AAVMC WELLBEING

# Guidelines for Embedded Counseling Programs

**AAVMC Guidelines for Embedded Counseling Programs Working Group**

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## 1. INTRODUCTION

Research has shown that veterinary trainees may be at risk for experiencing mental health problems.[1–11] Veterinary students may not be significantly different than other college students in terms of their mental health needs,[11,12] but they have cited numerous barriers to seeking professional help, including mental health stigma, financial constraints, difficulty scheduling services, and perceived lack of time to attend appointments.[13]

In order to improve access to mental healthcare for students, many universities have established embedded counseling programs in which mental health providers are housed in strategic locations around campus or within specific colleges or professional programs.[14–16]

Embedded counseling services have become common in colleges of veterinary medicine (CVMs).[17] They may offer several benefits, including:

- Flexibility for students scheduling appointments around courses or clinical rotations[17–20]
- Reducing stigma and normalizing help-seeking behaviors[17,20]
- Adapting clinical services to fit the unique needs of the student body[17,18,20]
- Developing wellbeing initiatives that may improve the learning environment[14]

On-campus counseling services promote academic retention among students experiencing mental health concerns,[21–23] and participating in embedded counseling services has been associated with reductions in psychological distress among veterinary students and house officers.[11]

## 2. PURPOSE AND AUDIENCE

Although embedded counseling programs are prevalent in CVMs, there are few guidelines available to assist embedded mental health providers (EMHPs) and stakeholders in developing and sustaining these services.

These guidelines are intended to serve as a shared reference to identify how these roles may operate in CVMs, support EMHPs in developing effective and ethical services, and assist administrators and operational partners in establishing consistent and practical expectations. CVMs utilizing this document could be at various stages of considering or implementing embedded counseling programs.

These guidelines are not intended to be mandatory or exhaustive and may not apply to every setting or situation. They also do not articulate all requirements in full or constitute legal advice. EMHPs should be aware of the professional practice standards and legal, ethical, and institutional requirements for their roles.

## 3. ESTABLISHING EMBEDDED COUNSELING SERVICES

When developing an embedded counseling program, CVMs should:

- Identify qualified mental health providers
- Consider organizational and supervision structures that support EMHPs and fit the needs of the program
- Secure sustainable funding
- Develop clear and appropriate expectations regarding roles and responsibilities for EMHPs and stakeholders

Failure to adequately address these areas can create significant challenges for an embedded counseling program, including unclear roles and responsibilities, insufficient support and supervision of EMHPs, funding instability, difficulty delivering consistent and effective service, and potential risk of litigation for the CVM or larger university system.

### Mental Health Provider Qualifications

Mental health providers with a variety of professional experiences and credentials may effectively provide embedded counseling services in CVMs. They should possess the proper credentials and training to practice and have a thorough understanding of legal and ethical standards for providing clinical mental health services. In the United States, the only professionals legally permitted to provide clinical mental health services are independently licensed or license-eligible individuals with graduate-level training in a mental health-related field. Other jurisdictions may have different regulations. Specific licensure titles and their license-eligible equivalents may differ by jurisdiction and could include:

- Licensed psychologists
- Licensed clinical social workers
- Licensed professional counselors
- Licensed marriage and family therapists

*Independently licensed* refers to a mental health provider who is authorized by their state board to provide clinical mental health services without mandatory oversight or supervision by another mental health provider. *License-eligible* refers to a mental health provider who has completed appropriate graduate training and is in the process of seeking licensure for independent practice while completing clinical hours under the direction of an approved supervisor.

If CVMs employ EMHPs who are not independently licensed, they will need to allow sufficient time for the EMHPs to receive clinical supervision. In this situation, CVMs may also need to allocate financial resources to provide compensation for the EMHPs' clinical supervisor, if supervision is not included as part of an agreement with a campus partner.

