeless about their treatment and recovery options (Farrer et al., 2019). For students in active addiction, the executive function may be impaired enough that they do not have a clear awareness of the services available or how to avoid losing their place in the HEI (Pedrelli et al., 2015). The CDC has reported that students using substances, including alcohol, had an increased likelihood of suicidal ideation and behaviors by nearly 40% (Ivey-Stephenson, 2022). Substance use alone or as a cooccurrence with mental health disorders increases the need for mental health services on campus.

### ***Suicidality***

When students report profound stress and anxiety related to their schoolwork responsibilities and financial futures, suicidal ideation intensifies (Brownson et al., 2016). Research continues to indicate that students show a stronger association with suicidal behaviors when they have had symptoms of moderate to severe anxiety and depression (Casey et al., 2022a; W. Li et al., 2020). Moreover, students with a previous mental health diagnosis have a higher prevalence of behaviors associated with suicidality, including ideation, intent, and planning (Casey et al., 2022b). Suicide is the second-leading cause of death among college

students and is profoundly influenced by feelings of loneliness and worry, which also rose during the global pandemic (Liu et al., 2020; Xiao et al., 2021).

Conrad et al. (2021) reported that relocation and changes in the living environment during the pandemic increased feelings of stress, anxiety, depression, and grief. However, suicide rates decreased for college students during that time, but they have since risen to higher than before (Statista Research Department, 2022). Current research indicates this dip in suicide was related to the immediacy and panic of the pandemic as well as the focus on health concerns which briefly disrupted students' concept of mortality (Lederer et al., 2021; Lee et al., 2021). Since then, the ongoing trauma and grief surrounding the pandemic have led to increased suicidality (Brocato et al., 2021).

### **Risk Factors for Special Populations**

Several risk factors in the college and university setting impact specific students' need for services that address their mental health needs. Students with racial, ethnic, or diverse cultural identities often experience marginalization and othering, which impacts their ability to feel safe in their learning environments (Curtis-Boles et al., 2020). They are more likely to experience overt racism and discrimination than their white counterparts (Hussain & Jones, 2021). Rates of depression and anxiety among racial, ethnic, and cultural minorities are nearly twice as high as among non-marginalized students, impacting their academics and chances of vocational success (Auerbach et al., 2018; Lipson et al., 2019). Graduation rates for students of color are disproportionately lower (40%), especially in predominantly white HEI (de Brey et al., 2019). In a study of mental health diagnoses by race and ethnicity, Chen et al. (2019) noted that Asian/Pacific Islander and multiracial minority students demonstrated higher suicidal ideation and behavior rates. Since the pandemic began, many Asian, BIPOC, and Latinx students who

were already vulnerable to mental health distress due to racial and ethnic trauma have experienced increased prejudice, stereotyping, and violence in since the pandemic (Litam & Hipolito-Delgado, 2021; Meyer & Young, 2021).

In the university setting, LGBTQIA+ students are another group that must contend with problems such as discrimination, erasure, and hate crimes which can impact their mental health (Mundy, 2018). Tetreault et al. (2013) found that their professors' level of outness and perception of treatment strongly influenced participants' overall feelings about campus climate. Mundy (2018) reported that students from southeastern HEI found it hard to trust their institutions when reporting microaggressions, discrimination, and harassment. Lack of trust and the inability to report painful experiences of threat and unsafety are significant causes of the mental risk factors like depression, substance abuse, and suicidality (Kaniuka et al., 2019). Mistrust was exacerbated during the pandemic when abrupt changes to housing in HEI caused students in the LGBTQ+ community to become displaced and increased the risk of homelessness for those with unaccepting families (Gilbert et al., 2021). For LGBTQ+ students, having to return home to possibly unwelcoming or hostile environments may have led to increased experiences of violence from family members (Lederer et al., 2021). Certainly, underrepresented and marginalized students have additional risk factors that further challenge their mental health.

### ***Issues within a Program's Culture***

The cultural atmosphere within HEI majors also impacts students' access to mental health services. Some professional degree programs have subcultures that encourage competition, perfectionism, and self-reliance (Evans et al., 2018; Levecque et al., 2017; Lipson et al., 2016). The pressure from this type of program culture may negatively impact mental health while discouraging help-seeking. Gatekeeping becomes a matter of avoiding inquiry altogether, which

fosters misrepresentation of the mental health and wellbeing of the population of a degree program to sustain the illusion of meritocracy (Jensen & Cross, 2021; Vinkenburg, 2017). Research on specific degree programs such as medicine, law, and engineering all noted the dearth of evidence regarding substance use by students in their programs, indicating that this information may have been deliberately obfuscated to avoid the need for mental health services (Ayala et al., 2017; Jensen & Cross, 2021; Nahar et al., 2019). Programs often prefer a closed system to keep outsiders from potentially scrutinizing and holding them accountable for their students' mental health (Pacis et al., 2020; Tett, 2015). Some programs' severe stress and competitive nature can raise student anxiety and depression (Nahar et al., 2019). Subsequently, students possess little awareness of screening and support systems to help, even though such programs are available in the college community (Ayala et al., 2017). Given the severity and scope of students' mental health needs, there is a high demand for comprehensive mental health service provision within the HEI.

### **MH Service Provision in the HEI**

Depending on the source, students' service utilization of mental health resources is around 40 to 60% of a given campus (Gorman et al., 2020; Statista Research Department, 2022). Mental health service provision in the HEI continues to grow and develop depending on population, demand, and funding. Through funding, most HEI have been able to offer 1) university counseling centers, 2) university health clinics, 3) wellness centers, and 4) disability support services (Bourdon et al., 2020).

University counseling centers (UCC) provide services such as talk therapy, counseling groups, psycho-educational support, and substance use programming (Brunner et al., 2014). Many UCC also implement outreach programming and health and wellness education to provide

information on prevention (The Association for University and College Counseling Center Outreach [AUCCCO], 2022). Most college counseling centers must offer session limits per individual client because of resource constraints and even then, clients may be seen on a bi-weekly basis (Center for Collegiate Mental Health, 2022). Based on the diverse needs of students, UCC are frequently staffed with a mix of mental health professionals to address concerns from multiple perspectives. The philosophy of practice and scope influence the learning environment as well, creating a rich, collaborative experience (Vereen et al., 2018). The majority of counseling center directors hold PhDs in clinical psychology (32.4%), counseling psychology (30.2%), or counseling (23.4%). Throughout the pandemic, a number of UCC also began to utilize telemental health services to help accommodate students during isolation (Gorman et al., 2020). According to data from a survey of campus pandemic responses, the majority (over 80%) of the responding centers reported supplementing in-person services with one or more telemental methods helped to alleviate some of the increased demand for services (American College Health Association [ACHA], 2021).

University health clinics (UHC) Focus on screenings for a broad variety of health conditions and service students' physical, mental, and educational needs, providing brief medical treatment for illnesses, which can include mental health issues (Kunz et al., 1993). The mental health and wellness aspects of this can include employing full-time psychiatrist on staff, who can provide diagnoses and medication treatment for more serious mental health issues like depression, PTSD, or psychosis (American College Health Association [ACHA], 2022). In many cases these are the first line of inquiry students may use in order to find mental health help. Staffing in UHC includes an interdisciplinary staff of administrative support, nurses, advanced nurse practitioners, physicians, assistance, physicians, psychiatrists, and, in the case of embedded

UCCs, allied health professionals such as counselors, social workers, and psychologists for the provision of mental health services (ACHA, 2022). The focus is usually on training students from those professions in their internship phase. During and post-pandemic, many UHC shifted to inclusion of telehealth services (ACHA, 2022).

According to Strand et al. (2010), around 80% of HEI had a wellness program or center. Wellness programs and centers traditionally focus on campus support for physical health (i.e., recreation and wellness centers), although a growing number of them are now including holistic health and wellness (Benson-Tilsen & Cheskis-Gold, 2017). The services available can include health and wellness education and referrals, intramural sports individual fitness programs, nutrition mental health services, outdoor recreation, sports clubs, peer mentors, massage or physiotherapy, and child-care services (Benson-Tilsen & Cheskis-Gold, 2017). Directors of wellness centers are typically from the professions of recreation, sports, and medicine. Supporting staff tend to be students using work study programs in addition to graduate researchers, looking to extend their depth of knowledge with practical work experience (Benson-Tilsen & Cheskis-Gold, 2017). As wellness is an important aspect of recovery in the post-pandemic era and one that lends itself to resilience and healing (J. Johnson et al., 2019), these centers attempted to promote these services although many lacked the staffing and infrastructure to meet the additional demand (Redden, 2021).

Lastly, campus disability support services (DSS) function to increase inclusion rates in HEI settings and to facilitate the career development and opportunities of students with disabilities (Scott & Marchetti, 2021). Students with diagnosable mental illnesses may warrant protection under the American Disabilities Act of 1990 and 2008 through their DSS, which can provide reasonable accommodations to allow these students to gain equal access to their courses

and success in their college endeavors (Kiuahara & Huefner, 2008). According to Scott and Marchetti (2021), DSS directors are usually master's level administrators (72%) holding work experience in fields of teaching in higher education (37%), elementary and primary education for students with disabilities (30%), allied mental health professionals (e.g. counseling , psychological services, social workers, etc.), or student/academic affairs administrators.

Overall, however, as the pandemic and subsequent crises continue, HEI have not been able to meet the needs of their students and there are still gaps in mental health service provision. Many universities have retained the collaborative spirit that the pandemic forced them to confront, collaborating and partnering within the HEI, breaking down barriers to communication and opening to the greater community, and utilizing web-based services and communication to foster innovative policy options (ACHA, 2021). In many cases, counselors and counselor educators have been an integral part of the ongoing process to meet mental health demands. The following section examines the implications for how CE might engage intentionally in the collaborative efforts to build partnerships that help meet these demands.

### **Implications for Counselor Educators**

The purpose of this manuscript was to examine the current literature on the specific mental health issues college students face on campuses nationwide. Key problems were reviewed to better understand the at-risk populations and the communities engaged in serving them. The following implications use relevant literature to illustrate the ways in which CE may be of service in helping to address unmet needs in their campus communities alongside those established services and programs, followed by actions CE can incorporate to increase their effectiveness moving forward. As Fullmer et al. (2021) highlighted, "Addressing mental health concerns among college students is a shared initiative across campus communities" (p. 7).

CEs already work collaboratively within their communities to address gaps in mental health services and provide the relevant training for students, demonstrating the core values of the counseling profession (Chan et al., 2019; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016; Kaplan & Gladding, 2011). The importance of moving quickly to address gaps in care has been evidenced through the increasing rates of mental health issues. To accomplish this goal, CEs can demonstrate aspects of their professional identity as clinicians, educators, and advocates. The activities are meant to offer a myriad of ways CE can assist with on-campus mental health needs so that they can identify those that best fit with their expertise, available time, and resources.

### ***Clinical Partnerships***

Consistent with literature on CEs successful partnerships outside the campus community, CE can provide mental health resources to students who may be at greater risk for attrition, mental health disorders, and systemic oppression (Cohen et al., 2020). Counseling training provides skills needed for successful treatment for a variety of mental health disorders. CE are able to provide prevention and intervention for addictions, crisis- and trauma-informed care, and various mental health concerns (CACREP, 2016). Additionally, CEs can use their ethics training to help partners maintain high standards of care and best clinical practice.

Fostering clinical partnerships requires awareness of institutional statistics, as well as transparency regarding planning and goals with other professional programs, especially for programs that already house community- or campus-based training clinics. (O'Halloran & Glosoff, 2019). Having a clear concept of professional identity in counseling and the areas of expertise faculty hold can help alleviate miscommunication, outline professional responsibilities, and enhance mutual respect between professions (K. F. Johnson et al., 2015; Shoffner & Briggs,

2001). When counselor education programs work on campuses, it is vital that they approach multidisciplinary collaborations with the awareness and cooperation of the UCC and other mental health services on campus. UCC can offer a wealth of learning opportunities for clinical mental health counseling students as an internship site, as well as providing partnership and collaboration opportunities for program-centered training clinics, but transparency helps to minimize duplications of effort, wasted resources, and political issues.

### ***Educational Collaborations***

When CEs work collaboratively with educators from different academic programs, they can create broader interventions and unite students from separate fields to help them diversify and propel their education. The recent years' events had many untrained educators in HEI needing to respond to the growing mental health demands of their students (Gulliver et al., 2019; Liu et al., 2020). However, this requires adequate training and literacy in mental health to identify the situation and direct students to the appropriate resources (Gulliver et al., 2019). Additionally, when educators do not feel adequately supported to help with those efforts, they may feel ineffective, exhausted, or burdened by their workload causing them to question the necessity of staying in a profession that demands them to work beyond the scope of their training (Awa et al., 2010). Suppose CEs, many of whom have invested time and energy into research focused on training and wellness, can help them identify strategies for implementing wellness into the curriculum. In that case, the overall health of the system will benefit. In collaborating with other programs, workload and resources may be shared between budgets, and ingenuity may be dispersed more equitably.

In previous literature, CEs have demonstrated that paying attention to the specific aspects of holism has helped students increase their self-awareness, coping strategies, and empathy with

others from different professional backgrounds (K. F. Johnson et al., 2015; Reese, 2019).

Developing mutually effective educational relationships enriches students' experiences and enhances professional advocacy for the counseling profession.

### ***Advocacy Opportunities***

CE working in leadership in various roles in the HEI understand the impact of their professional counselor identity during discussions of funding, advocacy, and support, and they can use their position to advocate for students' mental health needs (Chan et al., 2018; Pérez & Carney, 2018). CE can demonstrate their awareness and education concerning social justice inequities and work to change legislation with policymakers, both on campus and off, to establish pathways to better service provision for all (Chan et al., 2019; Farrell & Minton, 2019).

CEs have demonstrated that they can work with individuals and groups to create culturally sensitive approaches that are mindful of the systemic histories of oppression (King & Summers, 2020). They may choose to utilize the Multicultural and Social Justice Counseling Competencies (MSJCC) framework to address systemic inequities of care for underserved communities in the HEI. Consequently, CE can help to normalize and destigmatize topics in communities where discussions about mental health and wellness may still be considered taboo or threatening (Overton & Medina, 2008).

### ***Moving Forward***

Addressing the mental health crisis can seem daunting given the scope and severity of the problems. However, it should be noted that this manuscript exemplifies the many ways in which the framework and structure of the HEI may be used to develop interprofessional relationships and collaborations that promote student wellness. Using that knowledge, the following action

steps illustrate practical ways in which CE, as individuals and as a faculty group, may help address HEI students' mental health.

**Action 1. Begin to analyze current interprofessional relationships.** As individuals, CE can start by recognizing opportunities to engage in meaningful discourse surrounding mental health issues by exploring relationships that have already been cultivated through other activities. Reviewing the types of programs in which a relationship exists may yield support and solutions to previously unaddressed problems without creating an undue burden on the workload. As a faculty group, regularly scheduled reviews of interprofessional relationships will help generate dialogue for professional development, motivation, and focus, in order to create a pattern of campus-oriented awareness.

**Action 2. Create a plan of advocacy.** For both CE individuals and faculty groups, using the MSJCC as a framework can facilitate bridging educational silos and administrative programs. Interprofessional communication requires cultural awareness and knowledge, so educating oneself on a profession's history with mental health, problem areas, and specific stigmas may help smooth collaborative efforts. Similarly, making efforts to understand systemic lenses when working with administrative programs like student support services or wellness centers will have a more positive effect if the collaborators demonstrate cultural humility and curiosity.

**Action 3. Build a solid collaborative relationship with the Office of Technology (OIT).** Given the recent upswing in telehealth services, technology can and should be used to facilitate student wellness and provide psychoeducation. OIT departments can often offer a wealth of resources to faculty and students, including helping to create collaborative services to address specific gaps in care. For example, a technology-based clinical directory for depression, anxiety, substance use, and suicidality can be used to connect students to their campus

community by dispersing self-assessments, holding regular developmental and professionally appropriate trainings, creating relevant materials, and generating discourse with their student populations. As an individual faculty member, it would be worth analyzing the other tech-based services and resources that may exist for strength-based approaches. Counselor perspectives afford clients a wellness perspective of their mental health journey that could be linked to those resources through more intentional collaborative efforts.

**Action 4. Provide specific course experiences that increase mental health literacy.**

CE as individuals can offer various educational experiences through classroom exercises or facilitate specific training on wellness, holism, and strengths-based self-awareness in the campus community. These are strategies to help the student body explore mental health in an engaging way that also offers an opportunity for students to become knowledgeable about the distinctions among the mental health helping professions. Such efforts could be enacted by partnering with a wellness center to offer combined mental health with fitness classes, engaging with the DSS to create more inclusive activities or make sure materials and classroom experiences are inclusive, offering counseling centers information about future special topics classes, or creating a specific needs assessment to determine which mental health classes might be the most relevant for a program.

**Action 5. Create a campus-wide discussion of wellness and holism.** Foundational to the profession of counseling is the concept of the rights each person has toward achieving their "optimal state of health and wellbeing" (Myers et al., 2000, p. 252). This action blends seamlessly with CE leadership and advocacy work when the previous steps are taken because the intentionality has been integrated throughout their work. As a faculty group, CE can help HEI identify mental health resource gaps and strategies for implementing wellness into the overall

system. Counselor strength-based approaches allow the HEI community (e.g. students, staff, faculty, and administrators) to engage with more intentional programming, policymaking, classroom activities, program interventions, and crisis prevention.

### **Conclusion**

Throughout this manuscript, the underlying theme has been that mental health services and college campuses cannot meet the current demand and major global systemic problems embedded in the larger culture. A vital implication is examining how CE may contribute to the HEI to address these challenges. Further research is needed to determine what CE are currently doing in the HEI community regarding mental health service provision. Action research and applied learning opportunities can provide evidence for funding, which may come from collaborative relationships wherein mutual goals can be established to address mental health deficits and resource needs. The need for mental health services continues to grow, and CE are trained in education and mental health and wellness provision, making them ideal partners for employing effective strategies for prevention.

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## **Chapter II: Counselor Educators' Engagement in Mental Health Services in Higher Education Institutions**

## **Abstract**

Higher education institutions have a responsibility to the Counselor educators are professional counselors, leaders, or advocates who provide the training for the future counselors of our society. for the wellness of student populations in HEI. It is more than likely that CE are engaged in diverse service efforts in their HEI community, revealing and promoting holism and wellness with other programs, departments, and administrations. It is an area that has yet to be defined in the literature. This current study aims to provide a clearer picture of the characteristics of CE who participate in addressing mental health issues in their HEI, including whether their identities as professional counselors, organizational stewards, or multicultural and social justice advocates influence their participation. Participant survey data from a quantitative study of 73 Counselor Educators working as faculty in Higher Education Institutions for at least one year were assessed following an 8-week recruitment process. Variables were measured using Point Biserial Bivariate Correlation and Standard Logistic Regression analyses to assess if professional identity development, organizational stewardship, and social justice advocacy, related to CE engagement level (no engagement, engagement). The findings of the present research, results indicated correlations between the three independent variables, professional identity development, organizational stewardship, and social justice advocacy, but no relationship between any of the independent variables and CE mental health engagement. A discussion of the implications for counselor educators' leadership, advocacy, and professional identity development follows. The implications include an examination of current literature surrounding the variables of interest, intersections of gender on leadership and advocacy, and a brief exploration of the moral and ethical responsibility of collaboration within the HEI.

## **Counselor Educators' Engagement in Mental Health Services in Higher Education Institutions**

As mental health stigma has been lessening, the demand for mental health services has risen steadily in Higher Education Institutions (HEI) over the past two decades (Lipson et al., 2019). This increase has recently been exacerbated by the stressors of the global pandemic (Liu et al., 2020), environmental catastrophes (Comtesse et al., 2021; Cox et al., 2021), and rising aggression against marginalized communities (Gilbert et al., 2021; Tessler et al., 2020; Vasquez Reyes, 2020). College students have demonstrated increasing anxiety, depression, and suicide in response to these more recent global and environmental changes (American Council on Education, 2018; Lederer & Oswalt, 2017). However, there are indications that campus-based counseling and health centers may not be able to support these increased mental health needs alone (Bourdon et al., 2020; Gilbert et al., 2021; Liu et al., 2020). As trained mental health providers who educate future counselors, Counselor Educators (CE) are skilled professionals capable of helping bridge the gap between mental health services and student demand (American Counseling Association [ACA], 2014). This study examines how the relationship between CE' identity as counselors, leaders, and advocates impacts their involvement in addressing the mental health needs of students at their HEI.