CVMs are encouraged to include a licensed mental health provider on hiring committees to help screen candidates and assess their training experiences and license eligibility. CVMs should also consult with general counsel and/or other university mental health partners to ensure that job postings and provider qualifications for positions are consistent with ethical, jurisdictional, and institutional requirements. CVMs should prioritize candidates with training in evidence-based practices and relevant professional experiences.[24–26]

### Supervision Structure

Administrative and clinical supervision structures may depend on organizational partnerships. Some EMHPs may only be affiliated with their CVMs, while others may have joint affiliations with university counseling centers, student health centers, or other academic departments. For administrative purposes, EMHPs often report to deans of student or academic affairs, or similar positions, in their CVMs, but those with joint affiliations may also report to university counseling center or student health center leadership for administrative and clinical oversight.[17]

EMHPs who are only affiliated with their CVMs may have more procedural flexibility in some circumstances. Alternatively, joint affiliations may offer clinical supervision opportunities for EMHPs in the process of completing licensure requirements, opportunities for consultation and training, pre-established clinical policies, and broader referral options. With joint affiliations, it may be necessary for EMHPs to modify pre-established processes to improve efficiency for clients in the CVM.

### Funding and Resources

CVMs should consider ways to sustainably fund embedded counseling programs, which may include EMHPs' salaries, professional development and licensure fees, electronic medical record services, office space, technology support, and budgets for mental health programming. Insufficient or unstable funding may limit a program's ability to retain qualified EMHPs, maintain necessary infrastructure and resources, and provide consistent mental health services over time.

Funding sources may depend on whether EMHPs are only affiliated with their CVMs or if they have joint affiliations with other organizations on campus. Funding sources may also influence clinical service eligibility for prospective clients. If embedded counseling programs are funded primarily through student fees, access to clinical services may be limited to those who have paid such fees, whereas funding from general operational budgets may not have the same restrictions.

### Workload and Time Allocation

CVM administrators, EMHPs, and other involved parties should collaborate to determine reasonable workloads and ensure mental health providers have adequate time to devote to various aspects of their professional roles. International Association of Counseling Services[27] guidelines suggest full-time university and college mental health providers in predominantly clinical roles should spend 65% or less of their time in direct service, which may include providing counseling, assessment, or consultation services.

The remainder of their time may be dedicated to non-direct service activities, including completing clinical documentation, case management, administrative tasks, research, developing and providing presentations, or professional development.

Decisions regarding time allocations may consider access to support staff, priorities of the CVM, provider wellbeing, and clinical, administrative, and programming responsibilities.

### Memorandum of Understanding

CVMs are encouraged to develop a memorandum of understanding (MOU) in collaboration with EMHPs and other relevant stakeholders, such as university counseling centers or student health services. The purpose of the MOU is to explicitly define the roles and responsibilities of all parties involved to minimize potential conflicts and promote ethical, sustainable services. The MOU may describe:

- Responsibilities for funding and salary adjustments
- Supportive resources
- Supervision
- Expectations regarding clinical caseloads
- Typical work hours
- On-call or crisis responsibilities
- Expectations for scope of services

The MOU may contain provisions to limit providers' involvement in activities that could increase the likelihood of ethical violations, impair objectivity, or damage the therapeutic relationship with current or prospective clients, such as:

- Providing mandated counseling
- Conducting evaluations to determine a student's readiness to return to school following a leave of absence
- Serving on readmissions or disciplinary committees
- Formal advisory roles or teaching assignments that include direct evaluative authority over students or trainees.

Relevant practice standards should be discussed preemptively with organizational partners when developing an MOU, but EMHPs should also be diligent in educating faculty, staff, administration, and trainees about providers' ethical and legal obligations as new situations present. It is imperative that these expectations remain clear, as misunderstandings may create ethical and legal risks for both the EMHP and the CVM.

### Clinical Policy Manual

EMHPs are encouraged to develop a clinical policy manual to promote consistency in practices and continuity of the embedded counseling program in the event of staff turnover.

The clinical policy manual will differ between programs. It may include a mission statement, descriptions of the roles and responsibilities of EMHPs, a list of services offered, eligibility and service limitations, policies regarding client scheduling and attendance, standards regarding documentation and record retention, case management procedures, protocols for referrals, and policies pertaining to risk assessment and crisis response.

The clinical policy manual may also include templates for documentation, email correspondence, or clinical forms.

### Distributing Information About Services

Information about embedded counseling services should be easily accessible to the CVM community, preferably in an online format. It may include information about:

- Service eligibility
- Instructions for scheduling appointments
- Contact information for emergency and non-emergency mental health services
- Frequently asked questions
- Information regarding services offered and their limitations
- Links to other wellbeing resources

To establish expectations and help connect students to resources efficiently, EMHPs may choose to list examples of presenting concerns that could be most effectively addressed within an embedded counseling model, presenting concerns that may warrant longer-term or off-campus referrals, and services that are not offered.

Information about embedded counseling services can also be provided during orientation programming for the CVM community or during regularly scheduled trainings. CVM leadership can support awareness and utilization of EMHP services by encouraging faculty, staff, and trainees to become familiar with and promote available resources.

## 4. OPERATIONS

EMHPs should consider a variety of operational factors, including:

- Setting up office space to ensure both accessibility and privacy
- Establishing record-keeping practices that are consistent with standards of care and applicable rules and statutes
- Establishing client scheduling protocols
- Developing policies and procedures for crisis response and referrals
- Navigating provider leave

Careful attention to these operational factors supports accessible, consistent, and responsible delivery of mental health services while helping to mitigate risks related to data security, ethics, and regulatory compliance.

### Office Setup and Privacy

EMHPs' offices should be comfortably furnished and large enough to accommodate the services they offer. Offices should be easily accessible to clients, while at the same time ensuring privacy. It may be best to locate offices away from heavily trafficked areas, lectures halls, or administrative offices, and consider effective sound mitigation strategies.

### Technology and Record Keeping

CVMs and EMHPs should work with their campus IT departments to ensure that office equipment and technology protocols are in line with all relevant standards regarding protected health information in the jurisdictions in which EMHPs are practicing.

EMHPs typically need:

- A secure computer that is able to run an office software suite and software for clinical documentation
- An external or integrated camera capable of transmitting video, and a secure virtual meeting platform that meets privacy and security standards
- A private printer for session preparation or other clinical tasks
- Locking filing cabinets or other storage solutions that meet security standards of relevant privacy laws
- Secure methods for transmitting confidential client information

EMHPs are encouraged to maintain confidential client records using electronic health record (EHR) software, such as Titanium Schedule, Point and Click, SimplePractice, Medicat, or similar platforms. EHRs have several benefits, including improving data security and accessibility, reducing clinical errors, enhancing efficiency, and making it easier for mental health providers to integrate clinical progress monitoring measures into their practices.[28–31]

CVMs and EMHPs may be able to collaborate with university counseling or student health centers, as well as their IT departments, to determine if site licensing or other agreements may make EHR systems feasible for their programs.

If an EHR system is not accessible and EMHPs maintain paper records, they should be aware of requirements in their jurisdictions regarding controlled access, safeguarding records during transport, and record retention and disposal.

EMHPs are encouraged to use standardized clinical outcome measures, such as the Counseling Center Assessment of Psychological Symptoms (CCAPS)[32,33] or other instruments throughout the counseling process to track clients' progress. There are numerous benefits to incorporating progress monitoring measures into clinical practice, including:

- Improving mental health providers' conceptualization and clinical judgment[34,35]
- Monitoring safety concerns[36]
- Promoting client self-awareness[36]
- Improving counseling effectiveness[37,38]
- Informing policies and funding decisions regarding mental health programming[17,36,39]

EMHPs are also encouraged to collect data on rates of service use, attendance, wait times, and client satisfaction to improve programming and inform resource-allocation decisions.