### **Mental Health Services at HEI**

Prior to the pandemic and concurrent environmental and political crises, the necessity for mental health services at HEI was already growing. As the stigma surrounding mental health issues continued to decrease (Lipson et al., 2019), a growing wellness culture and more widespread awareness of systemic problems of oppression created an increased demand for services that most college campuses struggled to meet (Lederer et al., 2021; Liu et al., 2018). In

2021, over 80% of college presidents surveyed by the American Council on Education reported a change in prioritizing students' mental health, citing an increased demand from students, faculty, and staff (Melidona et al., 2021). This was due, in large part, to high rates of depression and anxiety, which climbed as high as 40% in self-reported studies of student mental health (Eisenberg & Lipson, 2020; Oh et al., 2021). Relatedly, Bourdon et al. (2020) reported alcohol and drug use rates to be a primary reason for students seeking treatment. These coinciding mental health factors can powerfully impact suicidal ideation and behaviors (Casey et al., 2022b; Gratz et al., 2021) and suicidal ideation rates continue to remain high at around 10% and are still the second leading cause of death for college-aged populations (Oswalt et al., 2020).

These mental health concerns rise significantly more if the people experiencing them belong to a group that has been marginalized or oppressed culturally. Prior to the pandemic, the National Center for Education Statistics (NCES; 2022) reported that “race and sexual orientation were the two largest categories of bias motivating hate crimes at postsecondary institutions in 2019, accounting for about two-thirds of crimes” (p. 5). In an article examining the specific impacts of the COVID-19 pandemic on college student mental health, Liu et al. (2020) noted that mental health issues disproportionately affected those with minoritized and marginalized identities, in many cases increasing oppressive systemic narratives. Molock and Parchem (2021) reported that, in addition to increased rates of anxiety and depression, students from communities of color reported disruptions to economic and environmental security which significantly impacted their ability to navigate the challenges of the pandemic. Specifically in the U.S., the violence against BIPOC students led to an increase in hate crimes, which grew to include Asian and Pacific Islanders as racist rhetoric spread misinformation about the origins of the pandemic (Newman et al., 2022). Added to that, some students of the LGBTQ+ community were left

without housing when universities moved into isolation and relocation and families had rejected and abandoned them (Conrad et al., 2021). Mental health for underserved and marginalized groups remains a major concern and requires attention to effectively address gaps in care.

Traditionally, college counseling centers are responsible for providing mental health services on campuses (Bourdon et al., 2020). However, these centers are often supplemented by campus training clinics in mental health professions, campus wellness centers, disability services, and local community agencies outside the university (American Council on Education, 2018; Bourdon et al., 2020; Gorman et al., 2020). According to the 2020 Annual Survey of University and College Counseling Center Directors, universities have steadily increased funding for mental health services in college counseling centers over the last decade.

Demand, however, still far exceeds session availability (Gorman et al., 2020). For instance, during the pandemic, the HMS reported that 60% of students found it difficult to access mental health services from their university (Oh et al., 2021). These difficulties were often the result of short supply (Liu et al., 2020), lack of knowledge about where to find resources (Bourdon et al., 2020), and in some cases, lack of therapist diversity, including the offering of telehealth services (K. F. Johnson & Rehfuss, 2020). In all of these studies, the authors emphasized the need for HEI to prioritize strategies to reach more students before crises escalate and to provide more widespread education concerning mental health and wellness (Bourdon et al., 2020; Lederer et al., 2021; Liu et al., 2020). Given the current health, environmental, and political challenges that the HEI faces, CE could be welcome contributors to providing mental health services and education.

## **Counselor Educators**

Through their dual identities of counselor and educator, CE are model leaders for whom advocacy embodies the foundational charge of the counseling profession (Chan et al., 2019; Woo et al., 2016), which is “to empower diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (Kaplan et al., 2014, p. 366). Currently, there are over 900 counselor education programs located on campuses across the U.S. (CACREP, 2022). The ACA Code of Ethics (2014) indicates that CE work as leaders in counseling, directing and shaping the profession as educators, supervisors, and practitioners. CE consistently demonstrate strong leadership and advocacy for the counseling profession through communicating the shared values of holism, wellness, and care for others (Calley & Hawley, 2008; Gibson et al., 2015; Peters & Vereen, 2020). Recently, Hays et al. (2021) conducted a grounded theory study in which they noted that CE build relationships and carry out professional obligations in the HEI that align to their value system and professional identity, often intertwining with their knowledge base as counselors and their advocacy for social justice. While there is very little quantitative evidence of the connections between these foundational characteristics of CE, qualitative research rich with description on how to understand the relationships between CE and their work in HEI to address mental health disparities does exist.

### **Professional Counselor Identity**

The core tenets of counselor identity are human development throughout the lifespan, engagement in preventative care, and a holistic orientation that focuses on strengths and wellness (Kaplan et al., 2014; Kiselica & Robinson, 2001; Mellin et al., 2010; Myers & Sweeney, 2008; Woo et al., 2016, 2017). Along with the core definition described above, counselors can now describe their professional distinctions to the communities in which they serve and counseling

leaders can advocate systemically for resources and rights on behalf of the profession (Chan et al., 2019; Farrell & Minton, 2019).

Counselor identity is a central component of CE identity, particularly for those who focus on advocacy and leadership work in their communities (Brat et al., 2016; Woo et al., 2016). This is because CE first trained as counselors with the same ideologies and history in humanism which cause the counselor identity to be firmly imbedded into their educator role (Woo et al., 2016). Vereen et al. (2014) stated “The counseling profession’s emphasis on human growth and development is demonstrated through action, education and training, and scholarship” (p. 192). Focusing on helping others has tremendous cultural, social, and political implications. Peters and Vereen (2020) explored these narratives about the ways CE maintain their identities. Their participants described how profoundly this impacts their engagement within their communities through the strength of their counselor identities, their connections with their cultures, and their responsibilities to clients and the profession. This responsibility empowers CE to clarify the work of counselors and establishes them as educators of wellness and holistic health.

CE often demonstrate their commitment to counselor identity through their community-based outreach. Much of this is though the development of skills and standards associated with the identity of counseling for their students, their peers, and administrators, decreasing role confusion when working with other mental health professionals, another significant aspect of CE community work is in creating advocacy inroads that normalize mental health help-seeking within client populations. Frequently this means liaising with established community representatives and formulating lines of communication and services that meet (Chan et al., 2018; Paolini & Topdemir, 2013). Given the overwhelming need, CE could use their counselor identity to help with mental health service provision in the HEI as well.

## **Leadership through Organizational Stewardship**

For many CE, their relationship with leadership is an extension of their identity as advocates and counselors. Subsequently, many CE find their beliefs and values closely align with servant leadership. Greenleaf (1977) described servant leadership as leading through compassionate acts of service from a place of altruism. It starts with a noble desire to help, which then motivates people to create opportunities for others. These opportunities allow others to have what they need for the support and achievement of their goals and the transformation of their lives (Greenleaf, 1977). Servant leaders focus on understanding problems from the perspective of the community and developing solutions alongside them. They facilitate this process of addressing problems using the skills of empathy and compassion. This leadership style focuses on the emotional connection, helping others to grow and succeed, and using organization to attain goals. According to Barbuto and Wheeler (2006), the defining characteristics of servant leaders are: a) altruistic calling, b) emotional healing, c) wisdom, d) persuasive mapping, and e) organizational stewardship.

The use of servant leadership has been endorsed broadly by CE because it reflects curiosity, selflessness, and empowerment as a basis for increasing an individual's or community's autonomy, closely aligning with the counseling profession's goals of autonomy, service, and beneficence (American Counseling Association, 2014; Barbuto & Wheeler, 2006; Prasath & Bhat, 2021). In a recent article by Prasath et al. (2021), the authors described how counseling was a natural precursor to servant leadership in various organizations, including schools, businesses, and local government because of the intrinsic values of autonomy and empowerment, that foster cooperation and a sense of purpose among the members of the

community. This is best reflected through the specific aspect of servant leadership: organizational stewardship.

Organizational stewardship is distinguished from the totality of servant leadership because of its specific focus on service to the community for the betterment of the system and the future generations (Simpkins & Lemyre, 2018). Barbuto and Wheeler (2006) define it as “the extent to which leaders prepare an organization to make a positive contribution to society through community development programs and outreach” (p. 319). The concept of organizational stewardship is endorsed through CE work to support communities by transmitting their understanding of the impacts of relational experiences in training future counselors to address mental health advocacy (A. M. Evans et al., 2016). Even so, it is unknown whether CE’ involvement in HEI mental health service provision can be connected to a sense of organizational stewardship.

### **Social Justice Advocacy**

Similar to the premises of servant leadership, social justice outlines the concepts of equity, access, participation, and harmony within the counseling profession (Lyons et al., 2013). In their seminal article on the history of advocacy in counseling, Kiselica and Robinson (2001) described social justice as a human rights issue that required activism to help clients achieve their personal growth. The work of social justice centers around acknowledging how power and privilege create oppression and injustice that must be counteracted through intentionally engaging in awareness, education, and intervention (Shah, 2018).

The Multicultural and Social Justice Counseling Competencies (MSJCC) represent the best efforts of the counseling profession to provide a unified standard of practice and training for counselors regarding social justice advocacy work (Ratts & Greenleaf, 2017). CE utilize the

MSJCC to connect their work with students to social justice and advocacy actions in the communities in which they serve (Ratts & Greenleaf, 2017; Sue et al., 1992). CE report working with a variety of community partners to address mental health issues, including with K-12 schools (Gay & Swank, 2021; Geesa et al., 2020; Novakovic et al., 2020), veterans (Duchac et al., 2020; Prosek & Burgin, 2020), and local non-profits (Grimmett et al., 2017; Smith & Cashwell, 2010). However, a dominant implication has been for CE to address the dearth of literature on empirically validated social justice advocacy efforts that counselors and counselor educators are doing in their communities (Chan et al., 2019; Hays, 2020; Prosek & Burgin, 2020). To date, research has only minimally explored social justice and work at HEI.

### ***Purpose of the Study***

At this point in time, there is no research indicating the amount of impact CE are making as professional counselors, leaders, or advocates for the wellness of student populations in HEI. It is more than likely that CE are engaged in diverse service efforts in their HEI community, revealing and promoting holism and wellness with other programs, departments, and administrations. It is an area that has yet to be defined in the literature. This current study aims to provide a clearer picture of the characteristics of CE who participate in addressing mental health issues in their HEI, including whether their identities as professional counselors, organizational stewards, or multicultural and social justice advocates influence their participation.