### Scheduling

EMHPs should establish an efficient system for scheduling clients and administering appropriate forms prior to initiating clinical services, as unclear or inefficient processes may delay access to care or create confusion about the availability of services. Decisions regarding scheduling protocols depend on resources that are available. EMHPs may use online scheduling tools or email accounts established specifically for scheduling purposes. If email is used for scheduling, limits to confidentiality should be clearly explained, EMHPs should specify when the account will be monitored, and other resources should be provided for after-hours support.

Some EMHPs may offer appointments outside of typical business hours.[17] While flexible scheduling may improve access for some students, CVMs are encouraged to ensure that didactic and clinical absence policies support students attending mental health appointments during regular business hours. EMHPs who provide services outside of regular business hours should also consider implications for clinical consultation, supervision, and crisis-response resources.

Telehealth services may also be an option,[40] depending on clients' preferences and clinical needs. Students tend to view telehealth services as convenient and accessible,[41,42] and studies have supported their effectiveness[42,43] for mental health concerns. EMHPs offering telehealth services should be aware of relevant statutes in their jurisdictions and the potential limitations of remote delivery.

### Crisis Response

Crisis response is a shared institutional responsibility and should not depend primarily on the availability of the embedded provider. EMHPs should work with their CVMs and other partners to develop clear protocols regarding how to respond if a student or trainee is in crisis or needs immediate care. This may include defining what constitutes an imminent crisis or emergency versus a non-emergency concern and identifying situations that may warrant a welfare check or intervention from law enforcement or emergency medical services.

The crisis response protocol should clearly delineate parties to contact in various scenarios and identify services that are available on campus or in the community, depending on the level of intervention that is needed. In many cases, EMHPs may not be able to respond quickly and consistently in crisis situations, due to scheduling conflicts or being unavailable. Therefore, crisis response protocols should clearly identify alternative resources available for urgent concerns. Partnerships with established crisis resources are strongly recommended. Ensuring that faculty, staff, and trainees are aware of these protocols and supportive resources that are available will help ensure consistent expectations and prompt access to services.

EMHPs should be aware of ethical considerations regarding privacy, autonomy, and self-determination involved in initiating contact with clients in crisis situations.[44–47] Prospective clients need to provide full informed consent, and this should be documented, prior to establishing clinical mental health services. Because informed consent carries both ethical and legal obligations, EMHPs should ensure that their practices meet applicable laws, regulations, licensing requirements, and professional standards. EMHPs should also have established policies and procedures regarding transportation and hospitalization for clients in situations involving imminent risks of serious harm to self or others.

### Referrals

EMHPs may refer clients to additional resources on campus or in the community when longer-term care or specialized services are warranted. EMHPs are encouraged to maintain an up-to-date database of local, regional, or online mental health resources, which may include options for longer-term counseling, inpatient and intensive outpatient services, psychological testing, and medication management.

It may also be helpful to include information regarding:

- Accepted insurance plans
- Telehealth services
- Evening and weekend availability
- Reduced fee options
- Providers who offer specialized services

When providing referrals, EMHPs should offer several options based on clients' specific needs and preferences, and document referral discussions in the clinical record.

### Provider Leave

CVMs should establish plans and policies to ensure that clients have access to mental health resources when EMHPs are on leave or are unavailable.

## 5. SCOPE OF SERVICES

CVMs and EMHPs should determine the scope of services offered, including making decisions regarding service models, the types of clinical and non-clinical services provided, and the populations eligible to participate in certain services. An unclear or overly broad scope of services can create unrealistic expectations, strain available resources, and make it difficult for EMHPs to provide services within the boundaries of their roles and competencies. These decisions should be made in consideration of local needs and resources, funding sources, and ethical standards. Therefore, the services provided and populations served by EMHPs may differ between CVMs.

### Clinical Services

***Service Models.*** The service models used by EMHPs, including session limits, may be considered in the context of clinical demands, scholarly literature, and available resources. A survey of EMHPs in CVMs[17] found approximately half reported they did not impose specific session limits for counseling services. However, they tended to describe their service models as brief or time-limited.