### ***Research Questions:***

1. In what ways are CE involved in addressing mental health issues in HEI?
2. What specific factors influence CE to engage in on-campus mental health services?

H<sub>1</sub>: Based on prior research, I hypothesize that CE with a higher counselor identity will be more likely to engage in on-campus mental health services.

H<sub>2</sub>: Based on prior research, I hypothesize that CE with higher levels of organizational stewardship will be more likely to engage in on-campus mental health services.

H<sub>3</sub>: Based on prior research, I hypothesize that CE with a greater degree of social change advocacy will be more likely to engage in on-campus mental health services.

### **Method**

This study follows a non-experimental, descriptive research design, using a web-based cross-sectional survey. Cost-effectiveness, ease of use, availability, and reliability are strengths of the quantitative survey approach to research (Gravetter et al., 2020). The gap in the literature has been established, and there is not yet information to support the need for larger-scale studies with interventions.

#### **Participants**

To be eligible for this study, participants needed to hold a Ph.D. in counselor education, be a CE working as faculty in an HEI environment (Approximate population is N=2400; CACREP, 2015), and have at least one year of experience working in this setting. Demographics on participants were collected as part of the survey and are detailed below.

The total number of respondents for this study was 106. Thirty-two cases were removed due to ineligibility determined by the screening questions asked prior to survey measures. One additional case was removed for answering unsure on the dichotomous dependent variable. Missing data were assessed through frequencies and independent t-tests which revealed showed that the missing data were missing completely at random (MCAR; Garson, 2015). The final participant total was 73. See **Table 1** for a summary of demographic characteristics.

The majority participants identified as White/European American (71.2%). Remaining participants identified as Black/African American (12.3%), Asian, Asian Indian, and Asian American (5.5%), American Indian/Alaska Native (4.1%), and four participants identified as more than one race. Most participants (n=42) were between the ages of 31-45. Many of the participants identified as female (65.8%), with the remaining participants identifying as male (30.2%), or non-binary/genderqueer (4.1%). The participants from this survey described homogeneous educational and licensing backgrounds. Fifty-five participants identified themselves as having graduated from a Counseling Masters graduate program and 65 from a Counselor Education doctoral program. The majority held current clinical or school counselor licenses in their state (86%).

**Program Characteristics.** Nearly all participants (90.4%) identified that their program was CACREP accredited at the time of this survey. Around half of the participants described having their program tied to a counseling center or a center that provides counseling services on campus (n=35) and similarly, around half identified that their program run a training clinic for counselors-in-training (n=37). Most participants currently worked as an Assistant Professor (35.6%) in their university, followed by associate professor (22%). Most participants described their programs as mostly or fully in person (n=43) under normal circumstances/non-pandemic. Most of the respondents reported having worked between 1 and 10 years at that university (n=54) which matched the amount of time most participants had been counselor educators.

### ***Instrumentation***

**Survey of CE Involvement in On-Campus Mental Health Services (SCEMHS).** The 7-item SCEMHS was developed for this study to measure the kinds of mental health service provision CE engage in within their HEI community. The survey begins with a dichotomous

(yes/no) question to ascertain if the participant is currently involved in addressing mental health issues on their campus. If participants answer yes to question 1, they will be asked to provide details via checkboxes and short answers on their specific experiences regarding the types of mental health services they engage in and the people they serve in their HEI (see [Appendix B](#)). Examples of these inquiries are “What type of mental health programming are you currently or previously involved with on your campus?” and “What types of topics do your services address?”.

### **Professional Identity Scale in Counseling -Short Form (PISC-S; Woo et al., 2018).**

The PISC-S is a 16-item short-form version of the Professional Identity Scale in Counseling (PISC). The original PISC was a 52-item scale designed to measure the constructs of the unified professional identity of counseling, such as “engagement behaviors, knowledge of the profession, professional roles and expertise, attitude, philosophy of the profession, and professional values” (Woo, 2013, pp. 9–10). The scale uses a five-point Likert scale (i.e., not at all, somewhat, neutral/uncertain; mostly, and totally in agreement). The items for the PISC-S are summed according to four domains labeled I) professional knowledge, II) professional competency, III) attitude toward the profession, and IV) engagement in the counseling profession, or a total score may be used (see [Appendix C](#)). Scores may be totaled for higher scores indicate a greater degree of counselor identity. Internal reliabilities for the short form ranged from .72 to .85 (good). This version of the PISC needs further testing to ascertain validity, but in the initial formation of the measure, the PISC had a correlation of .70 with a similar instrument of its kind, demonstrating its construct validity (Woo et al., 2017). For this specific sample, Cronbach's alpha for the PISC-S in this study was 0.825, which indicates a high level of internal consistency.

**Organizational Stewardship Subscale, Servant Leadership Questionnaire (OSS-SLQ; Barbuto & Wheeler, 2006).** The five-item OSS subscale of the SLQ (see [Appendix D](#)) measures the degree to which people engage in interprofessional collaboration and community development programs and outreach. Barbuto and Wheeler (2006) reported that organizational stewardship was the highest correlate subscale in the SLQ for extra effort, employee satisfaction, and perceptions of organizational effectiveness. Sample items like “I see the organization for its potential to contribute to society” and “I am preparing the organization to make a positive difference in the future” demonstrate the ways in which leaders see themselves as change-agents for the larger systemic issues. Each item in this subscale uses a four-point Likert scale (i.e., 1 = strongly disagree, 2 = somewhat disagree, 3 = somewhat agree, and 4 = strongly agree) wherein a higher score indicates higher levels of organizational stewardship. In previous studies, the OSS has demonstrated consistent reliability coefficient with alphas of .89 and .92 (Barbuto & Wheeler, 2006; Mahembe & Engelbrecht, 2013). According to Barbuto and Wheeler (2006), the SLQ in its entirety has demonstrated strong convergent, divergent, and predictive validity, and factor structure making it a valuable tool for research of this kind. Chronbach’s alpha for the OSS-SLQ in the current study, had high reliability with .819.

**The Advocacy Competencies Self-Assessment (ACSA; Ratts & Ford, 2010).** The ACSA is a 30-item measure that measures social justice advocacy (see [Appendix E](#)). This self-report measure examines counselor advocacy efforts and social justice engagement across six domains: 1) client/student empowerment, 2) community collaboration, 3) public information, 4) student advocacy, and 5) systems advocacy, and 6) social/political advocacy. The survey uses a three-point Likert scale (i.e., almost always, sometimes, almost never). Sample items include “I support existing alliances and movements for social change” and “I assist clients/students with

developing self-advocacy skills". Higher scores indicate a greater degree of social change advocacy. The items are summed according to domains, and then each domain is totaled for a global measure of advocacy competency. In a study specifically designed to determine the reliability and validity of the ACSA, Bvunzawabaya (2012) reported that it had demonstrated the reliability of  $\alpha = .93$  and concurrent validity between ACSA and Multicultural Counseling Inventory,  $r = .51$ . For this specific sample, Cronbach's alpha for the ACSA was 0.936, which indicates a strong level of internal consistency for our scale with this specific sample.

**Demographics Questionnaire.** Participants were asked to respond to 15 demographics variables that are specific to the population of interest, counselor educators (see [Appendix F](#)). The demographic questionnaire contains items that ask participants to describe their race, age category, ethnic, gender and sexuality identity attributes, as well as attributes related to their professional identity such as years in practice memberships and types of work they do in their university.

**Global Pandemic Quality of Life Scale. Covid 19 Pandemic Impact Scale (COV19-QoL).** The COV19-QoL is a brief, 6-item self-report survey instrument that measures responses on a 5-point Likert scale. It is based on a preliminary study which measured "perceptions of quality of life deterioration in relation to the COVID-19 pandemic" (Repšti et al., 2020).

## **Procedures**

Following IRB approval, participant recruitment took place through email invitation distributed via the counselor education listserv: CESNET and via individual emails to CE whose email contact is provided publicly. All faculty who responded to the email and met the inclusion criteria were directed to an online consent form and accessed the online survey at the end of the study description. Qualtrics survey platform was used for data collection for the online survey.

Data collection was originally set to occur for a six-week period utilizing these means. However, since the number of responses did not meet the necessary amount for rigorous statistical analyses ( $n=110$ ), data collection continued for another two weeks using snowball sampling via personal emails, Facebook solicitation, and conference flyers. All potential participants, regardless of survey completion, had an option of providing an e-mail contact to be entered in one of three \$50 Amazon gift cards on a separate google form (see Appendix G). Responses from that form were randomized and three recipients were emailed the gift cards directly from the website. An a priori analysis was conducted to determine adequate sample size for the current study. Given an alpha level of .05 and a moderate effect size, a sample size of 91 was necessary to achieve adequate power ( $1 - \beta = .80$ ; Gravetter et al., 2020; Tabachnick & Fidell, 2019). Given that this number was not achieved, all results should be considered exploratory.

## **Results**

Prior to completion of data collection, a detailed data codebook was created to organize the measures by documenting the variable, label, value, and the statistical plan for each (Morrow & Skolitz, 2017). For the data cleaning process, SPSS statistical software was employed to address missing values as the survey responses did not allow for data irregularities. Initially, the missing data were assessed through frequencies and independent t-tests which revealed that the missing data were missing completely at random (MCAR), indicating that there was no relationship between the missing data and the participants responses. After these results were scrutinized, missing data was found to be almost exclusively the result of conditional answers which prevented participants from answering further questions of a survey section or participants were allowed to select as many as they agreed applied to their experiences. Subsequently, all missing data for this participant pool were coded as zero for analysis purposes (Garson, 2015).

Zero was used exclusively for coding missing data and not used as a code for nominal answer choices. Although the data set was small, the sample size (n=73) exceeds the standard model of 14 participants per predictor variable (3; Wilson Van Voorhis & Morgan, 2007).

SPSS 27 was used for the remaining statistical tests and graphing. To answer RQ1, “What ways are CE involved in addressing mental health issues in HEI?”, descriptive statistics were analyzed to summarize participants’ involvement in on-campus mental health services and demographic information about the participant pool. For those engaging in MH service provision in their universities (n=51, 68.92%), 39 (76.5%) participants reported spending up to 20% of their week in working in MH service. Most reported they provided direct programming in the form of individual counseling (n=18), group counseling (n=11), and wellness or psychoeducational programming (n=27). Those that engaged in indirect programming stated they spent the majority of their time providing supervision of students who offer MH services (n=38) and in general advocacy for student wellness (n = 37). Most (n = 46) stated their work served students (both undergrad and grad) and some who responded “other” (n = 13) described their work as serving special populations in their HEI such as LGBTQIA+, BIPOC, veteran, athletes, and TRIO program student populations (see **Table 2**).

Additionally, a number of participants stated they served specific populations in their communities such as school children, persons with disabilities, and older adults. Nearly all participants who provided MH services in their HEI stated the most important reason they were involved in it was due to a sense of moral and ethical responsibility. Other reasons salient reasons include it being part of their job or service requirements and providing research opportunities. Forty-three stated that they focused on general wellness and health in their programming, followed by anxiety (n=34), depression (n=32) and social justice and multicultural

issues (n=30). An open-ended question asking participants to describe their work with MH services in HEI was also a part of the original survey. However, less than 10% of participants responded, so results were not analyzed.

Prior to regression analysis, independent samples t-tests were used to assess certain demographic characteristics to check for differences within the independent variables (i.e. gender, job title, and training clinic; see **Table 3**). Differences by gender were found for all three of the independent variables, with female-identifying participants reporting significantly higher counselor identity, organizational stewardship, and social justice advocacy. There were no differences by professional title. For those reporting having a program training clinic, only differences in organizational stewardship were found, with those without a clinic reporting slightly higher stewardship levels.

Then, to answer RQ 2, a dichotomous categorical variable (1 = yes, 2 =no) was created for “Are you currently involved in addressing mental health issues on your campus (i.e., providing direct counseling or wellness programming or indirect supervision, advocacy, research, prevention services)?”, the dependent variable (DV). Prior to regression analysis, independent samples t-tests were used to compare means between the two groups of participants and each of the predictor variables. There was homogeneity of variances, as assessed by the Levene’s test for Equality of Variances, between the DV, MH in HEI, and the PISC-S (.910 > .05), OSS-SLQ (.215>.05), and ACSA (.329>.05). Finally, Logistic Regressions using the were conducted for each of the hypotheses to test the extent to which scores of the PISC-S, the OSS-SLQ, and the ACSA predicted involvement in campus MH, of which the results are detailed below.

The first hypothesis predicted that the total scores from the PISC-S would be higher in counselors who engage in on-campus mental health services than those who do not. An independent samples t-test revealed that there was not a significant difference between the responses to the PISC-S based on involvement in MH in HEI,  $t(71) = -1.193, p = 0.910$ . Point-Biserial correlational analysis results for MH in HEI with PISC-S  $r(72) = -0.140, p = .237$  were also not a strong indicator of relationship between these variables.

The second hypothesis predicted that the total scores from the OSS-SLQ would be higher in counselors who engage in on-campus mental health services than those who do not. An independent samples t-test revealed that there was not a significant difference between the responses to the OSS-SLQ based on involvement in MH in HEI,  $t(71) = -0.177, p = 0.860$ . The subsequent point-biserial correlational analysis also revealed no strong correlations for MH in HEI with OSS-SLQ  $r(72) = 0.021, p = .860$  were also not a strong indicator of relationship between these variables.

The third hypothesis predicted that the total scores from the ACSA would be higher in counselors who engage in on-campus mental health services than those who do not. An independent samples t-test revealed that there was not a significant difference between the responses to the ACSA and MH in HEI,  $t(71) = -0.861, p = 0.392$ . After conducting a point-biserial correlational analysis, and finding no strong correlations for MH Engagement with ACSA Total:  $r(72) = 0.102, p = 0.392$ , it was not surprising that similar outcomes for Standard Logistic Regression analyses yielded no statistically significant results for any of the three independent variables (see **Table 4** and **Table 5**).

All assumptions for logistical regression were met using SPSS tests for multicollinearity, normality, linearity, and outliers (Tabachnick & Fidell, 2019). Multicollinearity was assessed

and all independent variables were above the established .1 The PISC was rated .737, the OSS-SLQ was rated .658, and the ACSA was rated .688. All were below the value of 10 *VIF* at 1.356, 1.519, and 1.452, respectively. There were no major outlying residuals when assessed by a regression scatterplot. With three independent variables, the critical value is chi sq. 16.27. Only one case with a MAH of 19.39 was identified but was not removed due to low overall impact and due to the fact that the Cook's Distance (0.141) for the residuals maximum distance was well below 1, indicating that there was no significant influence to predict the outcome (Tabachnick & Fidell, 2019).

Following the main survey, 33 participants agreed to participate in the optional scale, *Global Pandemic Quality of Life Scale*. Overall, those participants reported median negative impact to their mental health, physical health and quality of life. Many respondents stated that they did feel more tense (n=15). However, most participants (n=19) did not agree that their personal safety was at risk, nor did they feel more depressed than before (n=18).

### **Discussion**

This study examined CEs identities as professional counselors, organizational stewards, and multicultural and social justice advocates and whether those qualities influenced their participation in MH service provision for students at their HEI. Furthermore, this research sought to add to the professional literature on CE leadership and advocacy by examining the way they relate to these aspects of CE identity. Although no strong statistical relationships were demonstrated by the predictor variables, descriptions of counselor educators MH work with students within the HEI were still helpful in understanding the care and intention that CE put into their wellness work on their campuses. While overall the results showed no significant relationship with the dependent variable of MH participation, point biserial analyses revealed

that the relationships between the independent variables, counselor professional identity, organizational stewardship, and social change advocacy showed strong positive correlations. The strong relationships between the three variables suggests that they are important components for counselor educators but appear unrelated to their decision to participate in mental health services at the HEI.

The parallels between the goals of servant leadership and social justice advocacy and their inherent connection to counselor identity can be seen scattered throughout the literature pertaining to CE. Prior research with counselor identity and community-based outreach has demonstrated that CE align strongly with their counselor identity especially as leaders in their organizations and in advocacy for social justice in education (Chan et al., 2019; Grimmer et al., 2017; Minton et al., 2021). It is through the process of educating students that many CE faculty find their hope of engaging students with the missions of counseling surrounding community engagement and mental health destigmatization (Hays et al., 2019; Prasath et al., 2021). This is also demonstrated in previous research exploring social justice advocacy through the MSJCC which helps counselors, at all stages of their development, focus on both “individual- and community-level change” (Ratts et al., 2016). CE have used this work to build in their programs the practice of multicultural awareness that leads to counselor self-efficacy and competence that transform the profession of counseling beyond the HEI (Binkley & Minor, 2021; Chang, 2022). Other research regarding HEI faculty has demonstrated strong correlations between servant leadership and empathy, performance, educational readiness, crisis leadership, readiness and teacher morale (Al-Asfour et al., 2022; Steels, 2022), other typical CE characteristics.

Furthermore, the lack of relationship between the between counselor professional identity, organizational stewardship, and social change advocacy and MH service provision may

have more to do with the ways in which CE define their job criteria. Counseling is a young profession that has only sought to define itself with distinction within the last decade (Kaplan et al., 2014). This lack of professional identity has made it complicated for CE to identify their job parameters, as well as determine where their professional obligations and opportunities lie (Calley & Hawley, 2008; Chan et al., 2019; Woo et al., 2016). Moreover, it could be said that counselor educators have struggled similarly, as with other mental health faculty, to create interprofessional opportunities because of conflicts related to lobbying and political opposition, in government and on campuses (Brady-Amoon & Keefe-Cooperman, 2017). These conflicts can interfere with collaborative efforts to engage in MH advocacy in campuses and may be an underlying cause for CE to focus efforts on outside community engagement.

Differences by gender identity existed between all three independent variables in this research study. The established differences in gender and professional identity have been attributed to the comfort with the specific aspect of leadership and engaging in promotion of the profession (Healey & Hays, 2012). To date, gender differences for the PISC have had inconsistent results due to population inconsistencies (Klein & Beeson, 2022; Woo et al., 2017). However, historically, the data on servant leadership has demonstrated more cohesion within genders due to the way in which it seeks to represent a balanced attention to gendered norms through its language and scaling (Reynolds, 2011). Importantly, in Barbuto and Gifford's (2010) study on gender with the SLQ, they did not find gender differences specifically with the Organizational Stewardship Scale. Ironically, the reason for some of the disparity with the outcomes for this measure of servant leadership may have something to do with how counselor educators intentionally engage with their professional identity and their intersecting cultural identities. To wit, there may be fluctuating cultural dynamics, including gender, within the

counselor educator profession, especially within faculty working in systemically oppressive HEI environments that are creating these interactions-- as several multicultural and social justice research studies have remarked (Chan et al., 2018; Davis, 2019; Hays et al., 2021; Woo et al., 2016).

Perhaps one of the more interesting highlights of the MH survey was the number of participants who stated that their work in MH service in the HEI carried a moral or ethical responsibility. The counselor identity is shaped by the moral foundations embedded in professional requirements from the first day of training (Forester-Miller & Davis, 1996). Concepts of autonomy, nonmaleficence, beneficence, justice, and fidelity continue to guide ethical principles that shape counselor relationship. However, there has been very little research studying CE morality outside of Woo et al.'s (2017) work to use measurable outcomes to demonstrate specific aspects of the counselor identity, especially professional knowledge and advocacy for the profession. One possible explanation for this result may be connected to the fact that the participants in this study were mostly new counselor educators. During this decade, there have been profound changes to the counseling profession to define itself even to the exclusion of its divisions, and updated CACREP accreditation standards that shape CE professional identity in terms of degree restrictions, job requirements, and training standards (Adkison-Bradley, 2013). Finally, other aspects that could have influenced a sense of moral obligation to MH participation is the time and place contexts of COVID-19 pandemic and changing systemic opportunities in HEI and in the job community that might impact how CE view the value of service and the responsibility they feel to their student populations.

## **Limitations of the Present Study**

As with all research, several limitations impact the findings of this study. The low response rate impacts the validity of the current findings. This survey took place immediately following the COVID-19 global pandemic which may have impacted participation rate. This survey relied on recruitment through email outreach and professional listserv, so it is unlikely all eligible participants received an invitation to participate. Consistent with previous research on counselor education, the population demographics of the survey were mostly female and white. Some demographic differences can be explained by the similarity between the independent variables and the population, as such there is a possibility that the difference in gender influenced the outcome of the study results. Additionally, the choice to participate in this study could have been due to self-selection bias which could indicate a level of passion for MH advocacy in HEI settings that could have interfered with the results of the data. Thus, there was a lack of variability in participant demographics also limited the ability to make comparisons between identity groups. Finally, some participants may have responded in a manner that made them appear more socially desirable because of the moral or ethical implications as noted throughout this discussion.