In general, research shows that there tends to be a positive association between the number of counseling sessions clients attend and subsequent reductions in psychological distress, within the context of time-limited treatment models.[48,49] Clients presenting with more significant symptoms may also require additional sessions to respond favorably to treatment.[48,50] Data suggest clients who attend counseling sessions weekly, versus less frequently, may be more likely to experience symptom recovery[51] and demonstrate clinically significant improvements sooner.[51,52] Therefore, it may be important for EMHPs to consider the pros and cons of various approaches and exercise flexibility when it is warranted, while at the same time ensuring there are sufficient resources to sustain the service models.

EMHPs will typically terminate counseling when clients' treatment goals are achieved, service limits are reached, or clients need additional resources to continue demonstrating improvements. *Termination* involves reviewing clients' progress toward identified goals, processing the ending of the therapeutic relationship, solidifying insights and skills, and planning for the future. Depending on the service model, EMHPs may also discuss options for continued support, including the possibility of scheduling follow-up appointments if resources allow.

***Individual Counseling.*** EMHPs tend to offer a variety of services, most of which focus on delivering direct clinical interventions to clients, such as individual counseling or psychotherapy. In this context, the term *client* refers to the person receiving counseling services.

While some veterinary students and trainees may seek counseling to address academic concerns, other common presenting issues include stress, anxiety, depression, perfectionism, sleep difficulties, family and relationship distress, eating and body image concerns, career development, grief/loss, trauma, and adjustment issues.[11] Counseling may involve meeting with a client on one occasion to address a specific problem, or meeting on a regular basis (e.g., weekly or biweekly) to address identified

goals. The frequency and duration of individual counseling services may depend on clients' clinical needs, service models, and EMHPs' resources.

***Crisis Counseling.*** EMHPs may offer crisis counseling,[17] which involves providing immediate interventions to support a client experiencing acute distress, assessing safety risks, focusing on coping skills to promote stabilization, and connecting clients with other resources if they need a higher level of care.

In many CVMs, offering crisis or walk-in services is not feasible due to resource constraints. CVMs should develop clear protocols regarding how to respond if a student or trainee needs immediate care, to ensure consistent expectations and prompt access to services for those in distress.

***Couples Counseling.*** In addition to individual interventions, some EMHPs may offer couples counseling.[17] Couples counseling involves an EMHP meeting with both partners simultaneously to address problems within and between clients that affect their relationship.

EMHPs offering these services should have appropriate training and competency in couples interventions.[44–47] They should also be aware of potential ethical challenges or liability risks, such as when the EMHP might have a pre-existing relationship with an individual (e.g. previous individual counseling with the EMHP) in the dyad or one of the clients is not affiliated with the university. In some cases, programs without multiple EMHPs may not be able to effectively mitigate risks or attend to ethical dilemmas that may occur, since they would not be able to provide both individual and couples counseling for the same client.

***Group Counseling.*** EMHPs with appropriate training[44–47] may provide group counseling,[17] which involves providing counseling to several clients simultaneously. Although group counseling has been shown to be effective in treating a variety of mental health concerns,[53,54] in an embedded model, there is a higher likelihood of pre-existing relationships between group members or between group members and EMHPs, which could pose ethical challenges or interfere with elements of treatment.[55]

These issues may be less salient in psychoeducational groups, which tend to be structured and focus on teaching group members practical skills, versus process-orientated groups, which tend to include disclosures about thoughts, feelings, and interpersonal patterns.

***Access to Clinical Services.*** DVM students are the most common client population served by EMHPs,[17] and they are typically eligible to participate in available clinical services. CVMs hosting DVM students while they complete clinical training toward their degrees at another institution may also have agreements in place to allow them to access clinical services through the embedded counseling program.

In many CVMs, graduate students completing master's or doctoral degrees and house officers completing internship or residency programs may also be eligible for clinical services, but this may depend on funding sources and clinical case capacities.