## **Implications for Counselor Educators**

Although it was anticipated that the research would return findings that indicated CE engage in MH service provision in their HEI, the present study truly sought to understand the aspects the ways in which CE work to improve student MH. It is critical to continue this exploration as times become more challenging due to environmental, economic, health and safety, and political challenges. Examining CE collaborative relationships may place CE in a better position to lead in their advocacy efforts within the hierarchy of the HEI setting.

Additionally, CE who take such positions can help highlight the ways in which organization and funding can be better utilized (Kalkbrenner et al., 2021). Additionally, focusing on these issues through interprofessional collaboration with other faculty may allow CE to positively impact student well-being.

It has been well established that student MH remains concerning. Rates of depression, anxiety and suicidality have increased for all students, but for students with more minoritized or marginalized identities, mental health concerns have nearly doubled since the onset of the pandemic (Lipson et al., 2022). Lipson (2022) noted that “Findings show that little progress has been made—and indeed a worsening of inequalities has occurred—when it comes to the mental health ‘treatment gap’ for racial/ethnic minority students” (p. 145). Moreover, when students encounter systemic oppression within their degree programs it impacts their ability to complete their degree program (Lederer et al., 2021; Lipson et al., 2015). The opportunity to impact dramatic change and bridge gaps in services while advocating for wellness and social justice is the work of CE and it is necessary now for the sake of these students. Providing ongoing MH support and services in demonstrable way for CE to lift up the marginalized voices of students with mental health needs (Chan et al., 2019). In this way they avoid professional pitfalls of performative allyship and use their power and privilege as leaders in the HEI community to amplify the voices of their students.

There are many ways CE can help change the culture of highly competitive programs and work to destigmatize MH. For example, at a large southern university, a partnership between a CE program and a college of law (COL) was formed to address the mental health needs of students because of high rates of depression, anxiety, addictions, and suicide. The collaborative aspects of this partnership included funding for one licensed professional counselor in the

counselor education doctoral program to serve as a graduate research assistant, providing mental health services, including counseling, wellness education programming, and a training session for faculty on warning signs and resources for high-risk mental health concerns. At the end of the first year of the partnership, students requested more counselors and resources, stating they liked having that service and felt that it was too finite. CE faculty advocated for more resources to continue the work to address ongoing mental health disparities in marginalized populations within the law school, especially as the COL had begun to increase diversity intentionally without changing any of their historically oppressive systemic issues related to ranking and curriculum. Results from subsequent MH assessments showed decrease in depression and anxiety, as well as no suicides, which were attributed to onsite mental health services. The partnership continues to evolve and grow with mutually beneficial gains.

Finally, counseling, as a profession, needs to maintain its focus on addressing professional distinction and identity development--not for the purpose of competition but for the purpose of collaboration. The future of the counseling profession starts with counselor education as CE are the educator-leader-advocates. It is their relationship to mental health advocacy that is modeled for future counselors. The HEI community needs to see the ways in which counselor identity impacts the overall wellness of the academic system and the discussion on mental health and destigmatization. Collaboration concerning MH is a natural extension of the counselor identity which could have an immediate impact on students in the HEI.

### **Future Research**

Despite the limited statistical results and the limitations of this research, several important observations can be drawn from the information gathered that highlight the need for continued exploration into CE engagement in mental health service provision in HEI.

Understanding the ways in which CE see themselves as collaborators in MH service provision would be a solid next step in exploring this complex issue. Many CE responded in the survey that one of the main ways they contribute to MH for students is in wellness advocacy. Thus, continuing to broaden the evidence base for how counseling wellness advocacy work impacts the student populations would benefit both HEI and CE programs. Additionally, more qualitative studies focusing on the reasons CE actively engage in MH provision at HEI would help to provide reasons for engagement and potentially create a way to direct professional advocacy efforts for faculty working in HEI. Further, explorations of other characteristics that may impact decision to be involved in MH services at HEI.

Future studies could also explore other factors that may impact MH provision at HEI by CE. For example, it would be helpful to understand if MH counseling background impacts the self-efficacy and confidence that CE faculty feel in engaging directly with student MH needs. It would also be beneficial to further explore the ways in which CE define the experiences working with college students from outside their programs or how that work impacts demands on their time or mental load. Finally, the definition of counseling needs more research in terms of how it impacts the development of moral and ethical responsibility within the professional identity. Conversations surrounding morality and ethics should continue to develop and shape the literature, including dissenting perspectives, as the profession deepens its commitment to multiculturalism and social justice advocacy.

## **Conclusion**

This research began as an examination of the relationship between CE MH work in their campuses and three leadership and advocacy identity factors. The findings of this research add to the developing areas of research that include CE community relationships and wellness

advocacy. While not statistically significant in showing differences between CE who engage in MH provision in their campuses, the results do demonstrate a consistency with CE professional identity that align with the direction and intention of the profession since Calley and Hawley's (2008) seminal article. Regardless of their participation in MH services in their HEI, CE from this survey demonstrated a high alignment between counselor professional identity, organizational stewardship in servant leadership, and multicultural and social justice advocacy. Additionally, CE, who had the opportunity to describe their participation in mental health services in their universities offered overwhelmingly consistent with doing so as a moral and ethical responsibility. However, future efforts should be directed at understanding how these philosophical alignments may be demonstrated as measurable outcomes for both CE and the students they serve in the HEI.

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## Appendices

### Appendix A. Sample Recruitment Letter

Dear Counselor Educators,

Thank you for taking the time to read about my study. My name is Kristen Carlosh, and I am a Ph.D. candidate in Counselor Education from the University of Tennessee, Knoxville. I am currently recruiting Counselor Educators (CE) for my dissertation survey entitled: *Predictors of Counselor Educators' Engagement in Mental Health Services in Higher Education Institutions*, and I am requesting your help. I have developed a survey of CE collaborative work to support mental health services in higher education institutions (HEI) for this study. Understanding CE engagement in mental health support services at their HEI may provide a platform for intentional leadership strategies to address gaps in mental health advocacy and address social justice disparities. To participate, you must a) be a counselor educator and b) have at least one year of experience working in higher education settings (i.e., community colleges, four-year colleges, universities, etc.).

There are no significant risks involved in participation, and you may discontinue the survey at any time without penalty. The study link will direct you to an informed consent agreement prior to survey items. Most participants can complete the survey in about XX minutes. As an incentive for signing up, upon completing the survey, you will have an opportunity to complete a separate Google Form to win one of three \$100 Visa gift cards.

If you have any questions about this study, you may contact Kristen Carlosh (Principal Investigator) at [kcarlosh@vols.utk.edu](mailto:kcarlosh@vols.utk.edu) or contact Dr. Melinda Gibbons, [mgibbon2@Utk.edu](mailto:mgibbon2@Utk.edu) (Dissertation Chair). If you have any questions regarding your rights as a research subject, you may contact the Office of Research, Innovation & Economic Development at the University of Tennessee, Knoxville at a) phone: 865-974-7697 or b) email: [utkirb@utk.edu](mailto:utkirb@utk.edu). Thank you for your time and consideration. Please feel free to share this email with anyone you know who meets the participation criteria.

Sincerely,

Kristen Carlosh

## Appendix B. Survey of CE Involvement in On-Campus Mental Health Services (SCEMHS)

I am interested in learning about the mental health service connections that you are involved with on your campus.

1. Are you currently involved in addressing mental health issues on your campus (i.e., providing direct counseling or wellness programming or indirect supervision, advocacy, research, prevention services)?\*
  - Yes
  - No
  - Unsure

*\*Conditional survey section for participants who answered yes to 1*

2. What type of mental health programming are you currently or previously involved with on your campus?
  - a. Direct programming. Select all that apply. (checkboxes)
    - Individual counseling
    - Group counseling
    - Wellness or psycho-educational programming
    - Other (specify)
  - b. Indirect programming. Select all that apply. (checkboxes)
    - Supervision of students who provide mental health services on campus
    - General advocacy for student wellness
    - Research on college student mental health on campus
    - Preventative programming
    - Other (specify)
3. Does the programming you are involved in serve the following? Select all that apply. (checkboxes)
  - Undergrad students
  - Graduate students
  - Special Populations
    - Specify: (please list the special populations you serve)
4. What specific topics/issues does your programming focus on? Select all that apply. (checkboxes)
  - Anxiety
  - Depression
  - Peer and intimate relationships
  - General wellness/health
  - Social justice/multicultural issues
  - Trauma
  - Other: (specify)
5. Briefly describe the MH programming at your HEI you are currently involved in (type of program, population, purpose). (long response) \_\_\_\_\_
6. What is your primary reason for being involved with MH programming at your HEI? (short response) \_\_\_\_\_

## **Appendix C. Professional Identity Scale in Counseling Short Form (PISC-S)**

Instructions: This 16-item inventory is developed to assess your thoughts and beliefs about the counseling profession and your professional identity. Please indicate your agreement with each statement by ranking your agreement on the following scale: Not at all, Somewhat, Neutral/Uncertain; Mostly, and Totally in Agreement

### **Factor I: Professional Knowledge**

1. K2. I am knowledgeable of the important events and milestones (e.g., establishing ACA, state-level licensure) in counseling history.
2. K5. I am familiar with accreditation organizations (e.g., CACREP: Council for Accreditation of Counseling & Related Educational Programs) and their standards for professional preparation.
3. K6. I am familiar with certification organizations (e.g., NBCC: National Board for Certified Counselors) and their requirements for credentials.
4. K7. I am familiar with professional counseling associations (e.g., ACA: American Counseling Association) and their roles and accomplishments in the profession.
5. K8. I am knowledgeable of professional counseling journals (e.g., JCD: The Journal of Counseling & Development, journal(s) relevant to my specialty area) and their contents' foci and purposes in the profession.
6. P1. I am able to distinguish the counseling philosophy from the philosophy of other mental health professions (e. g., counseling psychology, social work, and psychiatry).