EMHPs should also consider how to manage continuity of care in the event of enrollment changes, such as when a student or trainee takes a leave of absence or if they are dismissed from an academic program. Clear policies can help prevent unexpected disruptions in care and reduce uncertainty for both clients and providers when eligibility for services changes. These policies should be developed in consultation with the CVM, counseling center or student health center administrators, and general counsel, since enrollment status may impact funding sources or professional liability.

EMHPs should also develop policies regarding mandated counseling, which involves a third-party conditionally requiring an individual to initiate services. Mandated services are ethically complicated, due to issues surrounding client autonomy, informed consent, and dual relationships.[56]

Most EMHPs do not offer clinical services to individuals who are not affiliated with or enrolled in CVM training programs[17] and would typically refer to other established resources. Likewise, most EMHPs do not offer clinical services to faculty or staff affiliated with the CVM and may provide referrals to an Employee Assistance Program (EAP) or options in the community.

In addition to prioritizing resources for veterinary trainees, this decision recognizes the ethical risks associated with EMHPs developing a therapeutic relationship with a person while also maintaining a collegial relationship. While multiple relationships are sometimes unavoidable for EMHPs and they are not inherently unethical, ethical standards broadly dictate that EMHPs should refrain from entering into multiple relationships if they could impair objectivity, reduce clinical effectiveness, result in exploitation, or otherwise cause harm.[44–47]

For similar reasons, EMHPs are cautioned against providing clinical mental health services to veterinary teaching hospital clients (i.e., pet owners) if they are also involved in providing clinical services to DVM students or house officers. In many CVMs, supportive services for veterinary teaching hospital clients are primarily offered by veterinary social workers or other providers with focused roles.

### Consultation

EMHPs may offer brief consultation services to trainees, other members of the CVM community (e.g., faculty or staff), or those affiliated with trainees (e.g., friends, partners, or family members) about situations pertaining to trainee mental health, even if these individuals would not be eligible for clinical services.[17] Client populations eligible to

participate in clinical mental health services would usually also be eligible for brief consultation services if they are offered. In these situations, EMHPs should take reasonable steps to promote objectivity, including speaking in terms of hypothetical scenarios, rather than about specific individuals.

### Psychoeducational Programming

In addition to providing direct clinical services, EMHPs may be involved in developing and delivering non-clinical psychoeducational programming about topics related to mental health and wellbeing, including stress management, suicide prevention, compassion fatigue, mental health literacy, mindfulness meditation, healthy relationships, interpersonal effectiveness, test anxiety, grief and loss, learning strategies and study skills, human-animal bond, and diversity.[17]

Psychoeducational programming may provide opportunities for the CVM community to learn about topics that may not be covered in veterinary medical curricula and provide information and tangible skills for those who may not otherwise engage in mental health services.

Psychoeducational programming could be delivered during orientation sessions, in coordination with student groups, or within academic courses or clinical rounds sequences. If EMHPs are delivering content as part of a formal course, they should be aware of ethical standards regarding multiple relationships and should not assume a direct evaluative role in the course.

Developing and providing educational programming or outreach presentations can be resource-intensive, and these opportunities may be limited by EMHPs' clinical demands, areas of competency, or logistical constraints. EMHPs are encouraged to collaborate with campus partners to maximize resources if similar programming is available outside of the CVM.

EMHPs should consider the pros and cons of delivering presentations to mixed audiences, depending on the content and goals of the presentation. Trainees may sometimes be less likely to participate in facilitated discussions if faculty members are also present, but in some situations, faculty engagement can signify institutional support for mental health and wellbeing initiatives.

## 6. SYSTEMIC WELLBEING

While EMHPs play an essential role in supporting mental health and wellbeing within the CVM, individual clinical services alone are insufficient to address all factors that contribute to wellbeing. Systemic interventions are also necessary and may include policy changes to reduce structural stressors, modifications to curricula, leadership development, or initiatives that foster a more inclusive and supportive institutional culture.

Responsibility for implementing system-level changes typically rests with administrators and other institutional leaders who have the authority and resources needed to evaluate and modify organizational structures, policies, and practices. EMHPs may provide valuable consultation and insight to inform these efforts, but they should not be solely responsible for leading or implementing comprehensive organizational wellbeing initiatives.

## 7. SUSTAINING EMBEDDED COUNSELING SERVICES

EMHPs within CVMs may be associated with unique challenges, such as a sense of isolation from other mental health providers, role ambiguity and boundary confusion, and difficulties offering clinical services within the context of complex organizational cultures with established norms.[14,17] Embedded counseling programs also tend to have significant staff turnover.[14] To ensure the effectiveness and long-term sustainability of embedded counseling programs, the following are essential:

- Access to clinical and professional consultation resources
- Thoughtful planning regarding EMHP onboarding
- Professional flexibility
- Ongoing advocacy and communication with administrators

### Support

Some EMHPs have reported experiencing isolation in their roles, especially if they are functioning as the sole EMHP in their CVMs.[17] This may be mitigated by participating in opportunities to connect with other EMHPs through the AAVMC Academic Wellbeing Professionals Community and/or by pursuing local options for peer supervision, clinical consultation, or professional staff meetings.

Since these opportunities are important for both clinical care and staff retention, administrators are encouraged to work collaboratively with EMHPs to ensure they have adequate time to pursue and maintain professional relationships and support.[14,17]

### Onboarding

It is recommended that EMHPs have a dedicated onboarding period before they take on clinical or administrative responsibilities to allow adequate time for meeting campus partners, orienting themselves to CVM facilities and academic programs, and learning or developing clinical policies and procedures.

If an EMHP is starting the position when another provider is leaving, CVMs are strongly encouraged to allow time for both providers to review policies and procedures, address questions that may emerge, and ensure that service terminations or client transfers are managed in a way that ensures continuity of care and is in line with current ethical practice standards.[44–47] Mentorship may help promote consistency in the program and ensure that new EMHPs have the best chances of being successful in their roles.

### Flexibility

EMHPs may experience significant stress associated with heavy administrative and clinical workloads, as well as perceived pressure to be constantly available to their CVMs.[14] Therefore, EMHPs are encouraged to be flexible when adapting clinical protocols to promote efficiency and meet clients' needs, while also maintaining ethical and professional standards. Factors to consider could include:

- Flexible attendance policies for clients
- CVM-specific appointment types
- Streamlined documentation procedures
- Service eligibility requirements for clients
- Comp time for EMHPs' work completed outside of regular hours

### Advocacy and Education

Strong institutional support and role clarity are important factors for the longevity of EMHPs and the success of embedded programs. EMHPs may need to engage in ongoing advocacy and education with CVM leadership to promote understanding of the value of embedded mental health services and the resources necessary to sustain them. Advocacy efforts may include raising awareness around:

- The role of EMHPs and their scope of services
- Current status and effectiveness of embedded mental health programming
- The staffing, operational, and institutional resources needed to support effective embedded mental health programming

As mental health needs, services, and institutional priorities evolve over time, ongoing engagement with leadership can help ensure that embedded programs remain appropriately resourced, integrated into the broader CVM mission, and responsive to the needs of the community.

## 8. SUMMARY

The fundamental purpose of this document is to provide support and direction to EMHPs and CVM administrators involved in developing and sustaining embedded counseling services. These guidelines are based on university counseling practice standards, scholarly literature, and the experiences of the authors, and they are not intended to be mandatory or exhaustive. CVMs may apply them flexibly to fit their specific needs and resources, while also ensuring adherence to ethical and legal standards. Readers of this document are invited to reach out to AAVMC, the authors, and the AAVMC Academic Wellbeing Professionals Community for additional support and guidance on any questions or concerns that may arise.

## RECOMMENDED CITATION

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