### **Factor II: Professional Competency**

7. R6. I have completed professional training and standard education to perform my duties in my roles.
8. R7. I have professional knowledge and practical skills required to successfully perform my roles.
9. R9. I am knowledgeable of ethical responsibilities and professional standards relevant to my roles.

### **Factor III: Attitude Toward Profession**

10. A3. I value the advancement and the future of my profession.
11. A10. I am satisfied with my work and professional roles.
12. A12. As a counseling professional, I share my positive feelings (e.g., satisfaction) when working with people in other fields.

### **Factor IV: Engagement of Counseling Profession**

13. B2. I actively engage in professional counseling associations by participating in conferences and workshops every year.
14. B4. I engage in certification/licensure renewal processes (e.g., LPC: Licensed Professional Counselor, NCC: National Certified Counselor).
15. T4. I keep in contact with counseling professionals through training and/or professional involvement in counseling associations.
16. T5. I keep involved in ongoing discussions with counseling professionals about identity and the vision of my profession.

**Directions for scoring:** Sum the total scores for each of the factors.

\*Permission received on September 21, 2021, from the publisher via CCC RightsLink: “Taylor & Francis is pleased to offer reuses of its content for a thesis or dissertation free of charge contingent on resubmission of permission request if work is published.”

Citation: Woo, H., Lu, J., & Bang, N. (2018). Professional Identity Scale in Counseling (PISC): Revision of factor structure and psychometrics. *Journal of Counselor Leadership and Advocacy*, 5(2), 137–152. <https://doi.org/10.1080/2326716X.2018.1452078>

**Appendix D. Organizational Stewardship Subscale, Servant Leadership Questionnaire**  
**(OSS-SLQ)**

This questionnaire describes your leadership behaviors and attitudes as you perceive them. Please answer all of the questions. Please indicate how well each of the following statements describes you.

Use the following rating scale:

Not at All, 0

Once in a While, 1

Sometimes, 2

Fairly Often, 3

Frequently, If Not Always, 4

1. I do everything I can to serve others.
2. I believe that our organization needs to function as a community.
3. I see the organization for its potential to contribute to society.
4. I encourage others to have a community spirit in the workplace.
5. I am preparing the organization to make a positive difference in the future.

Citation: Barbuto, J. E., & Wheeler, D. W. (2006). Scale development and construct clarification of servant leadership. *Group & Organization Management*, 31(3), 300–326.  
doi:10.1177/1059601106287091. Used with the author's permission.

**Directions for scoring:**

Sum the total score for the attribute. High score: 20

## Appendix E. Advocacy Competencies Self-Assessment (ACSA) Survey©

**Directions:** To assess your own competence and effectiveness as a social justice change agent, respond to the following statements as honestly and accurately as possible, using the following ratings: Almost Never, Sometimes, or Almost Always.

1. It is difficult for me to identify client's strengths and resources.
2. I am comfortable with negotiating for relevant services on behalf of client/students.
3. I alert community or school groups with concerns that I become aware of through my work with clients/students.
4. I use data to demonstrate urgency for systemic change.
5. I prepare written and multi-media materials that demonstrate how environmental barriers contribute to client/student development
6. I distinguish when problems need to be resolved through social advocacy.
7. It is difficult for me to identify whether social, political and economic conditions affect client/student development.
8. I am skilled at helping clients/students gain access to needed resources.
9. I develop alliances with groups working for social change.
10. I am able to analyze the sources of political power and social systems that influence client/student development.
11. I am able to communicate in ways that are ethical and appropriate when taking on issues of oppression public.
12. I seek out and join with potential allies to confront oppression.
13. I find it difficult to recognize when client/student concerns reflect responses to systemic oppression.
14. I am able to identify barriers that impede the well-being of individuals and vulnerable groups.
15. I identify strengths and resources that community members bring to the process of systems change.
16. I am comfortable developing an action plan to make systems changes.
17. I disseminate information about oppression to media outlets.
18. I support existing alliances and movements for social change.
19. I help clients/students identify external barriers that affect their development.
20. I am comfortable with developing a plan of action to confront barriers that impact clients/students.
21. I assess my effectiveness when interacting with community and school groups.
22. I am able to recognize and deal with resistance when involved with systems advocacy.
23. I am able to identify and collaborate with other professionals who are involved with disseminating public information.
24. I collaborate with allies in using data to promote social change.

25. I assist clients/students with developing self-advocacy skills.
26. I am able to identify allies who can help confront barriers that impact client/student development.
27. I am comfortable collaborating with groups of varying size and backgrounds to make systems change.
28. I assess the effectiveness of my advocacy efforts on systems and its constituents.
29. I assess the influence of my efforts to awaken the general public about oppressive barriers that impact clients/students.
30. I lobby legislators and policymakers to create social change.

**Directions for scoring:** Score numbers 1, 7, and 13 first, and then record the score next to the corresponding number below:

Almost Never = 4 points

Sometimes = 2 points

Almost Always = 0 points

Then score the remaining items by recording the score next to the appropriate number.

Almost Always = 4 points

Sometimes = 2 points

Almost Never = 0 points

Total the number of points earned for each domain. Then, add the score earned for the six domains to determine your advocacy rating scale.

**Client/Student  
Empowerment**

1. \_\_\_\_\_  
7. \_\_\_\_\_  
13. \_\_\_\_\_  
19. \_\_\_\_\_  
25. \_\_\_\_\_  
Total: \_\_\_\_\_

**Community Collaboration**

3. \_\_\_\_\_  
9. \_\_\_\_\_  
15. \_\_\_\_\_  
21. \_\_\_\_\_  
27. \_\_\_\_\_  
Total: \_\_\_\_\_

**Public Information**

5. \_\_\_\_\_  
11. \_\_\_\_\_  
17. \_\_\_\_\_  
23. \_\_\_\_\_  
29. \_\_\_\_\_  
Total: \_\_\_\_\_

**Client/Student Advocacy**

2. \_\_\_\_\_  
8. \_\_\_\_\_  
14. \_\_\_\_\_  
20. \_\_\_\_\_  
26. \_\_\_\_\_  
Total: \_\_\_\_\_

**Systems Advocacy**

4. \_\_\_\_\_  
10. \_\_\_\_\_  
16. \_\_\_\_\_  
22. \_\_\_\_\_  
28. \_\_\_\_\_  
Total: \_\_\_\_\_

**Social/Political  
Advocacy**

6. \_\_\_\_\_  
12. \_\_\_\_\_  
18. \_\_\_\_\_  
24. \_\_\_\_\_  
30. \_\_\_\_\_  
Total: \_\_\_\_\_

**Advocacy Rating Scale:**

100-120 You're on the way to becoming a strong and effective social change agent.

70-99 You've got some of the pieces in place. However, you need to do some work to develop your competence in specific advocacy areas in order to be an effective social change agent.

69 & Below If you earn low scores in certain advocacy domains (e.g., client/student empowerment, systems advocacy), obtaining training in these areas can greatly improve your effectiveness as a social justice counseling advocate. If being an advocate at the client/student level is a low area, you can expand your repertoire by familiarizing yourself with feminist counseling principles and multicultural counseling competencies. If, however, low scores are in the majority of domains, you may want to reconsider your commitment to being a social justice advocate

Citation: Manivong J. Ratts, Ph.D., N.C.C. Seattle University, Department of Counseling and School Psychology and Dr. Amy Ford, Ph.D., Northwest Christian University, Department of Counseling, Eugene, OR.

## Appendix F. Demographics Questionnaire

**The following questions will collect basic information about you and your program of study.**

1. Please describe your race and ethnicity. Select all that apply. (checkboxes)
  - White or European American
  - Black or African American
  - American Indian or Alaska Native
  - Asian Indian
  - Asian
  - Hawaiian or Other Pacific Islander
  - Other race \_\_\_\_\_
  - Hispanic, Latinx
  - Other ethnicity \_\_\_\_\_
2. What is your age? (In ranges; dropdown)
  - younger than 26 years old
  - 26-30 years old
  - 31-35 years old
  - 36-40 years old
  - 41-45 years old
  - 46-50 years old
  - 50-50 years old
  - 46-50 years old
  - 51-55 years old
  - 56-60 years old
  - 61-65 years old
  - 66-70 years old
  - older than 71 years old
3. Would you please describe your gender identity? Select all that apply. (checkboxes)
  - Male
  - Female
  - Non-binary
  - Genderqueer
  - Transgender M/F
  - Transgender F/M
  - I don't label myself as anything
  - Other \_\_\_\_\_
4. Please select all the options that best describe your educational experience in graduate program. Select all that apply. (checkboxes)
  - Psychology Masters
    - Concentration: \_\_\_\_\_
  - Counseling Masters
    - Concentration: \_\_\_\_\_

- Social Work Masters
    - Concentration: \_\_\_\_\_
  - Other Masters \_\_\_\_\_
  - Specializations (please list) \_\_\_\_\_
  - Counselor Educator Doctoral Degree
  - Psychology Doctoral Degree
    - \_\_\_\_\_
5. Please select the current licenses you hold. (checkboxes)
- Licensed Professional Counselor (LPC)
  - Licensed Mental Health Counselor (LMHC)
  - Licensed Clinical Professional Counselor (LCPC)
  - Licensed Professional Clinical Counselor of Mental Health (LPCC)
  - Licensed Clinical Mental Health Counselor (LCMHC)
  - Licensed Mental Health Practitioner (LMHP)
6. Please provide your current job title. Select all that apply. (checkboxes)
- Graduate Teaching Assistant
  - Adjunct Instructor
  - Visiting Scholar
  - Clinical assistant professor
  - Clinical associate professor
  - Clinical full professor
  - Assistant Professor
  - Associate Professor
  - Full Professor
7. Please describe how long you have been working as a counselor educator?
- a. How many years have you been a counselor educator? (drop-down)
    - 1-5 years
    - 6-10 years
    - 11-15 years
    - 16-20 years
    - 21-25 years
    - 26-30 years
    - 31-35 years
    - 36-40 years
    - 41-45 years
    - 46-50 years
    - More than 50 years
  - b. How many years have you been with your current university? (drop-down)
    - 1-5 years
    - 6-10 years
    - 11-15 years
    - 16-20 years
    - 21-25 years

- 26-30 years
  - 31-35 years
  - 36-40 years
  - 41-45 years
  - 46-50 years
  - More than 50 years
8. Is the program where you work CACREP accredited? (y/n)
  9. Is your counseling program tied to the counseling center or a center that provides counseling services on campus?
  10. Is there a university expectation that the counseling program provide counseling and/or outreach to students?
  11. Which of the following best describes your program format (under normal circumstances/non-pandemic)?
    - a. Mostly or fully in person
    - b. Hybrid or mixed in person and online
    - c. mostly or fully online
    - d. other (please describe)
  12. Does your program run a training clinic for counselors-in-training? (y/n)
    - a. Does it serve the student population within your HEI community? (y/n)
    - b. Does it serve persons from your local community outside of your HEI? (y/n)
    - c. Does it serve a specific, special, marginalized, or minoritized community? (y/n)
      - If so, who? (open-ended)\_\_\_\_\_

## **Appendix G. Gratitude Remarks and Optional Survey Request**

Thank you very much for your participation in my research. If you would like to be entered into the drawing to win one of three \$50 Amazon gift cards, you may continue [insert hyperlink] to a Google Form where you can enter your contact information. The drawing is entirely optional, and you are under no obligation to participate.

If you would like to answer questions based on your experiences during the Global Pandemic, please click the link below to proceed with the additional survey questions (N=6). Again, this survey is entirely optional, and you are under no obligation to participate. Thank you so much for your time and consideration.

## **Appendix H. The Covid 19 Quality of Life Scale\* (COV19-QoL)**

Instructions: Please rate these items based on the following scale: totally disagree, mostly disagree, neutral, somewhat agree, completely agree.

1. I think my quality of life is lower than before.
2. I think my mental health has deteriorated.
3. I think my physical health may deteriorate.
4. I feel more tense than before.
5. I feel more depressed than before.
6. I feel that my personal safety is at risk.

\*Permission received from the author via a statement in the published journal article associated with the scale. <https://creativecommons.org/licenses/by-nc-nd/3.0/>

Citation: Repišti, S., Jovanović, N., Kuzman, M. R., Medved, S., Jerotić, S., Ribić, E., Majstorović, T., Simoska, S. M., Novotni, L., Milutinović, M., Stoilkovska, B. B., Radojičić, T., Ristić, I., Zebić, M., Pemovska, T., & Russo, M. (2020). How to measure the impact of the COVID-19 pandemic on quality of life: COV19-QoL: The development, reliability and validity of a new scale. *Global Psychiatry*, 3(2), 201–210. <https://doi.org/10.2478/gp-2020-0016>

## Appendix I. Table 1

**Table 1**

*Summary of Demographics*

| Characteristic                        | <i>n</i> | %    |
|---------------------------------------|----------|------|
| Gender                                | 73       | 100  |
| Male                                  | 21       | 28.8 |
| Female                                | 48       | 65.8 |
| Non-binary / third gender             | 3        | 4.1  |
| Transgender F/M                       | 1        | 1.4  |
| Race                                  | 72       | 98.6 |
| White or European American            | 52       | 71.2 |
| Black or African American             | 9        | 12.3 |
| American Indian or Alaska Native      | 3        | 4.1  |
| Asian Indian                          | 1        | 1.4  |
| Asian or Asian American               | 3        | 4.1  |
| Other                                 | 4        | 5.5  |
| Number of years as CE                 | 73       | 100  |
| 1-5 years                             | 33       | 45.2 |
| 6-10 years                            | 17       | 23.3 |
| 11-15 years                           | 7        | 9.6  |
| 16-20 years                           | 8        | 11.0 |
| 21+ years                             | 8        | 11.0 |
| Program CACREP                        | 73       | 100  |
| Yes                                   | 66       | 90.4 |
| No                                    | 7        | 9.6  |
| Program Clinic                        | 73       | 100  |
| Yes                                   | 37       | 50.7 |
| No                                    | 36       | 49.3 |
| University Expectation of MH Services | 73       | 100  |
| Yes                                   | 10       | 13.7 |
| No                                    | 53       | 72.6 |
| Unsure                                | 10       | 13.7 |

## Appendix J. Table 2

**Table 2**

*Summary of CE Involvement*

| Type of Programming                         | <i>n</i> | %     |
|---------------------------------------------|----------|-------|
| Direct Programming                          | 51       | 100%  |
| Individual Counseling                       | 18       | 64.7% |
| Group Counseling                            | 11       | 21.6% |
| Wellness/Psychoeducation                    | 27       | 52.9% |
| Other                                       | 9        | 17.6% |
| Indirect Programming                        | 51       | 100%  |
| Supervision of Student in Clinical Practice | 37       | 72.5% |
| General Advocacy for Student Wellness       | 36       | 70.6% |
| Research on College Student MH              | 23       | 45.1% |
| Preventative Programming                    | 24       | 47.1% |
| Other                                       | 5        | 9.8%  |

*Note. Results add up to more than 100% because participants could select multiple responses*

### Appendix K. Table 3

**Table 3**

*Independent Samples Tests for Demographic Variables*

| Gender Binary   | Male (n=21)        |           | Female (n=48) |           | <i>t</i> (67) | <i>p</i> | Cohen's <i>d</i> |
|-----------------|--------------------|-----------|---------------|-----------|---------------|----------|------------------|
|                 | <i>M</i>           | <i>SD</i> | <i>M</i>      | <i>SD</i> |               |          |                  |
| PISC-S          | 71.05              | 6.51      | 74.65         | 4.34      | -2.70         | 0.01*    | 5.09             |
| OSS-SLQ         | 20.62              | 3.14      | 22.23         | 2.25      | -2.41         | 0.02*    | 2.55             |
| ACSA            | 75.52              | 28.90     | 88.21         | 19.06     | -2.16         | 0.03*    | 22.46            |
| Current Title   | Asst. Prof. (n=26) |           | Other (n=37)  |           | <i>t</i> (61) | <i>p</i> | Cohen's <i>d</i> |
|                 | <i>M</i>           | <i>SD</i> | <i>M</i>      | <i>SD</i> |               |          |                  |
| PISC-S          | 72.88              | 4.01      | 74.30         | 5.21      | -1.16         | 0.25     | 4.75             |
| OSS-SLQ         | 22.08              | 2.43      | 22.11         | 2.34      | -0.05         | 0.96     | 2.38             |
| ACSA            | 86.62              | 21.82     | 85.62         | 21.92     | 0.18          | 0.86     | 21.88            |
| Training Clinic | Yes (n=37)         |           | No (n=36)     |           | <i>t</i> (71) | <i>p</i> | Cohen's <i>d</i> |
|                 | <i>M</i>           | <i>SD</i> | <i>M</i>      | <i>SD</i> |               |          |                  |
| PISC-S          | 73.43              | 4.75      | 73.64         | 5.69      | -0.17         | 0.87     | 5.23             |
| OSS-SLQ         | 21.11              | 2.63      | 22.47         | 2.42      | -2.30         | 0.02*    | 2.53             |
| ACSA            | 84.49              | 24.98     | 85.28         | 20.41     | -0.15         | 0.88     | 22.84            |

\**p* < 0.05

## Appendix L. Table 4

**Table 4**

*Descriptive Statistics and Correlations for Study Variables*

| Variable     | <i>n</i> | <i>M</i> | <i>SD</i> | 1     | 2      | 3      | 4 |
|--------------|----------|----------|-----------|-------|--------|--------|---|
| 1. MH in HEI | 73       | 1.30     | 0.462     | ~     |        |        |   |
| 2. PISC-S    | 73       | 73.53    | 5.199     | 0.140 | ~      |        |   |
| 3.OSS-SLQ    | 73       | 21.78    | 2.605     | 0.021 | .465** | ~      |   |
| 4. ACSA      | 73       | 84.88    | 22.68     | 0.102 | .425** | .518** | ~ |

\*\* . Correlation is significant at the 0.01 level (2-tailed).

## Appendix M. Table 5

**Table 5**

*Logistic Regression Analysis of MH Engagement with Each Independent Variable*

|           | Estimate | SE    | 95% CI L/U  | <i>p</i> |
|-----------|----------|-------|-------------|----------|
| MH in HEI | -4.775   | 4.173 |             | 0.253    |
| PISCS     | 0.067    | 0.062 | 0.946/1.208 | 0.286    |
| OSSSLQ    | -0.079   | 0.123 | 0.725/1.176 | 0.519    |
| ACSA      | 0.009    | 0.014 | 0.981/1.037 | 0.542    |

## **Conclusion**

College student mental health can impact student learning and development, educational success and completion, and future opportunities in job marketplace. Existing university programs have become overwhelmed by students' requests for services and support through increasingly stressful and uncertain times. The pandemic has only made it more difficult, especially for those who have been marginalized by prejudice, stereotyping, and violence. Counselor educators' focus on the development of mental health training positions them to engage with the university as leaders and advocates for their students' success. While there is a consistent theme in the literature regarding counselor educators' work to establish healthy clinical partnerships, emerging interprofessional collaboration and advocacy efforts are areas of new research for counselor educators. This dissertation offered both a practical set of steps that counselor educators could take to contribute meaningfully to their universities and an examination of the relationship between counselor educator identity and their possible involvement in addressing the mental health needs of students.

I intend for both of these manuscripts to support the continued efforts of CEs to engage in these types of activities and to help them recognize their work and define their contributions to their universities. Work that allows developing knowledge on prevention and intervention for mental health issues and disorders, especially concerning wellness and holism. The conversation Counseling is still a young profession compared to more established mental health professions. These efforts have the potential to create more recognizable outcomes for students' mental health and counselors in training. Additionally, they could help shape the knowledge and literature on wellness and lend distinction to the counseling profession. With a future of well-informed

clients, a clear path of advocacy and clarity of purpose can illustrate the power and efficacy of counselor education.

## **Vita**

Kristen Carlosh is a first-generation college student and a McNair Scholar. Kristen completed a Bachelor of Arts in Psychology and a Master of Arts in Dual Track for School and Clinical Mental Health Counseling at East Tennessee State University. After working as a school counselor in Washington County, Tennessee, she completed her licensure requirements for the State of Tennessee, working in crisis mental health. There, she developed a passion for educating wellness according to counseling principles. She then chose to pursue a Doctor of Philosophy degree in Counselor Education at the University of Tennessee, Knoxville, focusing on Evaluation, Statistics, and Measurement. Her research interests center around equitable mental health advocacy through the lens of the counselor's professional identity and the development of interprofessional relationships that bridge resources and services to people in need. Following graduation, she will continue her work as a mental health advocate, working in private practice and in leadership in online communities while providing education and supervision to the next generation of counselors.